A FRAMEWORK FOR THE DEVELOPMENT OF A POST-GRADUATE DIPLOMA PROGRAMME IN MENTAL HEALTH

by

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DECLARATION

I hereby declare that the work submitted here is the result of my own independent investigation. Where help was sought it was acknowledged. I further declare that this work is submitted for the first time at this University/Faculty towards a Ph.D. degree in Health Professions Education and that it has never been submitted (in part or as a whole) to any other University/Faculty for purposes of obtaining a degree.

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LIST OF ACRONYMS

CBT:	Cognitive Behaviour Therapy
CHE:	Council on Higher Education
CMSA:	College of Medicine in South Africa
CT:	Computed Tomography
DoE:	Department of Education
DoH:	Department of Health
DSM:	Diagnostic and Statistical Manual
EEG:	Electroencephalography
ETQA:	Education and Training Quality Assurer
FCPsych:	Fellow of the College of Psychiatrists
FET:	Further Education and Training
HEQC:	Higher Education Quality Committee
HEQF:	Higher Education Qualifications Framework
HPCSA:	Health Professions Council of South Africa
ICD:	International Classification of Disease
MPA:	Medico-Psychological Association
MRI:	Magnetic Resonance Imaging
NSB:	National Standards Bodies
NQF:	National Qualifications Framework
OBE:	Outcomes-based Education
OBET:	Outcomes-based Education and Training
ODL:	Online Distance Learning
PDA:	Personal Digital Assistant
PET:	Positon Emission Tomography
PGDipMH:	Post-graduate Diploma in Mental Health
PHC:	Primary Health Care
RAM:	Random access memory
RPL:	Recognition of prior learning
SAQA:	South African Qualifications Authority
SGB:	Standards Generating Body
SOLO:	Structure of the Observed Learning Outcome
UFS:	University of the Free State
VLE:	Virtual Learning Environment
WHO:	World Health Organization
WWW:	World Wide Web

SUMMARY

- **Key terms:** Adult learning; blended learning; **c**urriculum; Delphi Technique; E-learning; higher education; Mental health; Outcomes-based education; post-graduate education; Primary Health Care; programme; Psychiatry

This research was undertaken to develop a framework for a Post-graduate Diploma Programme in Mental Health. The paucity of psychiatrists in South (and Southern Africa) and the absence of tuition for doctors planning to obtain a Diploma in Mental Health from the college of Medicine in South Africa necessitated the study.

The overall goal of the study was to provide a framework whereby members of the medical profession could embark on formal post-graduate training, on a part-time base, utilising blended learning mode (including face to face contact sessions, directed learning and e-learning), that would support the requirements of the National Qualifications Framework (NQF), the College of Medicine, and the Professional Boards.

The specific objectives of the study were to conceptualise and contextualise the problem of the absence of training for a Post-graduate Diploma in Mental Health. Criteria were identified, using a survey of the literature, the researcher's own experience in psychiatry and a Delphi process, in order to compile an appropriate framework for the diploma programme. The aim of the study was therefore to establish a

framework for the development of a Post-graduate Diploma Programme in Mental Health.

The research design was based on a quantitative approach, enhanced by qualitative elements, used to ensure that sound and well-founded recommendations would be proposed in the final framework.

The methods which were used and which formed the basis of the study comprised an in-depth survey of the appropriate literature available and the use of the Delphi process. The Delphi questionnaire was developed using information gained in the literature study and the researcher's own experience in primary health care and Psychiatry.

The use of Outcomes-based Education had to be considered for this Programme, particularly involving methods in which electronic learning could be blended with traditional curricula to ensure that students would be able to remain in their usual working environments but still be able to interact with tutors and fellow students enrolled in the Diploma when necessary.

The Delphi questionnaire dealt with five major aspects relating to the development of the Post-graduate Programme. These included crucial exit level outcomes, format of the Programme content of the modules, contents of the Programme, education methodology, modes of delivery, and student evaluation.

The Delphi panel consisted of 12 experts selected according to their expertise in Psychiatry/Psychology, Family medicine, Medical education,

Electronic learning and Government Legislature. The results of the various rounds of the Delphi process were manually analysed by the researcher. These results are included in the Appendices. Pre-testing of the Delphi questionnaire was accomplished using a pilot study, in order to ensure reliability, validity and trustworthiness of the study.

The findings of the Delphi study were reported and used in order to develop the framework for the Post-graduate Diploma in Mental Health Programme in six phases. These phases are summarised as follows: the identification of the individual needs of the doctor as learner and the mental health care user (patient), content of the Programme, the description of the mode of delivery in which the Programme will be presented, the use of blended learning to consolidate different parts of the Programme in Mental Health, implementation of the Programme, and the final accreditation and acceptance of the Programme.

This research aims to make a significant contribution towards the improvement of mental health care in South Africa, especially at primary health care level.

OPSOMMING

- **Sleutelbegrippe:** Volwasseleer; gekomineerde leer; kurrikulum; Delphi-tegniek; E-leer; Höer onderwys; Geestesgesondheid; Uitkoms-baseerde onderwys; Nagraadse onderwys; Primêre gesondheidsorg; Program; Psigiatrie

Hierdie navorsing is onderneem om 'n raamwerk vir 'n Nagraadse Diplomaprogram in Geestesgesondheid te ontwikkel. Weens die tekort aan psigiaters in Suid- (en Suider) Afrika en die afwesigheid van onderrig vir dokters wat van plan was om die Diploma in Mental Health by die Kollege van Geneeskunde in Suid-Afrika te bekom het die studie 'n noodsaaklikheid geword.

Die algehele doel van die studie is om 'n raamwerk te voorsien waarmee lede van die mediese beroep met nagraadse opleiding kan begin, op 'n deeltydse basis met behulp van samesmelte leer (insluitend kontaksessies, begeleide leer en e-leer), wat die voorskrifte van die Nasionale Kwalifikasie Raamwerk (NQF), die Kollege van Geneeskunde en die Professionele Rade sou ondersteun.

Die spesifieke oogmerke van die studie is om die probleem van 'n gebrek aan opleiding vir die Nagraadse Diplomaprogram in Geestesgesondheid te konseptualiseer en te kontekstualiseer. 'n Oorsig van die literatuur, die navorser se eie ondervinding in psigiatrie en 'n Delphi-proses is gebruik om 'n toepaslike raamwerk vir die diplomaprogram saam te stel. Die doel van die studie was dus om 'n

raamwerk tot stand te bring vir die ontwikkeling van die Nagraadse Diplomaprogram in Geestesgesondheid.

Die navorsingsontwerp is op ‘n kwantitatiewe benadering gebaseer, versterk deur kwalitatiewe elemente wat gebruik is om te verseker dat gesonde en gegronde aanbevelings in die finale raamwerk voorgestel sou word.

Die metodes wat gebruik is, wat ook die basis van die studie gevorm het, het ook bestaan uit ‘n in diepte ondersoek van die beskikbare, toepaslike literatuur en die gebruik van die Delphi-proses. Die Delphivraelys is ontwikkel deur gebruik te maak van die inligting verkry deur die literatuurstudie en die navorser se eie ondervinding in primêre gesondheidsorg en in Psigiatrie.

Die gebruik van uitkomsgebaseerde onderwys moes vir hierdie program oorweeg word, veral metodes waarby elektroniese leer met tradisionele kurrikula saamgesmelt kon word. So kon verseker word dat leerders nog steeds in hulle gewone werksomgewings bly, terwyl hulle in staat sou wees om waar nodig, met hulle dosente en medestudente wat ingeskryf is vir die Diploma wisselwerking te kon hê.

Die Delphi-vraelys het uit vyf hoof aspekte bestaan wat betrekking het op die ontwikkeling van die program. Ingesluit hierby was noodsaaklike uittreevlakuitkomste, formaat van die programinhoud van die modules, inhoud van die program, onderwysmetodiek, afleweringsmodusse, en studentevaluering.

Die Delphi-paneel het uit 12 deskundiges bestaan weens hulle vaardigheid in Psigiatrie/Sielkunde, Huisartskunde, Mediese onderwys, Elektroniese leer en ervaring in die Staatsdiensbeleid. Die resultate van die verskeie Delphi-prosesrondtes is per hand deur die navorser geanaliseer. Hierdie uitslae word in die Bylaes ingesluit. Die Delphi-proses is vooraf getoets deur middel van 'n loodsstudie om die betroubaarheid, geldigheid en geloofwaardigheid van die studie te verseker.

Die bevindings van die Delphi-studie is gerapporteer en gebruik in die ontwikkeling van die raamwerk vir die Nagraadse Diplomaprogram in Geestesgesondheid (in ses fases). Die fases kan soos volg opgesom word: die identifikasie van die individuele behoeftes van die dokter as leerder en die geestessorgverbruiker (pasiënt), inhoud van die program, die beskrywing van die wyse van aflewering waarop die program aangebied gaan word, die gebruik van gekombineerde leer om verskeie dele van die program in Geestesgesondheid saam te voeg, implementering van die Program, en die uiteindelike akkreditering en aanvaarding van die Program.

Die doel van hierdie navorsing is om 'n betekenisvolle bydrae te maak om geestesgesondheid in Suid-Afrika te verbeter, veral op die vlak van primêre gesondheidsorg.

A FRAMEWORK FOR THE DEVELOPMENT OF A POST - GRADUATE DIPLOMA PROGRAMME IN MENTAL HEALTH

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Historically, madness has always been associated with institutionalisation. Since the Middle Ages, people who were mentally ill were removed from society - often forcibly - and "locked away" for lengthy periods of time. Many psychiatric patients died in hospital (Porter 2002:90). Generally, psychiatric patients were regarded as extremely dangerous and therefore society needed to be protected from them. In South Africa the first hospital to cater specifically for mentally deranged persons was established in 1711 (Emsley 2001: 382). The stigma is still prevalent today, perhaps to a lesser degree.

Since the middle of the last century, psychotropic drugs have been developed, which has allowed for the effective management (not cure) of most disabling psychiatric conditions (Ketter, Wang, Nowakowska & Marsh 2004:18). Patients could not only be effectively sedated when necessary, but also be helped to cope with mental illness (Shorter 1997:261).

Deinstitutionalisation became the order of the day (Kaplan & Sadock 1998:178) where long-term institutionalisation has only been utilised in chronic patients who are unable to function in the community.

Utilizing the so-called "Free State Model" (Gagiano & Venter 1992:34) psychiatric patients were treated as outpatients in clinics close to their homes, rather than being confined to the Oranje Hospital for weeks or months on end. Although many acutely psychotic patients were admitted to hospital, they were discharged into the community as soon as their condition started to enter remission. This approach is far more humane and more conducive to the human rights of people with psychiatric disease. It allows them to still play active roles in their families and communities. The onus rests on medical doctors, however, to care for patients with psychiatric disorders in the community to ensure that the patients do not have a relapse and need subsequent admission to hospital (Moosa 2004:37). Medical practitioners should also be able to diagnose and treat (or refer) new cases with psychiatric conditions, to alleviate the emotional suffering of patients and their families.

Post-graduate training in Psychiatry has been available for many years at South African university medical schools (cf. 2.5). In spite of this, there are only 325 psychiatrists registered in South Africa, many of whom work and live in other countries. Our current population is estimated to be 45 million people; thus the researcher is of the opinion that there is less than one psychiatrist for every 138 000 people. If these statistics are evaluated according to access to service, 440 000 people have access to one of the 91 state psychiatrists, while there is one private psychiatrist for every 33 000 people able to afford

psychiatric care; there are 234 private psychiatrists in South Africa (Keeton 2003:p1 of 3). This statistic shows the great need for other medical doctors to be involved in the field of mental health.

With the new Mental Health Care Act in use, (the law was passed on 17-12-2004), (published in the Government Gazette Vol. 449 Cape Town 6 Nov 2002. No 24024), additional demands will be placed on mental health care workers to provide adequate care for patients (also known as mental health care users) at a primary health care level, especially in the rural areas of our country.

In a Third-World setting, primary health care is vital in meeting the medical needs of the community, but - according to Kigozi (2003:28) - many trained specialists leave Africa to work in "the apparent safety of the West". Sadly medical educators in Malawi for example (Herzig 2003:32), are preferring to drop the standards of training in Psychiatry and opt for localised practical courses rather than internationally acceptable scientific training in the discipline. This will place a greater burden on doctors who wish to practice a high standard of psychiatric care on a par with international standards to acquire the education they need. The vacuum caused by decreased undergraduate training in Psychiatry will also mean that doctors wishing to formally specialise in Psychiatry will have a huge backlog in their knowledge of the subject.

The researcher is of the opinion that many medical practitioners, trained at internationally accepted medical schools, feel they have insufficient knowledge in the field of Psychiatry and would like to increase their expertise, but do not wish to specialise in this area. As

so-called 'generalists', they enjoy the diversity of family medicine or primary care and do not wish to restrict themselves to one facet of medical care. In 2003 there were 29 655 medical practitioners in South Africa (Hall & Erasmus 2003:522).

At present the College of Medicine in South Africa awards a Diploma in Mental Health to candidates who pass their examination. No formal tuition is offered by the College and candidates must rely on self-study or unstructured training to gain enough knowledge to successfully complete the diploma. Thus there is an apparent need to provide structured tuition and training for medical practitioners who wish to advance their knowledge in Psychiatry. This curriculum should be constructed in ways that are consistent with contemporary educational thinking.

Before proceeding, the meaning of certain terms should be defined:

Table 1.1 Definitions applicable to the study

FRAMEWORK	An extensive structure for describing a set of concepts, methods, technologies and cultural changes necessary for a complete product design and manufacturing process (CERN Engineering Data Management –Glossary 2001: P5 of 9)
PROGRAMME	A programme is the structure within which the cumulative learning that a student is required to complete successfully to master the exit-

	level outcomes of a qualification is indicated. This structure consists of a related combination of modules/learning units, expressed in outcomes-based format and having an academic and/or professional/career-orientated focus. Students may access the programme at different points or levels and may also exit at meaningful points or levels (University of the Free State 2006:7)
DISTANCE LEARNING	All arrangements for providing instruction through print or electronic media to persons engaged in planned learning in a place or time different from that of the instructors (Maguire 2005:p1 of 3)
MENTAL HEALTH	The prevention, treatment and curing of mental problems ensuring the maximum health and general well-being for all citizens (World Federation of Mental Health – Oosterhuis 2004:419)
POST-GRADUATE TRAINING	Academic training carried on after taking first degree (Soanes 2001:652)
OPEN LEARNING	Flexibility in time and place of learning, off-campus instruction and individualisation of degree requirements (American Council on Education 2000:25)
ELECTRONIC LEARNING	Education via the Internet, network, or standalone computer. Network enabled

	transfer of skills and knowledge. E-learning applications and processes include Web-based learning, computer-based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intranet/extranet, audio or video tape, satellite TV and CD-ROM (Google s.a. Definitions of e-learning on the Web. Retrieved 08-09-2004, p1 of 1)
BLENDED LEARNING	A model that incorporates a variety of delivery styles and accommodates different organizational needs to achieve the most effective knowledge transfer (Welch 2003:1).

1.2 STATEMENT OF THE PROBLEM

Due to a paucity of psychiatrists in South Africa - further aggravated by more South African psychiatrists emigrating to, among others, Canada, Australia, New Zealand and Great Britain as well as an ever-increasing burden of patients requiring psychiatric treatment – there needs to be more training in Psychiatry available to doctors who desire post-graduate training in Psychiatry, but who do not wish to specialise exclusively in this field. The tuition should be streamlined to train doctors involved in primary health care settings, for example rural hospitals or doctors in private practice.

Additionally, the questions which come to mind is why a relatively high number of candidates fail the DMH in spite of having professional mentorship? Is there a need to develop a Post-graduate Diploma programme offering tuition for doctors wishing to obtain this diploma and how can it be done? (cf. 2.5.1)

1.3 OVERALL GOAL, AIM AND OBJECTIVES OF THE STUDY

1.3.1 Overall goal of the study

The overall goal of this study was to stimulate and facilitate such an initiative on a national basis (and an international basis, especially for doctors working in the Southern African region) whereby doctors would be better empowered to meet the psychiatric needs of the community they serve. Although there is more than enough theoretical knowledge available on the Internet, as well as medical textbooks and journals, practitioners experience difficulties with so-called "operationalising constructs". Sinclair and Robin (1966:248) explain operationalisation as putting a theoretical construct to work in an applied setting. They warn however, that acquisition of knowledge was often exclusively considered to be based on cognitive constructs, while affective constructs were largely ignored.

The purpose of this study was to design a post-graduate programme to assist medical practitioners who desired tuition in order to prepare themselves to pass the Diploma in Mental Health. This was done to provide a framework whereby members of the medical profession could embark on formal post-graduate training, on a part-time basis, utilising

blended learning mode (including face to face contact sessions, directed learning and e-learning), that would support the requirements of the National Qualifications Network (NQF), the College of Medicine, and the Professional Boards.

According to Sinclair and Robyn (1966:248), Damasio persuasively argued that neurobiological evidence suggested that portions of our brains that deal with our emotions profoundly affect our thinking. Thus it could be presumed that if learners felt safe in a tutored situation where they knew they could trust their mentors and have open channels of consultation with them, their learning skills would be enhanced. An effective pedagogic facilitator provides the framework in which learners could glean knowledge for themselves from the resources available. Learners could also benefit from knowing that educators were available to guide, motivate and correct them where necessary, acting as "a safety net" for them.

1.3.2 Aim of the study

The aim of the study was therefore to establish a framework for the development of a Post-graduate Diploma Programme in Mental Health.

1.3.3 Objectives of the study

The objectives were the following:

- Conceptualising and contextualising the problem of the lack of provision of training for the Diploma in Mental Health offered by the College of Medicine of South Africa.
- Identifying criteria (using a survey of the literature and a Delphi process) for the construction of an appropriate framework for the diploma programme.
- Compiling a framework, using the criteria identified through the Delphi technique, a literature survey and the researcher's own experience.

1.4 DESIGN OF THE STUDY AND METHODS OF INVESTIGATION

1.4.1 Design of the study

A quantitative approach, enhanced by qualitative elements, was used to ensure that sound and well-founded recommendations would be proposed in the final framework. These terms namely "qualitative" and "quantitative" will be described in detail in Chapter 4 (4.2) of this thesis.

Forming an integral part of the study a Delphi questionnaire will be both qualitative and quantitative in nature. This process followed an in-depth survey of the appropriate literature available.

1.4.2 The methods of investigation

A key factor to conducting research was gathering reliable data. In this study, the Delphi technique was used to obtain pertinent data.

An in-depth survey of the appropriate literature available was undertaken. Academic reviews of similar programmes in other countries were to be included in the survey. Themes regarding "open" and "distance" learning internationally were also reviewed.

1.4.2.1 *Delphi Technique*

The Delphi process took its name from the Ancient Greek Delphi oracle's skills of interpretation and foresight. It is a highly skilled specialised application of the nominal group technique for developing forecasts and trends based on the collective opinion of knowledgeable experts.

The Delphi Technique rests on two assumptions:

- Group decisions are more valid than those made by an individual, especially if the members of the group are experts in the fields of study

- Face-to-face interaction may be influenced by domineering members or by group bias (Murry & Hammons 1995:426). Since the decision-making is rarely left to one person, the success,

credibility and validity of the process is increased (Clayton 1997:373). Critcher and Gladstone (1998:432) mention that the Delphi technique allows a wide range of experts from different backgrounds and widely differing geographic locations to participate equally in the communication process.

The main characteristics of the Delphi Technique are:

- Anonymity
- Expert input
- Physical separation (Clayton 1997:377).
- Iteration as the process takes place using a number of rounds during which the "new" questionnaire – containing feedback from the previous round – is compiled (Woudenberg 1991:133).

- Statistical analysis of the responses, which allows each participant to see where his/her opinion lies when compared to the rest of the group (Clayton 1997:385).

- Controlled feedback which entails that the participants' responses after each round are analysed and each respondent receives feedback during the next round. Feedback is completely anonymous and, as it is a democratic process, each panelist has the opportunity to change and/or amend his/her previous opinion (Goodman 1987:730).

The Delphi Technique not only provides quantitative information about the subject of the study, but also qualitative information, because

definitions and solutions to problems related to the pertinent topic are provided by the participants. This is also reflected in Critcher and Gladstone's (1998:433) statement that the "Delphi straddles the divide between qualitative and quantitative methodologies".

The Delphi questionnaire was written in English. (Afrikaans and Sesotho were not used in this study, as all the experts are proficient in English.)

1.4.2.2 ***Sample selection***

1.4.2.2.1 *Delphi Technique target population*

The target population consisted of individuals possessing specific levels of knowledge and expertise related to the study. Experts in the following academic fields were asked to be panellists:

- Psychiatry
- Family Medicine
- Medical Education
- Electronic Learning
- Government Legislature

1.4.2.2.2 *Survey population*

This consisted of experts in the above-mentioned fields who consented to take part in the study. The rationale for these categories of experts needed for the study will subsequently be discussed in Chapter 4 (cf. 4.4.1.2).

1.4.2.2.3 *Sample size*

The sample size included a total of 12 experts representing the fields mentioned above. Owing to the nature of the study, a larger number of panellists were included representing and covering various fields of expertise. In keeping with the recommendations of Critcher & Gladstone (1998:432), the consensus obtained in this manner was of greater value, as compared to having only six panellists participating in the study

1.4.2.2.4 *Description of the sample*

The sample included individuals who had extensive expertise in their fields of experience and who were characterised by their active involvement with regard to research in their respective fields. They also had to be innovative, creative, resourceful and knowledgeable.

It is important to note that the Delphi experts were selected according to specifically compiled criteria and under the guidance of the supervisors (cf. 4.4.1.2). This took place after the in-depth literature study.

1.4.3 Data analysis

1.4.3.1 *The Delphi Technique*

The data obtained by means of the closed items in the questionnaire was analysed by the researcher. The open-ended questions were processed and interpreted by the researcher, while the opinions and ideas of the expert respondents were used to adapt the formulated set of criteria for each subsequent round of Delphi (Bezuidenhout 2002:111). This process was repeated until 80% consensus or stability had been reached (cf. 5.2.1.2). Recommendations made by the respondents were incorporated and integrated in the questionnaire for each successive round and submitted to the respondents for further comment. After the last round, a final set of criteria was compiled which served for the development of the framework.

1.4.3.2 *Pilot study*

After the Ethics Committee of the Faculty of Health Sciences of the UFS approved the project, a literature study was undertaken. After completion, a preliminary pilot study was undertaken to test the reliability and validity of the Delphi method procedure by using the electronic method of communication. A Delphi questionnaire was sent to four experts for their opinion. These experts were not part of the panel of 12 Delphi experts. The necessary changes to the questionnaire were made.

1.5 THE SCOPE OF THE STUDY

The scope of the study lay in the domain of Post-graduate Psychiatry Education and Health Professions Education, while it also included elements of Education Management, Programme Management and Service Delivery.

1.6 RELIABILITY AND VALIDITY

To clarify the term reliability, Babbie and Mouton (2001:1190) stated that "reliability is a matter of whether a particular technique, applied repeatedly to the same object, would yield the same result each time". Landman (1988:80) inferred that "reliability" referred to the extent to which studies could be replicated, that is, consistency of obtaining the same relative answer when measuring phenomena which have not changed.

Validity as defined by De Vos, Strydom, Fouché and Delport (2002:166), consists of two parts: "the instrument accurately measures the concept in question, and the concept is measured accurately. Obviously it is possible to have the first without the last, but not vice versa".

De Vos *et al.* (2002:168) stated that reliability has been defined as the accuracy of precision of an instrument; as the degree of consistency or agreement between two independently derived sets of scores; and as the extent to which independent administrators of the same instrument

yield the same (or similar) results under comparable conditions. The Delphi Technique was used in this study, thereby enhancing the reliability of the study.

Babbie and Mouton (2001:1190) stated that the term "validity" referred to the extent to which an empirical measure adequately reflected the real meaning of the concept under consideration. They accurately inquired how we can ever say whether a particular measure adequately reflected the meaning of a concept.

Landman (1988:96), in turn, states that validity is the extent to which an instrument or procedure satisfied the purpose for which it was constructed, in other words, it determined that which it was designed to determine.

The validity of the study rested on the in-depth literature study, the experience of the supervisors and of the researcher, as well as the scientific methods used in the pilot study and the formal study.

1.7 ETHICAL CONSIDERATIONS

The final protocol was submitted to the Evaluation Committee. It was then approved by the Ethics Committee of the Faculty of Health Sciences of the UFS. This ethics committee ensured that the research project complies with their ethical guidelines. The project was then registered and an ETOVS number was allocated to it (ETOVS number: 89/06).

The experts who agreed to form part of the Delphi panel (cf. 1.4.2.2.1) were asked to provide personal information relevant to the study, for example demographic details, the institutions that employed them, positions they held at these institutions, and their fields of interest and expertise, to ensure that a meaningful study could be conducted. They did, however, not have any information regarding the other members of the team. Their own anonymity as well as that of their responses was ensured. Experts were required to complete and sign consent forms. All the information collected was dealt with in a confidential manner. All correspondence was personally sent to the experts via e-mail or by using the postage system. All personal contact was telephonic. The names or findings of the experts were never divulged to other experts.

1.8 THE VALUE OF THE STUDY

- The results of the thesis will be of value to post-graduate training in Psychiatry that would also provide sufficient training for the learner to be able to successfully complete the Diploma in Mental Health of the College of Medicine. The knowledge gained would also be practically orientated to empower candidates to be able to function in primary health care settings and offer a more effective service to the general public.

- This initiative will serve as a generic platform for other medical schools in the country (or region), which may wish to offer post-graduate education and training in Psychiatry.

- The framework may serve as a bridging course for doctors who are interested in Psychiatry, but who only wish to specialise in the field at a later stage.

- The implementation of a framework for learners and educators in Psychiatry will serve to elicit research-based objectives, for example open learning, national and international networking, clinical training networks - especially in the African context - and a catalytic role in facilitating research.

1.9 ARRANGEMENT OF THE THESIS

In this chapter an orientation to the study has been provided; the rationale behind the investigation has been explained and the problems which initiated the study are described. The goal and the objectives of the study are stated and the methods of investigation are briefly discussed. The value of the study is also explained.

Chapter 2 pertains to the history of teaching of Psychiatry in South Africa. A literature study was undertaken on the history of teaching of Psychiatry in the Westernised world. The relevance of this study to current practice is also discussed.

Chapter 3 concerns the development of the programme and the curriculum for teaching Psychiatry using a blended learning mode. This entails the use of not only face-to-face contact sessions but the harnessing of new technology to provide Online Distance Learning (ODL). The information used in this chapter was gleaned from a literature survey.

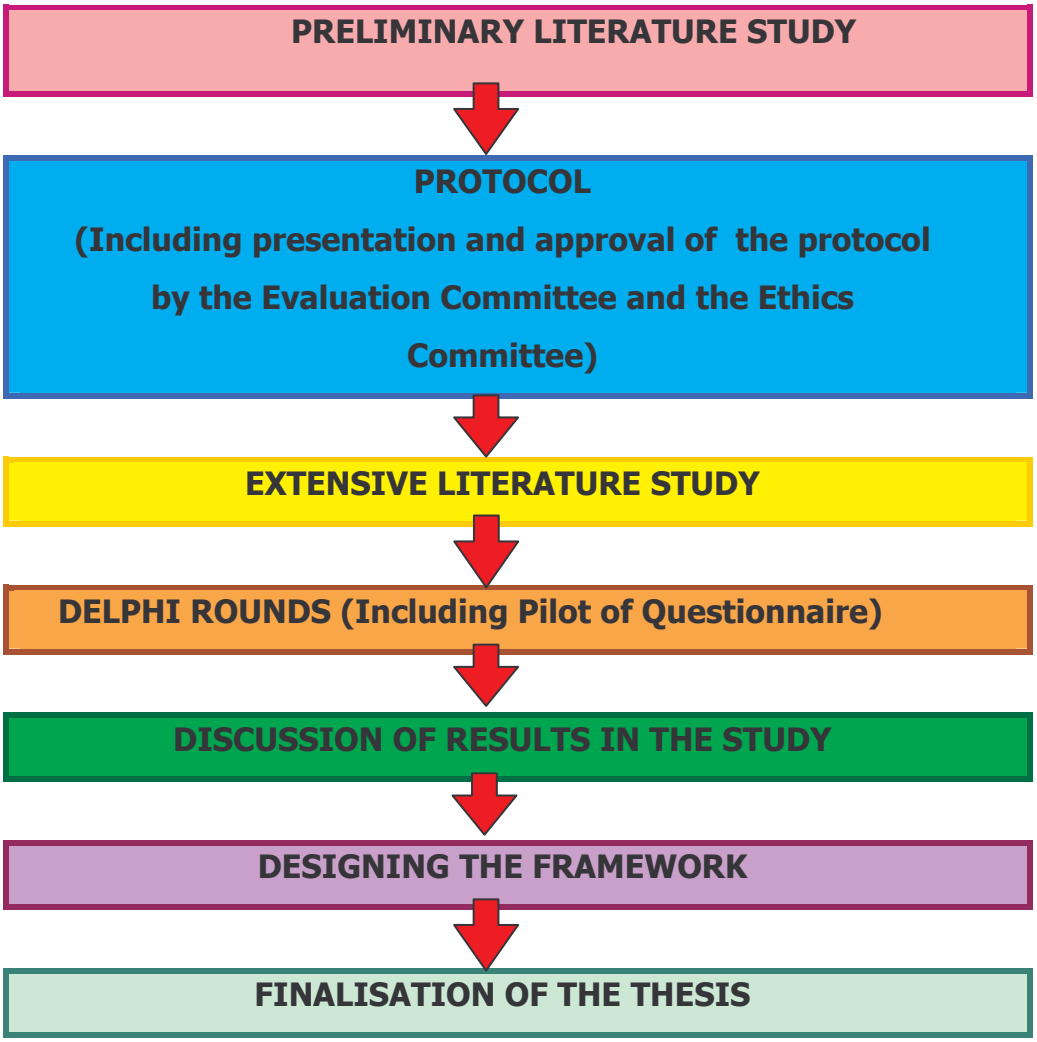
In Chapter 4 the research design and methodology are described. Theoretical aspects of research pertaining to this study are discussed. This chapter contains a report of the course of the study and explains how the data gained through the Delphi Process were to be processed.

Chapter 5 portrays the data analysis and results of the recommendations by the Delphi Experts.

In Chapter 6 the findings of the study are discussed and the structure of the Framework for the Post-graduate Programme in Mental Health outlined. The process of compiling the Framework is divided into six phases which are also discussed in this chapter.

In Chapter 7 the conclusions are summarised, and the limitations of the study and recommendations for future research are discussed.

Table 1.2 A schematic overview of the study



1.10 CONCLUSION

Chapter 1 provided the background and introduction to the research undertaken regarding the development of a programme that would be offered to general practitioners who wished to further their knowledge and expertise in Psychiatry without formally specialising in the field. Although a Diploma in Mental Health (College of Medicine) is available for candidates who pass this examination, no standardised formal

tuition is offered to candidates. It was deemed necessary to explain the importance of Psychiatry especially in the context of Primary Health Care in South Africa and to possibly harness newer forms of technology in order to promote knowledge of Psychiatry in ways that would be effective and relevant for the learner in remote regions.

Due to the shortage of medical practitioners especially in rural areas, the proposed programme would allow learners to work from their homes without having to take long periods of study leave in order to attend formal classes.

The concepts such as Frameworks, Programmes, Mental Health, Post-graduate Training, Open Learning, Distance Learning, Electronic Learning and Blended Learning are defined and discussed in context.

The methods which would be used are explained, namely, *inter alia,* a literature study; designing a questionnaire for a survey using the Delphi Technique in which experts in the fields of Psychiatry, Family Medicine, Medical Education, and Electronic Learning were asked to answer questions relating to the new proposed programme; and the formulation of a report using the information gained from the experts. This report was to be presented with necessary recommendations. The scope of the study and its significance and value were also discussed, as was the design of the study. The arrangement of the report was set out and explained.

The next chapter, entitled "'Teaching Psychiatry in South Africa" will be a study of the relevant literature. It will focus on the development of

Psychiatry as a science from primitive times until the present. Emphasis will be placed on how Psychiatry was taught to aspirant doctors, also with special reference to the teaching of Psychiatry in South Africa.

CHAPTER 2

TEACHING PSYCHIATRY IN SOUTH AFRICA

2.1 INTRODUCTION

'To understand a science it is necessary to know its history' – Auguste Comte (French social scientist and mathematician in Crystal 2005:58).

Teaching Psychiatry in medical schools can be described using category of "student" wishing to gain knowledge of the subject: undergraduate medical students, post-graduate education for general practitioners; post-graduate training for registrars training to be specialists in Psychiatry; and training for students in Allied Professions, where training in Psychiatry can be regarded as forming an integral but not all-encompassing part of Mental Health. According to Oosterhuis (2004:419), as a result of the international meeting of the World Federation of Mental Health which was held in London in 1948, the notion "mental health" replaced "mental hygiene" so as to underscore that not only prevention, treatment and curing of mental problems mattered, but that it was important to ensure maximal health and general well-being for all citizens. Emphasis was placed on the need for a multidisciplinary approach by teams of various non-hierarchical professional groups: psychiatrists, psychologists, pedagogues, psychiatric social workers and social-psychiatric nurses.

The teaching material used to teach Psychiatry in South Africa has been gleaned from knowledge gained over many years in different parts of

the world. In order to appreciate the richness of the legacy mastered by workers in Mental Health it is important to trace the development of science in this field in order to form a basis for this thesis.

This quest to understand the workings of the human mind can trace its origins to Ancient Greece, although much ignorance prevailed until the Middle Ages when different experts in the field of Psychiatry were starting to unravel the mysteries of neuroscience, a process which is still continuing into the 21st century. Modern Psychiatry gained momentum in two waves. The first biological wave ended before 1900, while the second wave started in the 1970s and is still gaining momentum, especially in the fields of neuropsychopharmacology, nosology and psychopathology. This chapter explains how this knowledge is taught to South African students at undergraduate and post-graduate levels.

Conceptualisations of mental health and mental disorders certainly existed in South Africa before the advent of colonialism, while disparate procedures pertaining to the welfare of the mind continued to be practised congruently to one another (Jones 2003:p3 of 19). Little is known of methods used to manage mental illness in pre-colonial times, because there is no formal recorded history. Various authors (Cheetham & Cheetham, 1976:39; Edwards, Grobbelaar, Makunga, Sibaya, Nene, Kunene & Magwaza 1983:214; Mwamwenda, 1990:164) describe aspects of traditional cultural views regarding psychopathology and treatment of mental illness but do not give specific historical facts.

2.2 THE HISTORY OF FORMAL TEACHING IN PSYCHIATRY (EUROPE AND OTHER WESTERNISED PARTS OF THE WORLD)

As tutoring in South African medical schools can trace its roots towards teaching styles of expertise gained from other countries, especially the German-speaking countries in Europe, it would be beneficial to see how Psychiatry came to be recognised as a specific discipline which needed to be taught in medical schools.

Psychiatry as we know it today is a science that has evolved over many years.

2.2.1 Ancient Greece

The ancient Greeks attributed insanity to the disfavour of the gods.
In ancient times Hippocrates developed a comprehensive holistic explanatory scheme for health and sickness which included madness (Porter 2002:41).

Health and illness were explained in terms of four "humours" (basic juices or fluids):

- Blood
- Choler (yellow bile)
- Phlegm
- Melancholy (black bile).

All was well when the vital fluids cooperated in their proper balance. Various physical illnesses could be linked to imbalances of humours. Specifically in terms of mental disorder, excesses of both blood and of yellow bile could lead to mania, whereas a surplus of black bile, being "too cold and dry", resulted in lowness, melancholia or depression, while someone having too much phlegm was seen as being pale phlegmatic in nature (Porter 2002:40). The teachings of Hippocrates were part of the syllabus in medical education in Europe in the 1580s (O'Malley 1970: 204).

The term melancholy is still used in modern Psychiatry even though the underlying aetiology is far better understood. Recently, Shorter (2007: 5) claims there has been a tendency to return the concept of two depressions: melancholic and non-melancholic illness.

2.2.2 Early period (post classical times) until after the Middle Ages

Early Christians and theologians saw mental illness as the works of the devil (Murray & Turner 1990:29). The mentally ill were cared for in religious houses. In time doctors began to replace the clergy in handling the insane. Asylums and madhouses were used as treatment facilities.

Over the years "experts" tried to explain mental illness and place different conditions in certain categories. Potential doctors were apprenticed to colleagues who had already qualified as doctors. The family doctor had to know something about psychiatric illness to deal

with upset families and mentally ill patients. The whole subject had to be "de-demonized" for the average medical student who arrived in class with the same preconceptions as the lay public.

Family physicians had to learn that mental illness was a familiar aspect of medical experience, as opposed to being bewitched. In their practices they would encounter much in the way of mania and depression, panic disorders, as well as dementia. The stakes were enormous in deciding who was sick, who needed to be treated at home, and who required institutional care (Shorter 1997:70).

2.2.3 Psychiatry in France

Two names are prominent in the history of teaching Psychiatry in France during the early 19th century, namely Philippe Pinel and Jean-Etienne-Dominique Esquirol. Pinel will be remembered as one of the first doctors to order the removal of chains from patients (Hunter & Macalpine 1963:606). He replaced the chains with straightjackets. He concluded that the asylum was a place where psychological therapy could be carried out. He published his observations of patients in a textbook in 1801. Esquirol was impressed by Pinel's lectures and teachings at the Salpêtrière in Paris. A firm bond developed between the two colleagues (Shorter 1997:13).

According to Shorter (1997:13) Esquirol completed a doctoral thesis in 1802 on the role of "passions" in mental illness. In 1817 he began lecturing on Psychiatry to medical students. Esquirol put many of Pinel's theories into practice by establishing "therapeutic communities".

Patients and physicians lived in the same building. Esquirol believed this isolation from the outside world would have a salutary effect, as protection from family and friends would protect them from the previously unhealthy passions which had ruled their lives (Shorter 1997:13). This approach was very popular and the concept of so-called "moral management" spread to many asylums on both sides of the Atlantic Seaboard in the 18th century. (In 2007 the institution is still regarded as the mainstay of therapeutic care for psychiatric patients needing in-patient care. Advancements in psychotropic medication, however, allow the vast majority of psychiatric patients to receive further management as out-patients.)

Esquirol will also be remembered for his transformation of the classification and diagnosis of mental disorders, a task which many "experts" had previously failed to perform. His classification was based on the abundance of data gleaned from asylums and enabled diagnosticians to build clearly defined profiles of psychiatric disease capable of being identified by their symptoms (Porter 2002:135).

In contrast to dynamic psychiatric and neurological discoveries in Germany, French Psychiatry in the mid-nineteenth century was characterised by political rivalries and little scientific progress. There were, however, a few outstanding individuals who had made a contribution which is still utilised in modern Psychiatry and Neurology:

- Josef Babinski described a pathological reflex, namely the raking of the sole of the foot will cause the big toe to turn up if brain pathology (upper motor neuron) lesions are present.

- Bénédict-Auguste Morel was among the first to describe schizophrenia (Abel 2004:2185). He also introduced the term "degeneration" which the German psychiatrists were to explore towards the end of the 19th century.

- Jean-Marti Charcot is remembered for his descriptions of joint pathology in advanced syphilis. He also believed that "hysteria", an undifferentiated mass of neurological complaints, was a real organic disease, transmitted genetically (Shorter 1997:85). Although modern medicine views hysteria in a different light, Charcot's teachings had a profound effect on the whole of Europe at that time. One of his most famous pupils was Sigmund Freud of Vienna.

In the early 20th century France developed psychodynamic traditions of its own which left it relatively impervious to Freud. In the wake of Charcot, Pierre Janet (1859-1947) elaborated on theories of personality development and mental disorders which had long dominated French dynamic Psychiatry (Porter 2002:195).

2.2.4 Psychiatry in the German-speaking countries of Europe

Johann Christian Reil, a German physician better known for his knowledge of neuro-anatomy and internal medicine, expressed his views on mental illness in his book *Rhapsodies on the Application of the Psychological Method of Cure in Mental Alienation* in 1803. In 1808 Reil coined the term "Psychiatry", or "Psychiaterie" (Hunter & Macalpine 1963:952), later shortened to "Psychiatrie" in 1816. He also described

the qualities which he thought would characterise a good psychiatrist, namely "Perspicacity, a talent for observation, intelligence, good will, persistence, patience, experience, an imposing physique, and a countenance that commands respect" (Shorter 1997:17).

In European medical schools there was a close alliance between Neurology and psychiatric disease. After 1850, university Psychiatry prospered in the German–speaking countries supported by those twin pillars which gave German medical education its prestige, namely the polyclinic and the research institute. These psychiatrists' 'orientation' was theoretical and investigative rather than the bureaucratic and therapeutic style of their English or the American counterparts (Porter 2002:145), causing the latter to lag further and further behind.

Shorter (1997:71) describes the advancement of Psychiatry in these terms, referring to the pioneers who were German or from the German-speaking countries: "There were two mechanisms for hooking teaching to research in the German University. One was the tradition of the doctoral dissertation, for all medical students had to produce a dissertation to get the MD degree (the French did too, but there were many more German students). Second was the post doctoral research project called the 'habilitation' required from PhDs and MDs aspiring to teach at universities. Unlike the dissertation, often an academic puffball, the habilitation had to make a serious contribution to knowledge to be accepted. After the habilitation, one would first be a private docent, entitled to lecture, then an associate professor (*ausserordentlicher professor)*, then a full professor (*ordentlicher professor).* In no other country were so many students and post-

graduates harnessed in this manner to publication and research. This academic structure, plus ample funds from the ministry, guaranteed scientific pre-eminence to Germany until 1933".

In Central Europe, lecturing in Psychiatry began with Johann Heinroth in Leipzig in 1811 while Ernst Horn of the Charité Hospital in Berlin started formal teaching in 1818. Although many German psychiatrists worked diligently in various asylums, Wilhelm Griesinger was to become the single most influential representative of the first biological Psychiatry (Shorter 1997:75). (This approach to Psychiatry has continued and has become more pronounced, especially since the 1970s when medical research and technology have been able to start unlocking the intricate secrets of psychopathology).

Griesinger was also influential in including certain psychiatric patients in General Hospitals rather than receiving full-time care in asylums, a pattern that is commonly practised in the 21st century during which Psychiatry is regarded as an integral part of medicine. He also established the modern model of the Department of Psychiatry as dedicated to teaching and research rather than custodialism. He believed a physician should be trained as a scientist, studying patients through direct observation at the bedside rather than relying on thousand-year-old observations of humours. Griesinger published a textbook of Psychiatry in 1845. He also founded the flagship journal of the new neurologically orientated Psychiatry, the *Archive for Psychiatry and Nervous Diseases* which would overshadow the old *Journal of General Psychiatry* of the asylum doctors (Shorter 1997:75). The

asylum doctors preferred the humanitarian, psychological approach rather than regarding disease as being linked to biological causes.

Another pioneer worth mentioning is Theodor Meynert, who was able to describe the microscopic structure of the brain using various stains to visualise various brain cells (neurons) under the microscope. He was able to differentiate different layers (the cytoarchitecture) of the cerebral cortex and other specialised parts of the brain. In 1890 he wrote: "The study of human anatomy in its current form has passed from a solely descriptive science to something higher, to a form of knowledge that attempts to explain… The more that Psychiatry seeks, and finds, its scientific basis in a deep and finely grained understanding of the anatomical structure [of the brain], the more it elevates itself to the status of a science that deals with causes" (Shorter 1997:77). Although Sigmund Freud studied under Meynert, he was to move away from Biological Psychiatry and pioneer Psycho-analysis.

Shorter (1997:80) names the two giants in the study of neuro-anatomy and cerebral localisation who both opened university clinics, namely Paul Flechsig in Leipzig in 1882 and Eduard Hitzig in Halle in 1885. Flechsig laid down the basic map of which regions of the cerebral cortex are responsible for what functions; the so-called "cerebral localization", while Hitzig established that the brain responds to electrical stimulation. Although these dynamic pioneers of Biological Psychiatry started a new approach, their consistent weak point was an indifference to clinical work. They were so interested in scientific discoveries (finding the anatomic origins of mental illness), that they neglected development of their own therapeutic skills. The main reason

why they spent so little time treating patients was probably because they believed that psychiatric illness was incurable. The first era of Biological Psychiatry slid to an end in the work of Carl Wernike, narrowly balanced between "neuromythology" and brain anatomy.

In 1874 Wernike established that when a patient has a stroke in a specific part of the brain (the posterior perisylvian region), he or she will be unable to understand the spoken word and will be able to speak only in incomprehensible jargon. This area of the brain is known as Wernicke's area and this particular aphasia is called "Wernicke's aphasia" (Shorter 1997:80).

In contrast to his colleagues, Emil Kraepelin believed that the course of psychiatric illness offered the sharpest clue to its nature (Porter 2002:184) rather than, as Wernicke believed, the kind of symptoms that the patient had at any particular moment (Shorter 1997:81).

Kraepelin's career marked the culmination of a century of descriptive clinical Psychiatry and psychiatric nosology. He wrought a great innovation in disease concepts and classifications. The classification of mental illnesses has continued into the 21st century (Ghaemi & Baldessarini 2007: 65). This process is also described in section 2.3.2 - and forms an integral part of academic Psychiatry.

Kraepelin, influenced by an experimental psychologist, Wilhelm Wundt, also pioneered psychological testing of psychiatric patients. This procedure, known as psychometry is widely practised in modern Psychiatry and Psychology. Among Kraepelin's colleagues was Alois

Alzheimer, whose research into senile dementia led to the major specialty of psycho-geriatrics (Porter 2002:185).

Perhaps the most famous German-speaking psychiatrist was Sigmund Freud (1856-1939). He advanced the fundamental theoretical postulates of psychoanalysis: unconscious mental states, their repression, and the ensuing neurotic consequences; infantile sexuality; and the symbolic meaning of dreams and hysterical symptoms. He also outlined the investigative techniques of free association and dream interpretation - two methods for overcoming resistance and uncovering hidden unconscious wishes - and he elucidated what clinical practice had revealed to him, namely therapeutic transference (Porter 2002:192).

In creative tension with Vienna, a vigorous tradition of depth Psychiatry emerged in Switzerland. At Burghölzli, the Zürich psychiatric hospital, Eugen Bleuler (1857-1939) deployed psychoanalytic theories in his delineations of "schizophrenia", his term for the condition he honed from Kraepelin's *dementia praecox*, one marked by delusions, hallucinations and disordered thought. Although different subtypes of schizophrenia having various characteristic features present were described, dissociative pathology held them together in a single disease entity (Carpenter 2006:639). In contrast to other Swiss psychiatrists, the influence of Carl Jung (1875-1961) continues to prevail in the 21st century.

Freud and Jung took separate paths in 1912 and Jung went on to develop his "alternate analytic psychology" – a less sexual and more idealistic rendering of the unconscious (Porter 2002:194).

While heredity played a certain part in his conceptual apparatus, Kraepelin was critical of the French degenerationist theory. Degeneration was defined as the notion that inherited mental illness worsens steadily over generations (Shorter 1997:69). Holding out slight expectations of successful treatment, Kraepelin, like the degenerationists, Shorter observed (1997:69), was gloomy about the outcome of major psychiatric disorders, especially *dementia praecox (*now called schizophrenia). By 1900 Pinelian optimism had run into the sands: "we know a lot and can do little," commented a certain German asylum doctor.

Endorsed by eugenism [Eugenics is defined by Soanes (2002:281) as the science of improving a population by controlled breeding to increase the occurrence of desirable characteristics which are able to be inherited] and degenerationism, psychiatric politics was emerging in a direction in which it could soon be decided that the very lives of the mentally ill were not "worth living". In the 1930s the Nazis deemed schizophrenics, no less than Jews, ripe for elimination. Between January 1940 and September 1942, 70 723 mental patients were gassed, chosen from lists of those whose "lives were not worth living" drawn up by nine leading professors of Psychiatry and 39 top physicians (Porter 2002:186).

2.2.5 Psychiatry in Britain

With the establishment of universities and medical schools, new theories relating to mental illness were expounded, for example William Cullen's psychological paradigm of insanity at Edinburgh University in 1726 (Shorter 1997:17). Shorter continues to describe how William Battie started lecturing in Psychiatry at St. Luke's Hospital in London in 1753, the governors of which had permitted Battie to "attract more gentlemen of the faculty… to make this branch of physics their particular care and study". The late 18th century psychiatric practitioners were called "alienists - one who treats mental alienation".

During the closing years of the eighteenth century when Pinel had ordered the removal of chains from his patients, similar interesting developments were taking place in England. Vierda Skultans (1975:10) describes how William Tuke, a Quaker and a wholesale tea and coffee merchant founded a Retreat for the Quaker insane after being dissatisfied with the local asylum in York. The Retreat became a life interest of William Tuke and subsequently of his son Henry and grandson Samuel, though neither father, son, nor grandson were medically qualified.

Moral reformers like the Tukes and Pinel (although unaware of each other's actions) viewed madness as a breakdown of internal, rational discipline on the part of the sufferer. Murray and Turner (1990:5) regard Pinel and the Tukes as products of the 'Age of Enlightenment' which began to impose a more humanitarian view about the 'right environment' for the mentally ill, and ushered in the 'era of moral

treatment'. The moral and psychological faculties of patients needed to be rekindled, so that external coercion could be supplanted by inner self-control. Psychiatry had had to reanimate reason or conscience. For this the closed environment of the asylum was tailor-made (Porter 2002:105).

The phenomenon of phrenology, as described by Wilson (2003:104), was regarded by the Victorians as a serious science. Kluger (2007:35), however, credits German physician Franz Joseph Gall to be the founder of this phenomenon. Phrenology's various proponents divided up the skull into areas - 26 in one scheme and 43 or more in another - in which it was purported that organs could be discovered explanatory of human behaviour. Quarrelsome people were found to possess a pronounced "organ of combativeness". The lumps and bumps of the human cranium were seriously supposed to relate to propensities and characteristics such as amativeness, hope, wonder, wit, and so on. The fact that no relation between brain functions and cranial formation could be demonstrated, did not prevent serious people, many of them scientists, from being wholly convinced by it. Technology and research have proved phrenology to be unscientific. In contrast to other German-speaking colleagues who left a foundation of valuable discoveries for modern day Biological Psychiatry, the workers in the field of phrenology left a bizarre legacy which has no place in medical education.

Shorter (1997:90) argues that the Achilles' heel of English Psychiatry was that it was all clinical medicine and little science. This is a very controversial statement. Walk (in Murray & Turner 1990:15) describes

how the Association of Medical Officers and Hospitals for the Insane came into being; the oldest of its kind in the world – later to be renamed the 'Medico-Psychological Association' (MPA). Besides building new asylums it held regular meetings and undertook the publication of a journal *The Asylum Journal.* The name was later changed to *The Journal of Mental Science.* The editor, John Bucknill aimed to cover 'mental physiology and pathology with their vast range of inquiry into all things which tend to cause mental disease or preserve mental health'. In time, future editors of the Journal would include Daniel Hack Tuke (great grandson of William Tuke), and Henry Maudsley. Bucknill and Tuke also edited the *Manual of Psychological Medicine* (Beveridge 2006:1530).

Shorter (1997:90) reports that in 1869 Maudsley was appointed professor of medical jurisprudence, essentially a professorship in Psychiatry, at the University College Hospital. He went on to become the best-known psychiatrist of the Victorian era. For Maudsley, as for Griesinger, mind disease was brain disease. In 1907, Maudsley offered £30 000 to the London County Council, the body that administered the asylums of the metropolis, for a new asylum on condition that:

- it accepts only recently ill people;
- it makes provision for teaching and research; and
- it should be in the heart of the city near the medical schools.

Although completed in 1915 and first used as a military hospital, only in 1923 (four years after Maudsley's death), did it start to become the medical facility he had envisioned for "exact scientific research on the

causes and pathology of mental diseases". England, therefore, had to wait almost 60 years before getting its first university psychiatric clinic similar to the German model made famous by Griesinger in 1865 (Porter 2002:186; Shorter 1997:90).

Psychoanalysis spread far more slowly to the United Kingdom. Early British psychoanalysis crystallised around Ernest Jones (1879-1958). In 1908 Jones and Carl Jung were involved in the First International Psychoanalytical Congress in Salzburg, Austria (Murray & Turner 1990:50). Jones was the founder of the London Society of Psychoanalysis (1913) and this Welshman whose zest, vanity and phenomenal energies made him a born proselytiser, became a close friend of Freud and eventually his biographer. Later, the London scene was animated by the theoretical battles waged by Melanie Klein (1882-1960) and Anna Freud (1895-1982), who had fled to England with her father in 1938 after the Nazi occupation of Austria: Freudians and Kleinians unforgettably crossed swords over the interpretations of infant/mother relations. In London the Tavistock Clinic, founded in 1920, promoted psychotherapy especially for children and families and fostered the British "object relations" school (Porter 2002:198). Porter (2002:199) further tells how from the 1940s great faith was vested by Donald Winnicott and John Bowlby in the nuclear family, and particularly the mother as the sheet anchor of psychosocial adjustment. Bowlby also reiterated this finding in his report to the World Health Organization (WHO) in 1951 (Clare 2000:163).

2.2.6 The United States of America (USA)

Benjamin Rush, regarded as "the father of American Psychiatry" and working in Pennsylvania, published his textbook on Psychiatry in 1812 (Shorter 1997:15). It was the first textbook on Psychiatry in the USA (Brady 1975:6) and exerted much influence on psychiatric thought in America and abroad.

Although the first American medical school was founded in 1795 (Nadelsohn & Robinowitz 1987:11), research and education in Psychiatry got off to a slow start. "In 1900," writes historian Rosemary Stevens, "less than 10 per cent of practicing physicians in the U.S.A. were graduates of genuine medical schools. About 20 per cent had never attended medical school lectures. The majority were the products of apprenticeship or of the proprietary schools" (Shorter 1997:91).

In 1892 Adolf Meyer, a German-speaking, Swiss trained psychiatrist emigrated to the USA. After working in different centres he was appointed as professor of Psychiatry at Johns Hopkins University in 1910. Here he implemented the European style where research and teaching would not be separated.

Nadelsohn and Robinowitz (1987:12) relate how medical education changed swiftly and dramatically following a period of investigation which culminated in the publication of the Flexner Report in 1910. Many medical schools especially the propriety centres were closed and stricter licensing requirements were introduced.

When the Nazi government came to power in Germany, many Jewish practitioners fled Europe, so the USA became the world headquarters of psychoanalysis (Porter 2002:197). In 1933 there were only 21 recognised Departments of Psychiatry in the 66 medical schools in the USA and Canada (Werkman 1966:9). By the mid-twentieth century American Psychiatry at large, in university departments and teaching hospitals, was heavily psycho-analytically orientated (Porter 2002:197).

2.2.7 Psychiatry in the Republic of South Africa (RSA)

Although the Dutch government was the first western nation to colonise the "Cape of Good Hope" in the mid seventeenth century, very little is known about any significant formal psychiatric treatment used.

In South Africa the first hospital to cater specifically for mentally deranged persons was established in the Cape Province in 1711 (Emsley 2001:382).

In his book "Masters of the Castle", Hymen Picard (1972:205) alludes to the depressive episodes experienced by the last Dutch Governor of the Cape Settlement under the Batavian Republic Lt General Jan Willem Jansens. Jansens governed from 1803 to 1806. No mention is made of formal psychiatric treatment or other mental health interventions during this time.

In 1818, Dr. Samuel Silverthorne Bailey opened a hospital and lunatic asylum (Laidler & Gelfand 1971: 142). It came to be known as the (Old) Somerset Hospital. Emsley (2001:382) describes how the Old

Somerset Hospital's patients were transferred to Robben Island in 1846. The former prison colony became a hospital for lepers, lunatics and other chronically ill patients. By 1912 the Robben Island Infirmary housed 500 patients. During this period, several other "lunatic asylums" were built, ensuring that mentally ill patients were largely isolated from the community. These included the Oranje Hospital in Bloemfontein, the Town Hill Asylum in Pietermaritzburg, the Fort England Mental Hospital in Grahamstown, the Valkenburg Lunatic Asylum in Cape Town and the Pretoria Lunatic Asylum.

When the Union of South Africa was formed in 1910, there were eight mental institutions catering for 3624 patients. In 1914, the Lunacy and Leprosy Laws Amendment Act (Jones 2003:p4 of 19) was passed to ensure that certifications of mental patients were recognized cross-provincially. Later, the Mental Disorders Act was introduced in 1916 (Jones 2003:p4 of 19). No provision was made for neurotic and personality disorders, alcohol dependence or learning disabilities. At this time, mental hospitals were similar to prisons, being defined as closed detention centres that mostly housed the underprivileged, disorderly and miscreant, while some wealthy patients could afford to be treated in their own homes.

Jones (2003:p4 of 19) describes the relationship between prisons and mental institutions; where jail cells had always housed those deemed to be mad. Even when permanent mental institutions had been erected, they were quickly filled and prisons continued to serve as temporary holding areas for the mentally disordered. Psychiatry was simply a neglected discipline and South Africa was late in formalising its

psychiatric specialty in relation to the rest of the world. For this reason there were insufficient trained psychiatrists in the Union (thus medical practitioners with an interest in mental disorders often oversaw the care of the mentally insane). Psychiatry as an independent discipline only emerged in South African universities in 1922 when physician superintendents at the Valkenberg Mental Hospital began training students (Jones 2003:p4 of 19). The medical school in Johannesburg also started training students in Psychiatry in the early 1920s.

According to Minde (1977:210), before the 1920s South Africans studied Psychiatry at universities overseas. The course was limited to an elementary study of the psychoses and a few perfunctory visits to a mental hospital. A class examination (which nobody ever failed) completed the course. This description refers to British universities, but the situation was similar on the Continent. This approach was also later used by the two South African medical schools (Minde 1977:210).

2.3 THE SEARCH FOR EFFECTIVE BIOLOGICAL TREATMENT IN PSYCHIATRY

As stated previously, psychiatrists working in the first part of the 20th century were able to care for patients but felt powerless to treat mental illnesses. Apart from psychoanalysis, no effective medications or therapeutic interventions were known. By the second half of the century, however, the face of Psychiatry was to change dramatically as knowledge increased. This newly discovered knowledge was also taught

to medical students and trainee psychiatrists. The following discoveries will subsequently be discussed:

- Behaviour therapy was pioneered by Ivan Pavlov in Russia. He was awarded a Nobel Prize in 1903 for describing "the conditional reflex and ways of producing it" (Corson & Corson 1966:6). Although his work related to physiological changes produced in dogs, his work also had much bearing on human conditioned responses. Watson, Skinner, Thorndike together with other workers developed theories of human learning and behaviour based on Pavlov's work (Sadock & Sadock 2003:144). Behaviour therapy is still used in modern-day psychotherapy where appropriate, while Behaviorism can be linked to the rationale behind Outcomes-based Education (OBE). According to behaviourist theories, each lesson in the curriculum should result in a desirable change in the behaviour of the student (Jacobs, Vakalisa & Gawe 2004:42).

- Prolonged sleep therapies induced by barbiturates, enjoyed a hazardous vogue in the 1920s (Porter 2002:200).

- In the 1930s insulin–induced coma was employed against schizophrenia and, though dangerous, it had some relief benefits. It was pioneered by Manfred Sake (Porter 2002:200).

- Chemical "shock treatment" is another discovery. Working with epileptics, the Budapest psychiatrist Ladislaus Joseph von Meduna developed a different shock treatment in which a

camphor-like drug was a convulsant agent. Although it caused a violent seizure, it was found to be of help with psychosis in schizophrenic patients (Porter 2002:201).

- Electro Convulsive Therapy (ECT) is also a discovery worth mentioning. Ugo Cerletti, working in Genoa, Italy began to use electric shocks (ECT) to alleviate severe depression (Porter 2002:202). Strangely enough, electricity had already been used to treat neurological diseases in medieval Persia by Ibn Sina and Abu Al-Faraj. The electrical shock that resulted when a live electric fish called a topedo or crampfish was applied to the fronto-temporal region of the forehead could cure a patient suffering from melancholia (Vakili & Gorji 2006:1864). Formal ECT is still used as a last resort in the treatment of severely ill patients in the 21st century (Taylor, Paton & Kerwin 2007:194).

- Psychosurgery was utilised in the 1930s. The neurologist Egas Moniz of Lisbon University claimed that obsessive and depressive cases could be improved by leucotomy, in other words surgical severance of the connections between the frontal lobes and the rest of the brain. Lobotomy and leucotomy (Minde 1977:210) procedures were enthusiastically taken up in the USA and in other parts of the world. By 1951 over 18 000 patients in the USA had undergone lobotomy, before it was overtaken by growing doubts and by the psycho-pharmacological revolution (Porter 2002:203). In spite of tremendous advancement in technology and expertise in neurosurgery, psychosurgery is

rarely utilised as a treatment modality for psychiatric patients in the 21st century.

- Psychopharmacology has probably contributed to the greatest advances in the management of psychiatric disorders. Therefore the teaching of psychopharmacology forms an integral part of a curriculum relating to medical education and Psychiatry.

In 1949 John Cade, the 37-year-old superintendent of the Repatriation Mental Hospital in Bundoora, Australia, was determined to find the treatment for mania. After initial studies on guinea pigs, he tested lithium on patients as well as on himself. He found that lithium had the best effect on manic depression (Porter 2002:205; Shorter 1997:256).

Shorter (1997:249) describes in detail how in 1951 Henri Laborit, a French surgeon stationed in Tunisia, was researching various synthetic antihistamines in the phenothiazine family synthesised by the Rhône-Poulenc drug company as a means of "potentiating" anaesthetics. Although Laborit had no interest in psychosis, he noticed that some of his surgical patients became quite indifferent to the world about them (ataraxic was the term subsequently applied) after being given phenothiazines. He shared this observation with a psychiatrist. Laborit was later transferred to the Val-de-Grâce Military Hospital in Paris. In June 1951 he asked Rhône-Poulenc for a sample of a new phenothiazine that company chemist Paul Carpentier had recently synthesised dubbed 4560 RP and later to be called "chlorpromazine". After dubious attempts to convince psychiatrists of the merit of the drug, Jean Delay and Pierre Deniker, working at Ste-Anne Mental

Hospital, began giving it to their patients in March 1952 with good effect. Chlorpromazine spread at once through the French system, dramatically transforming the atmosphere in the disturbed wards of mental hospitals in Paris (Shorter 1997:250). Chlorpromazine initiated a revolution in Psychiatry, comparable to the introduction of penicillin in general medicine. While it did not cure the diseases causing psychosis, it did abolish their cardinal symptoms so that patients with underlying schizophrenia could lead relatively normal lives and not be confined to institutions (Shorter 1997:255).

Shorter (1997:261) also relates how Roland Kuhn, a psychiatrist working at the Münsterlingen Asylum in Switzerland, in collaboration with the Geigy Pharmaceutical Company decided to test the drug G22355 on 40 depressed patients in 1955. Some of the recoveries were dramatic. The compound was called imipramine.

Psychopharmacology certainly brought a therapeutic boost to the psychiatric profession, promising as it did a cost-effective method of alleviating suffering without recourse to lengthy hospital stays, psychoanalysis or irreversible surgery (Porter 2002:206). Since the 1950s the pharmaceutical industry has grown with leaps and bounds with many more medications becoming available for use in Psychiatry.

Central nervous system drugs are currently the leading class of medicines sold in the USA, accounting for a quarter of all sales (Porter 2002:207). These therapeutic drugs are also being prescribed and utilised internationally. Some of the older drugs are still used, for example lithium carbonate is still considered an option in the treatment

of Bipolar Mood Disorder, while many of the earlier anti-psychotic drugs or the first antidepressants are widely used, especially in the so-called 'developing world' as these drugs are cheaper in price; they unfortunately also have many side-effects. The more advanced anti-psychotics are more "streamlined"; patients find it far easier to tolerate their side effects but these drugs tend to be much more expensive. International pharmaceutical research continues to discover and refine medications that are efficacious, having fewer and more tolerable side-effects for patients.

2.3.1 The rebirth of Biological Psychiatry

The neurosciences endeavour to make major psychiatric disorders understandable in terms of the chemistry and anatomic pathology of the brain (Shorter 1997:262). Stephen Stahl defines Biological Psychiatry loosely as: "The study of abnormalities in brain neurobiology associated with the causes or consequences of mental illness" (Stahl 2000:102).

This rebirth of Biological Psychiatry began to emerge in the 1970s (Shorter 1997:239). Nancy Andreasen (2001:338) noted that although in 1983 three dominant models shaped Psychiatry, namely Psychodynamic, Behavioural and Biological, there has been a definite shift towards the biological model since the 1980s.

In the 21st century Biological Psychiatry is strongly represented in most of Psychiatry for various good reasons, namely:

- The growth of a strong scientific base in neurobiology.

- The development of new and effective pharmacologic treatments.

- The value of reducing stigma by understanding mental illnesses within a medical framework of diseases of the brain.

- The growing body of evidence that demonstrates brain changes and abnormalities in a variety of mental illnesses.

Stahl (2000:102) summarises these ongoing approaches used in Biological Psychiatry as:

- Studies done in patients with psychiatric disorders.

- Taking direction from psychopharmacological studies indicating that drugs with known mechanisms of action on receptors or enzymes predictably alter symptoms in a specific psychiatric disorder.

- Searching for abnormalities in receptors, enzymes, neurotransmitters, genes, or gene products that correlate with a particular mental illness.

- Biochemical measurements using blood, urine, cerebrospinal fluid, post-mortem brain tissues, or plasma hormones after provoking hormone secretion by drugs.

- Measurements of structural abnormalities using Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) brain scans; and
- Measurements of functional or physiological abnormalities using Positon Emission Tomography (PET), Electroencephalography (EEG), evoked potentials or magnetoencephalography.

2.3.2 The move to standardise diagnoses in Psychiatry

Due to the nebulous nature of psychiatric illness, sometimes referred to as a grey science, a need remains to classify conditions in a manner which is internationally acceptable, in other words someone diagnosing schizophrenia in a patient in Japan would be using the same set of rules that a colleague in England would use. Porter (2002:213) describes this process as follows: "Mainstream academic and hospital psychiatrists remained committed to the programme of describing and taxonomising the mental disorders stemming from Kraepelin".

2.3.2.1 *The Diagnostic and Statistical Manual (DSM)*

The *Diagnostic and Statistical Manual* of the American Psychiatric Association - the profession's diagnostic handbook - was first published in 1952 (Porter 2002:213).

In the 1950s and the 1960s psychoanalysis consolidated its hold over American Psychiatry and the second edition of the *Diagnostic and Statistical Manual* that appeared in 1968, *DSM-II*, reflected this sway (Shorter 1997:299). The task force involved in compiling *DSM-III* relied

heavily on research evidence relevant to various kinds of diagnostic validity. This scientific work was published in 1980. The repositioning of American Psychiatry had a great impact on events elsewhere. By the early 1990s, *DSM-III* or the revised version of it that appeared in 1987 (*DSM-III-R)* had been translated into over 20 languages. The appearance of *DSM-III* was thus an event of capital importance, not just for America but for world Psychiatry (Shorter 1997:302). The publication in 1994 of *DSM-IV* confirmed the trend away from the psychogenic theories dominant in America a generation before, towards a more organic orientation. A revision of the fourth edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* called *DSM-IV-TR,* was published in 2000 (Sadock & Sadock 2003:vii).

2.3.2.2 *The International Classification of Diseases (ICD)*

In the early 1960s, the Mental Health Programme of the World Health Organization (WHO), became actively involved in a programme aiming to improve the diagnosis and classification of mental disorders. At that time, the WHO convened a series of meetings to review knowledge, actively involving representatives of different disciplines, various schools of thought in Psychiatry, and all parts of the world in the programme. It stimulated and conducted research on criteria for classification and for reliability of diagnosis, as well as producing and promulgating procedures for joint rating of videotaped interviews and other useful research methods. Numerous proposals to improve the classification of mental disorders resulted from the extensive consultation process and these were used in drafting the Eighth Revision of the International

Classification of Diseases (ICD-8)(Frances 1994:xvii). The ICD-8 was revised and published as ICD-9, which – in turn – was published after many years as ICD-10 in 1992 (Frances 1994:xix).

2.3.2.3 *DSM-IV-TR's relation to ICD-10*

There was a strong consensus that the diagnostic system used in the USA had to be compatible with the ICD-10 to ensure uniform reporting of national and international health statistics. ICD-10 is the official classification system used in Europe and many other parts of the world. All categories used in the *DSM-IV-TR* are found in ICD-10, but not all ICD-10 categories are in *DSM-IV-TR* (Sadock & Sadock 2003:288).

2.4 UNDERGRADUATE TRAINING IN SOUTH AFRICA TODAY

Medical education in South Africa is regulated by the Health Professions Council of South Africa. Psychiatry has been recognised as a sixth major clinical speciality together with Medicine, Surgery, Paediatrics, Family Medicine and Obstetrics (including Gynaecology). This measure ensures that during the clinical years time is devoted to the teaching of Psychiatry, especially in the hospital environment where both in– and out-patients are evaluated by medical students. Most medical schools are developing new curricula where M.B.,Ch.B. (medical) students receive five years of formal tuition – previously the degree took six years to complete. In spite of limited numbers of staff members, most medical schools provide good undergraduate teaching courses in Psychiatry. The goal of undergraduate training in Psychiatry is to ensure

junior doctors are able to recognise the most common psychiatric conditions and know how to manage them at a primary health care level. Doctors should also be able to recognise life threatening conditions associated with mental illness such as delirium or acute neuroleptic malignant syndrome and know how to apply emergency measures until the patient can be referred for specialist treatment. Medical students should also have a working knowledge of psychopharmacology. Young doctors should also know when to refer patients to psychiatrists, psychologists and other health professionals.

2.5 POST-GRADUATE PSYCHIATRIC TRAINING IN SOUTH AFRICA

In the early part of the 20th century most South African psychiatrists were trained in Europe. In 1959 and 1968 Psychiatry obtained its own full-time Chairs at the University of Witwatersrand and the University of Cape Town respectively (Jones 2003:p17 of 19).

The standard of post-graduate training in South Africa has traditionally been good and has enjoyed international recognition. Considerable effort has been made to ensure the maintenance of these high standards. University departments are responsible for specialist training. Two routes are available to assist an individual to qualify and register as a psychiatrist in South Africa, namely

- A M.Med. degree in Psychiatry through a university medical school.

- Completion of the Fellowship of the College of Psychiatry (Colleges of Medicine in South Africa) – F.C.Psych.

Both the M.Med. (Psych) and the F.C.Psych. degrees require a four year training period in an approved registrar post. Candidates for registrar posts must have obtained the M.B.,Ch.B. degrees and have completed two years' training, one year's housemanship and served one year as a Community Service Doctor. Both courses comprise Part I examinations, concentrating on the neurosciences and Psychology, as well as Part II examinations comprising general and special Psychiatry and Neurology. There are 130 registrar posts in South Africa at eight medical schools. Child and Adolescent Psychiatry is the only recognized sub-speciality within Psychiatry, with two years' additional supervised training (Emsley 2001:386).

2.5.1 The Diploma in Mental Health

The College of Psychiatry of South Africa awards a Diploma in Mental Health to medical doctors who pass the required written and oral examinations relating to Psychiatry.

There is, however, no standardized formal tuition available to potential diplomates. They are required to have spent at least three months working in a given academic psychiatric hospital, or at least six months working in the psychiatric ward of nine selected general hospitals in Southern Africa working under the supervision of a psychiatrist.

Doctors who have been formally mentored by a registered psychiatrist on at least ten cases may also be eligible to sit the examination.

No formal curriculum is available, but potential diplomats are given a list of topics they will be examined on.

Medical doctors who do not have direct access to a registered psychiatrist are therefore automatically disqualified from applying to write the Diploma in Mental Health even though they may be frequently managing many psychiatric patients at primary health care level.

Table 2.1 Statistics of doctors who wrote the Diploma in Mental Health 1997 -2007.

Source: College of Psychiatry of South Africa (2008).

Date of examination	Number of candidates who wrote	Number of candidates passed	% pass rate
May 1997	1	1	100
October 1997	3	3	100
April 1998	4	3	75
October 1998	4	4	100
April 1999	2	2	100
October 1999	6	5	83
May 2000	4	3	75
October 2000	5	5	100
May 2001	6	5	83
October 2001	12	9	75
May 2002	6	5	83

October 2002	14	13	93
May 2003	4	3	75
October 2003	20	16	80
May 2004	5	2	40
October 2004	18	15	83
March 2005	12	10	83
October 2005	16	7	44
March 2006	10	8	80
October 2006	22	19	86
March 2007	15	9	60
August 2007	29	23	79
Total	218	169	78

In summary, over a period of ten years 1997 until 2007, table 2.1 shows of the 218 candidates who wrote the Diploma in Mental Health, 169 (78%) were successful. Viewed from a different perspective, the College of Psychiatry of South Africa obtained excellent results in certain examination centres such as in May 1997, and October 1998 but less than satisfactory results in May 2004 and October 2005.

The researcher is of the opinion that a consistent pass rate of 100% would negate the need for formal standardised tuition for potential diplomates writing the DMH. However, considering the statistics in table 2.1, there is a need for certain diplomates to receive more thorough training. This need for tuition will be catered for in the PGDipMH.

Although having a PGDipMH will improve a doctor's chances of gaining a registrar post in Psychiatry, the diploma will not gain credits towards

obtaining a FCPsych or a M.Med (Psych) degree as the content of the programme is pitched at a post-graduate diploma level.

2.5.2 The South African Medical Association Foundation for Professional Development Short Course on Mental Health

The South African Medical Association Foundation for Professional Development offers distance education using comprehensive study manuals supported by a three day interactive contact session programme for medical practitioners in the field of Mental Health. The mode of teaching is thus face-to-face tuition and distance education where learners work through materials (self study guides) provided by the Foundation. Participants are assessed using multiple-choice questionnaires and essay questions. Doctors completing the course receive a certificate.

2.6 THE CURRICULUM

Each medical school has its own curriculum concerning the teaching of under- and post-graduate Psychiatry. The next paragraphs will explain the method of teaching registrars at the UFS where the M.Med. (Psych.) option is utilised.

Registrars are given two years in which to complete the primary part of the degree. They need to pass examinations in Neuroanatomy, Neurophysiology and Psychology after having attended lectures in these

subjects. In order to prepare themselves for the so-called "intermediary examinations" registrars, work with colleagues in the Neurology Department for two months and in the Internal Medicine Department for one month before having to pass oral clinical examinations in both subjects.

During the whole four years of training registrars are required to work as medical doctors while being trained in Psychiatry: the so-called "in-service training". Registrars work under supervision of consultants working in various fields of Psychiatry and are expected to have an in-depth knowledge of all the many different psychiatric conditions, as described in the *DSM-IV-TR* or alternatively the ICD-10 (cf. 2.3.2.3.).

Patients are often discussed during ward rounds. Registrars prepare formal lectures on various topics and present them to the Department. Additionally they are expected to offer in-service training to undergraduate medical students. Registrars are expected to read medical literature and attend congresses where new information on Psychiatry is presented. They are also expected to write and publish two original articles, based on their own clinical research, in medical journals accredited by the University of the Free State. Near the end of the four years, registrars have to pass written and oral examinations.

Registrars completing the course should be worthy of the job description 'medical specialist in Psychiatry'. They should be aware of new fields of development in the field of Mental Health and also be able to contribute to research in Psychiatry and publish information in

Psychiatric journals and other literature. Newly-trained psychiatrists should be on a par with colleagues in any other part of the world.

2.7 CONCLUSION

A rich heritage and legacy have been passed down through the generations to those who wish to know more about Psychiatry. Not only is there a wealth of information available in psychotherapy, but the dynamic fields of neuroscience and psychopharmacology continue to expand rapidly. The student at any level of Psychiatry (under-, post-graduate diploma level or post-graduate specialisation level) needs to tap into this wealth of knowledge and expertise. The overall goal of the study was to provide a framework whereby members of the medical profession could embark on formal post-graduate training on a part-time basis, utilising the blended learning mode (cf. 1.3.1). This will assist potential diplomates bridge the void caused by a lack of formal tuition at post-graduate diploma level in Psychiatry.

In the next chapter curriculum development and planning will be discussed. Novel ways of presenting information regarding Psychiatry to Post-graduate Diploma learners will be explored.

CHAPTER 3

PROGRAMME AND CURRICULUM DEVELOPMENT WITH THE ADULT LEARNER IN MIND

3.1 INTRODUCTION

Before planning any new programme, especially at tertiary educational level, extensive planning and research is needed. In this chapter, emphasis will be placed on identifying the appropriate South African legislative and university (University of the Free State) policies that should be considered and applied when designing a new programme. Where applicable comment has been made to discuss how these requirements will be met in the Post-graduate Diploma in Mental Health. Certain guidelines that have no bearing on postgraduate diplomas are not discussed.

If the necessary requirements are met and the programme is registered, students who enrol for it and pass their examinations can be assured that their qualification will be recognised as valid.

Another essential part of an effective programme is a well planned curriculum. This chapter not only discusses the model devised by Ralph Tyler, but also his work relates to Outcomes-based Education and Training (OBET) in South Africa with its various regulatory bodies.

Different aspects of curriculum planning and development are discussed, and how they can be adapted to a medical context in a so-called 'Post-modern' society. The content of the curriculum will be discussed in Chapter 6 of the thesis.

Learning forms an integral part of a curriculum. Educators often know how to facilitate learning in students but as a minor theme, this thesis explores how the human brain uses memory in the learning process. The association between different types of learning and aspects of curriculum development are examined. As all the learners who enrol for the envisaged Post-graduate Diploma in Mental Health will be adults, certain dynamics related to adult learners (in contrast to high school adolescents) are also discussed.

As the Post-graduate Diploma in Mental Health will cater also for medical doctors working in primary health care settings in rural regions, the most likely mode of teaching chosen will be online distance learning (ODL) utilising electronic learning (e-learning). Due to expansion in telecommunication infrastructure to even the most underdeveloped parts of South Africa, doctors with access to Internet lines will be able to enrol and participate as learners in the course, therefore E-learning is explored as an innovative method of instruction. In keeping with recent developments in e-learning, mobile learning (m-learning) is explained as a viable option available for use by learners in the 21st century (Leach, Power, Thomas, Fandani & Mbebe 2005:13).

A comprehensive programme that includes all the above-mentioned features can facilitate learning in this manner, and yet still remain within the necessary structures required for registration.

3.2 PROGRAMME PLANNING IN THE SOUTH AFRICAN CONTEXT

3.2.1 The adult learner and Outcomes-based Education and Training (OBET)

The origins of OBET can be traced to the Objectives Movement and the works of Ralph Tyler in the 1950s, who advocated the concept of curriculum design that included objectives (Brady 1975:70). Brady regards William G. Spady as one of the leading figures in Outcomes-based Education. Steyn and Wilkinson (1998:205) identified the underlying roles of four differing philosophies namely behaviourism, social reconstructivism, critical theory and pragmatism upon which OBE in South Africa is based.

Spady (1994:1) regards the OBET approach as a way of designing, delivering and documenting instruction in terms of goals and outcomes. This means starting with a clear picture of what is important for learners to be able to do, then organising the curriculum, instruction and assessment to ensure that learning ultimately happens (Spady 1994:1). This educational paradigm assumes that all learners are able to learn and succeed, but each one in their own individual way and time (Spady 1994:9).

An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused. The outcome provides the facilitator with a starting point and focus on the curriculum, assessment planning and implementation (Betts & Smith 1998:52; Killen & Hattingh 2004:72). The outcome is shared with and explained to the learner on a continuous basis to ensure that the "transparency" philosophy of OBET is fully realised (Spady 1994:9). A teamwork approach with learners and facilitators as partners is thus established to achieve visible and clear learning goals (Spady 1994:9).

Harden, Crosby and Davis (1999:9) describe the global move towards Outcomes-based Education and suggested that health professionals' education could benefit by adopting the principles of the OBET approach as a valuable education tool. Harden (2000:437) mentions that in using the OBET approach, the trend to learner-centred learning continues. Advances in medicine and biomedical science demands changes in patterns of delivery of health care.

3.2.2 The definition of an 'outcome'

Spady (1994:18) simply defines an outcome as high-quality, culminating demonstrations of significant learning in context. *Demonstration* is the key word: an outcome is not a score or a grade, but the end product of a clearly defined process that students carry out.

These demonstrations or end products of student work have other characteristics:

- They must be of a high quality and completed.

- They occur at the culminating point of the task, (not during the task).
- Exit level outcomes refer to those outcomes that occur at the end of a student's academic career.

- The demonstration must show (reflect) significant learning: significant content is essential.

- All demonstrations of learning must occur in some context or performance setting. The conditions and circumstances students face when performing, affect what they need to know, do and be like in order to succeed, quite apart from the cognitive, technical or impersonal nature of the task itself.

3.2.3 Structure of the Observed Learning Outcome (SOLO)

SOLO is an acronym for the Structure of the Observed Learning Outcome and the taxonomy was developed to provide 'a general framework for systematically assessing quality [of learning]' (Collis & Biggs 1986:1).

The SOLO taxonomy enables teachers to make inferences about the depth of learners' understanding by examining the way they structure their written or oral responses to open-ended questions.

There are five distinctive ways in which a learner may structure a response – these became known as the five levels of the SOLO taxonomy. The five levels progress in complexity in terms of the cognitive capacity needed to answer the question, the attempts the learner makes to relate his or her response to the question, the internal consistency of the answer, the closure of the answer and the overall structure of the answer. Killen and Hattingh (2004:77) summarised Collis and Biggs' five levels of the SOLO taxonomy as follows:

- When giving a *pre-structural response* the learner either does not engage with the task ('I don't know'), simply repeats information given in the question, or guesses the answer.

- A *uni-structural response* draws a simple correct conclusion, but is based on only one relevant aspect of the given data.

- A *multi-structural response* uses two or more pieces of given data to reach a correct conclusion. It may contain elements that are consistent with the question or data, but which lack integration with one another.

- A *rational response* builds on the multi-structural response by using a previously learnt concept or principle to integrate the multiple ideas and to explain the links between them. However

since understanding of the broad principle may be limited, such responses may be inconsistent across the different contexts.

- An *extended abstract response* goes beyond what has been taught and uses logical deduction to frame the answer. To produce an extended abstract response, the learner must not only attend to given information but must consider its relevance to overriding abstract principles and deduce a hypothesis that can be applied to a situation that is not given. Such responses will show consistency internally, externally and across different contexts. As the learner will feel a great need for consistency, they will tend to utilise all available data and their conclusions will be more open.

Therefore the comprehensive knowledge of students may be evaluated by assessing their portfolios of completed assignments (Green & Powell 2005:220; Snadden & Thomas 1998:192). Gask, McGrath, Goldberg and Millar (1987:362) suggest that video recordings can also be used to evaluate learners.

Spike and Jolly (2003:92), however question whether oral examination of learners is relevant to clinical practice and lifelong learning principles.

3.2.4 Outcomes-based Education and Training in South Africa

Cretchley and Castle (2001:489) mention that the OBET approach was introduced to South African educators in the 1990s. Policy-makers in

South Africa expressed the need to transform education and training, aiming to develop more skilled and flexible workforces. Thus the policy-makers turned to models of integrated education and training systems abroad that focus on the competency of learners (Cretchley & Castle 2001:487).

Restructuring of the education system has been an important priority of the new government in South Africa after 1994 (Van Wyk & Mothata 1998:2). The South African Qualifications Authority (SAQA) was consequently established through the SAQA Act No. 58 of 1995 (RSA 1995) to oversee the implementation of the NQF. Through the National Qualifications Framework (NQF) a single national education and training framework (the NQF) was created to transform education and training in South Africa with the aim to make it easier for learners to enter an educational system and make progress (RSA DoE 2001:19).

SAQA based the conceptualisation of the NQF on an outcomes-based philosophy of education, named the OBET approach (RSA DoE 2001:42).This system focuses on outputs as opposed to inputs and attainment of learning outcomes as demonstrated in assessment (RSA DoE 2001:42). OBET as a learner-centred approach was introduced to improve the quality of coherence of education and training in South Africa (Cretchley & Castle 2001:487). SAQA issued *The Regulations for National Standard Bodies* (NSBs) in March 1998 and simultaneously established the main parameters of the NQF (RSA DoE 2001:20). These "regulations" specify the requirements of a programme to be accepted as a qualification. They prescribe among others, the format in which programmes for SAQA approval and accreditation have to be submitted

(RSA DoE 2001:20). The format of a programme should consist of learning outcomes with defined purposes intended to provide learners with applied competence. It should add value to the qualifying learner in terms of enrichment of the person, enhancement of employability and open up routes of additional education and training (RSA DoE 2001:20).

The programme should also include both specific exit-level outcomes with assessment criteria and critical cross-field outcomes (generic skills) such as problem solving, critical thinking, teamwork, communication and the use of information (RSA DoE 2001:21). The OBET approach therefore requires philosophical changes and different approaches and strategies for the provision of education and training. These changes and developments have implementations on both learning facilitation and assessment. (Coetzee-Van Rooy & Serfontein 2001:4; Genis 2001:3; Kotzé 1999:36).

In the case of the proposed Post-graduate Diploma In Mental Health (PGDipMH), a M.B.,ch.B. or similar degree recognised by the Health Professions Council of South Africa will be an entry level requirement. The content matter of the diploma will depend on the recommendations of the experts in the fields of mental health, family medicine, medical education and e-learning answering the Delphi questionnaire. These recommendations will be incorporated into the programme in such a way that the SAQA objectives of SAQA are not violated (RSA 1995).

The content of the present Diploma in Mental Health is not formally taught in South African medical schools. The Diploma is awarded by the

Colleges of Medicine of South Africa, after candidates have passed written and oral examinations. The previous Head of the Colleges of Medicine of South Africa – Psychiatry, Prof. C. Allwood had assured the researcher that formal tutoring of the course would be welcomed (Allwood 2005:1).

The Diploma will be designed in such a manner that the parameters and criteria for qualifications design are met. The Higher Education Qualifications Framework (HEQF) (2006:p6 of 29), which is currently still a draft document, states that post-graduate diplomas should enable working professionals to undertake advanced reflection and development by means of a systematic survey of current thinking, practice and research methods in an area of specialization. This qualification demands a high level of theoretical engagement and intellectual independence. A sustained research project is not required but the qualification may include conducting and reporting research under supervision. Report 116 (1996: p25 of 33) which is currently still the applicable policy in terms of qualifications in higher education, states the primary objective of a post-graduate diploma should be to broaden the knowledge that students acquired during their undergraduate studies, or to give that knowledge a practical application. This objective should again be reflected in the curriculum containing the necessary prerequisite information needed by the National Qualification Framework, Exit level 8, having a minimum total credits of 120.

The Diploma will also be registered with SAQA and National Standards Bodies and will cover the field of Psychiatry. The Level Descriptor will

be on that of a Post-graduate Diploma. The mode of learning will be through blended learning (e-learning and face-to-face contact). The Diploma will be presented in English, and named the Post-graduate Diploma in Mental Health, abbreviated as PGDipMH.

3.3 CURRICULUM DESIGN

3.3.1 Definition of curriculum design

According to Pratt (1994:5) the original derivation of the word curriculum is from the Latin verb *currere*, which means to run. *Curriculum*, the diminutive form, came to mean a "racing chariot" or *"race track".* This view is shared by Soanes (2002: 200), who goes on to define the word curriculum as "the subjects included in a course of study in a school or college". Pratt continues to elaborate on this definition by stating that "curriculum …..means a plan for a sustained process of teaching and learning". The definitions of curriculum may range from rather narrow interpretations to broad, all encompassing interpretations which include virtually every aspect of the full education system. It may be easiest, however then, to consider curriculum, simply as "a blueprint for instruction" (Pratt 1994:5) or simply "all the opportunities planned by teachers for pupils" (Nicholls 1982:11). As the proposed Diploma in Mental Health will be offered by the Department of Psychiatry of the University of the Free State, the curriculum also has to be in line with the guidelines prescribed by this university (UFS 2006:1).

Stated differently, when the term curriculum is applied within a medical context, Langsley, McDermott and Enelow (1973:70) describe a certain challenge, namely to promote a good match between the resourcefulness of those highly talented and trained persons who become physicians (and psychiatrists), the resourcefulness of other colleagues and the mental health care needs of the population (cf. 6.1). The New Academic Policy for Programmes and Qualifications in Higher Education Discussion Document (2001:p92 of 104) views the curriculum as containing more than just the syllabus documentation but also caters for all the teaching and learning opportunities that take place in pedagogic institutions and also encompasses policies, strategies, plans and infrastructure both at the higher education system level and at institution level.

3.3.2 The ideal curriculum

Werkman (1966:90) predicts that the "ideal curriculum" (when teaching Psychiatry to post-graduate students), should assist medical learners to learn about growth and development, psychopathology, and clinical syndromes in Psychiatry. They, the doctors, must develop diagnostic familiarity with these syndromes and rudimentary confidence in handling them as general physicians. Also from Psychiatry and other courses they must learn to assess and deal successfully with the interaction between themselves and their patients, the so-called "art of medicine", in order to realize the optimal emphasis, integration and effectiveness. Nadelson and Robinowitz (1987:20) caution that medical school teaching needs to keep up to date with developments in research, managed health care and preventative approaches.

Pratt (1994:9), however takes a broader, more philosophical view identifying four orientations of curriculum theory which apply within the South African context including cultural transmission, social transformation, individual fulfilment and feminist pedagogy.

3.3.3 Designing the curriculum

The process of developing a curriculum is not linear, reflects Pratt (1994:66), and is not a matter of moving from one phase to another in strict sequence. In designing a curriculum, developers need to shuttle back and forth from one activity to another, creating, correcting, reconsidering and adjusting the content. This would best be described as weaving the curriculum. There is also no fixed sequence for planning the elements of curriculum, Pratt (1994:65) argues, but planners also need to clarify the intentions they hold for student learning, known as the curriculum rationale. The purpose of the curriculum rationale is to state why the aim of the curriculum is worth achieving, rather than just to repeat the aim and intended goals of the curriculum.

Previous systems of education in South Africa articulated curriculum aims and objectives. Aims were considered to be general statements of intent for a curriculum and objectives often reflected specific intents derived from the aims. With the transformation of the general education sector in South Africa and the higher education sector in particular, educators would now no longer consider and refer to curriculum aims and objectives but rather outcomes of the curriculum. These outcomes may be the exit level outcomes which would reflect

the general skills, knowledge and competencies that the learner would possess and demonstrate on completion of the curriculum, or the outcomes may be more specific to a particular phase of study during the curriculum programme. The outcomes must be significant, clear and concise. Barnett and Coate (2005:48) explain when developing outcomes-based education, trivial or inconsequential outcomes should not be included, but rather outcomes that are meaningful.

Barnett and Coate (2005:48) expand on meaningfulness within the context of a changing world, where prepositional knowledge within the context of higher education curricula needs to be rethought and repositioned alongside other more practical and personal forms of knowledge. In a curriculum for the twenty-first century, what matters is the student's own engagement with knowledge – in other words his or her *knowing.* Of equal importance the student also needs to know how to apply this knowledge in context (Dobson 1987:149). Individuals need to be able to work things out for themselves in their own situations (*acting)*. They have to become strong, careful, open, resilient and critical selves *(being)*. These three challenges are universal, and place a responsibility on educators to ensure that curricula with which they are associated are supplying responses of some kind to these three challenges.

3.3.4 Benefits of a systematic approach to course and curriculum development

Diamond (1989:4) recommends that in order for programmes to be developed and implemented, a model of curriculum development

should be used which provides the academic staff involved with a form of ownership of the programme, and the institutional administration with guidelines leading to maximum benefit for the institution. Diamond (1989:5) cautions however that before considering which models are suitable for curriculum and programme development, acknowledgement should be made of the complexity of the curriculum design and implementation process. The process requires sensitivity to the academic setting of the project and an awareness of the capabilities, interests and priorities of the students for whom the programme is designed to serve. The process also requires a knowledge and appreciation of the discipline and an understanding of the resources and options available to the faculty and educators involved.

3.3.5 Models of curriculum development

Oliva (2001:144) views programme development as the process for making programmatic decisions and for revising the products of those decisions on the basis of continuous and subsequent evaluation. A model serves to give order to the process. Taba (1962:11) mentions that "If one conceives of curriculum development as a task requiring orderly thinking, one needs to examine both the order in which decisions are made and the way in which they are made to make sure that all relevant considerations are brought to bear on these decisions".

3.3.5.1 *The Tyler model of curriculum development*

The Tyler model is regarded as one of the best models of curriculum development (Oliva 2001:140). Curriculum planners should identify

general objectives by gathering data from three sources comprising of the learners, contemporary life outside school and the subject matter itself. Two screens namely the educational and social philosophy of the school and secondly the psychology of learning are used to filter the various general objectives the planners have identified for use in the curriculum. The general objectives that successfully pass through the two screens then become the specific instructional or behavioural objectives (specific outcomes).

3.3.5.2 *The Taba model for curriculum development*

Hilda Taba (1962:456) took a so-called grass-roots approach to curriculum development. She believed that the educators themselves should design the curriculum, rather than have it designed by higher authorities who were not involved directly in its implementation. The Taba model therefore advocated an inductive approach to curriculum development, starting with the specifics of the programme and building up to a more general design. This is in contrast to the more traditional deductive approach of first starting with the general design and working down to the specifics.

Taba (1962:456) listed a five-step sequence for establishing a curriculum or curriculum change:

Step 1. Producing pilot units representative of the subject area

This would link the theory to the practice in which the following steps would be required for curriculum developers to produce the pilot units:

- Diagnosis of needs

- Formulation of objectives
- Selection of content
- Organisation of content
- Selection of learning experiences
- Organisation of learning activities
- Determination of what to evaluate and the ways and means of doing it, and checking for balance and sequence.

Step 2. Testing for experimental units. In this phase, the units developed, must now be tested to establish their validity and teachability and to set their upper and lower limits of required abilities.

Step 3. Revising and consolidating. The units are modified now to conform to variations in student needs and abilities, resources available and different styles of teaching so that the curriculum may suit all types of classrooms.

Step 4. *Developing a framework.* After a number of units have been constructed the curriculum planners must examine them as to the adequacy of scope and appropriateness of sequence. The curriculum specialist would assume the responsibility of drafting a rationale for the curriculum that has been developed through this process.

Step 5. Installing and disseminating new units. Finally, in this phase, the administrators become involved in order to arrange appropriate in-service training so that educators may effectively put the teaching units into operation in their classes.

3.3.5.3 *Moving beyond Tyler and Taba towards a Post - Modern curriculum*

Hunkins and Hammill (2002:40) argue that Tyler and Taba reflected a view of modernism: that life could be viewed as mechanical, that there existed a stable-state universe, that the process of curriculum development could be compartmentalised and de-contextualised, that goals could be separated from the experiences designed to address those goals, but currently, we are realizing with increasing sophistication that life is organic, not mechanical; the universe is dynamic, not stable; the process of curriculum development is not passive acceptance of steps, but evolves from action within the system in particular contexts; and that goals often emerge from the very experiences in which people engage. Therefore curriculum needs to keep abreast of scientific thinking in a real world that cuts across diverse disciplines.

3.3.5.4 *Post– Modern curriculum development*

In post-modern curriculum development Hunkins and Hammill (2002:21) suggest that the stress (emphasis) is not on the specific steps of action, but on the relations that result when people get together for the purpose of creating curricula. Curriculum development according to Doll (2002:42) is not the algorism that has been central to much of modern thinking but is more of a playful dance – a process in which the dancers (both teachers and students) engage in a dialogue of motions (goal setting, content selection, experience design), and are

thus transformed in ways influenced by the dynamics of the local "dance" situation. Although the researcher does not consider the experts that will serve on the Delphi Panel to be dancers, their input will certainly be dynamic.

Rather than denying our Tylerian past, we are adding needed complexity and creativity - imagination, if you will - to our heritage. We are transforming, rather than overturning, what Tyler and Taba urged us to consider. In sailing unchartered waters, new worlds are discovered and created, accounts of adventure are shared, and new educational communities are established (Hunkins & Hammill 2002:44).

3.3.6 The role of needs assessment in curriculum design

Pratt (1980:38) states there are four main information sources of great interest when considering needs assessment in curriculum development, namely opinion surveys, task analyses, social indicators and test and research data. Oliva (2001:200) lists these as the needs of the students/learners in general, the needs of society, the needs of particular students/learners, the needs of the particular community and the needs derived from the subject matter.

According to Diamond (1989:102) these factors include: accreditation requirements (cf. 3.2.4), credit restrictions, fiscal and staff constraints, and effectiveness of existing courses and programmes.

3.3.7 Evaluating the curriculum

According to Soanes (2002:282) evaluation can be defined as "the forming of an idea of the amount or value of a thing". Curriculum evaluation therefore involves the determining worth of a document, as compared with programme evaluation, which involves evaluating the activities that occur when a curriculum is implemented in the class or lecture theatre, and thus forms an integral part of implementing and developing educational activities (Goldie 2006:210).

The first step might be called internal evaluation whereby an interval is allowed to elapse, of perhaps two to three weeks after the curriculum is completed before the developer returns to reread it carefully (Pratt 1994:298). Inevitably after this time period certain time changes will be made to the document and out of this process would emerge the revised draft. This revised draft should then be submitted to experts in curriculum development as well as one or more persons who are subject specialists or experts (Wall, Woodward, Whitehouse, Kelly, O'Regan, Dykes & Cook 2001:24).

Table 3.1 provides an example of a checklist with criteria that may be used to evaluate a curriculum. Although the guide is not written in terms of outcomes-based education, the principles could still be applied to any programme curriculum.

Table 3.1 The Curriculum Guide

Source: Pratt (1994:298).

THE CURRICULUM EVALUATION GUIDE
Needs Assessment • Was a needs assessment conducted? • Are the methodology and results described? • Are the results used appropriately in the design curriculum?
Aim • Is the aim of the curriculum stated? • Does it express the overall intent of the curriculum? • Does it match the objective and the curriculum content? • Is it clear and concise? • Is it worthwhile? • Would it be meaningful and significant to the learners?
Rationale • Is there justification for the programme given? • Are all the important arguments for the programme included? • Is the rationale eloquently written and convincing? • Are the main objectives anticipated and dealt with? • Does the rationale deal appropriately with the social and personal significance of the curriculum?
Objectives • Are all the main objectives of the curriculum identified? • Do the objectives meet the student needs? • Do the objectives go beyond the cognitive? • Are the social and personal objectives included?

- Are priorities, particularly the critical objectives identified?
- Are the objectives written in a clear and consistent style?
- Are the objectives relative to the aim?
- Do the objectives collectively exhaust the meaning of the aim?
- If all the objectives were achieved, would the aim be realized?

Assessment

- Are appropriate means suggested to assess the attainment of each objective?
- Are measures valid, reliable and efficient?
- Are measures low in anxiety for less able learners?
- Are assessment measures intrinsic to the curriculum, rather than formal and artificial?
- Is there adequate diagnostic formative assessment?
- Where appropriate, are standards of mastery clearly indicated?
- Do mastery standards set high expectations?
- Could students make valid judgements about their own proficiency?
- Is the grading system clearly described?
- Is the grading system aligned with the objectives?
- Does the grading system ensure that the critical objectives are mastered?

Context

- Are the social, community and instructional contexts described?
- Is it clear how this curriculum fits with other

programmes? • Is linkage clear with preceding and following courses or units? • Is the relationship to national guidelines shown?
Entry characteristics • Are the learners adequately described? • Is the cultural background of the students acknowledged and respected? • Is the selection process clear? • Are the necessary prerequisites identified? • Is provision made for students who have already mastered the objectives? • Is there guidance for design and use of pre-assessment?
Instruction • Does the instruction match student needs? • Does the instruction match the curriculum objectives? • Is instructional content appropriate and interesting? • Does the instruction ensure early significant success? • Is the sequence and pacing of instruction appropriate? • Are teaching strategies varied, interesting and challenging? • Are there appropriate strategies for students with different learning styles? • Do strategies involve active and co-operative learning?
Individual differences • Is there provision for identifying individual difference in aptitude and motivation? • Are there plans for effective remediation?

• Is there effective use of tutoring and peer tutoring? • Is there adequate provision for faster and more motivated learners? • Is there provision for cultural differences? • Is there provision for students with special needs?
Resources • Are consumables and communication materials described? • Are high-quality materials included in the curriculum or readily available to educators? • Is relevant instructional software listed? • Is the required equipment described? • Are there recommendations for lecture room layout? • Are uses of facilities outside the lecture room suggested? • Are instructor qualities and responsibilities defined? • Are the roles of parents, guests and administrators indicated? • Is total time consumption calculated? • Is the budget complete?
Try out • Is there provision for pilot and field testing? • Are the results, pilot and field tests described?
Programme Evaluation • Are criteria suggested for evaluation of all aspects of the programme? • Are multiple measures and data sources suggested? • Is there provision for feedback on the curriculum from users?

• Is there provision for ongoing revision of the curriculum?
Implementation • Were significant groups involved throughout development of the curriculum? • Are the names and affiliations of the curriculum planners shown? • Are they credible? • Do they include people other than educators? • Is there a realistic adoption and implementation plan? • Is there sufficient provision for in-service training (experiential learning)?
Production Qualities • Is the curriculum professional in appearance? • Is it printed and illustrated? • Are the binding and cover attractive and of high quality? • Is it well written and easy to follow and read? • Is it free of jargon, vagueness and pretentiousness?

3.4 IMPORTANT FACTORS WHEN PLANNING A PROGRAMME/CURRICULUM FOR ADULT LEARNERS

3.4.1 The adult learner

All the learners who enrol for the Post-graduate Diploma in Mental Health will be part of the category of learners considered to be adult (in contrast to adolescents starting undergraduate studies). While general higher educational goals and standards must remain consistent

for all academic programmes, the policies, practices and standards necessary to serve adult learners require particular attention (Dent & Harden 2001:345).

Certain dynamics particular to this group of students will be discussed. According to Gravett (2005:9), adults enter education events with a large quantity of experience that differs from individual to individual. The heterogeneous life experiences of adults hold several implications for teaching, as their life experience is often linked intimately to their identity. Therefore if adults' experience is devalued or ignored, they may feel that they are being rejected as people. On the other hand adults' experience can serve as a rich resource for learning – for the learners themselves and for their fellow learners.

However, experience can sometimes also be an obstacle to learning. Adults often have well established attitudes, convictions and thinking patterns and they may find it difficult to learn new ways of thinking and doing if these contradict their beliefs and experience. This may affect learners' attitudes to Outcomes-based Education. Many adult learners will, however, immediately feel at home and thrive in a situation where learner participation is invited and valued. Gravett (2005:10) cautions, there are some learners whose previous educational experience will have socialised them to accept a posture of passivity and to view the role of the educator as the expert teacher whom learners do not question or challenge. Stated differently, learners assume that knowledge is certain and possessed by the authority.

Some students are not accustomed to have their experience valued in the learning process. Magolda (2002:393) used Shor's argument that people are born learners and that their natural curiosity is often stifled by environments in which they are expected to memorise rules and existing knowledge. True education is the process of developing one's own perspectives in the context of existing understandings of the world. Teaching students how to self-author their beliefs is a matter of creating conditions to promote their development. As stated in section 1.3.1 of this thesis, such an environment encourages risk-taking, but learners feel psychologically safe. This implies that the learning and the learning environment should evoke positive emotions such as interest, enthusiasm and enjoyment (McLachlan 2006:716).

Learning, however, should never be regarded as entirely comfortable. Leamnson (1999:5) explains: "When a mental process is easy it is either trivial or needs only previously well-stabilized synapses". Such processes certainly qualify as brain use but not as learning. Learning requires the use of "not-yet-stabilized synapses" and is therefore inherently taxing. It is a fallacy that educators can make learning fun and easy by merely entertaining learners. Learning requires learners to engage in cognitive learning activities that challenge the brain to create new synapses or follow relatively unused synaptic pathways.

Magolda (2002:396) suggests a continuum of learning approaches utilised by tertiary education learners, called the Epistemological Reflection Model. Initially learners tend to focus on 'absolute' knowing. Here the factual knowledge is cut and dried. It is either right or wrong. If you know the information you can do well. You just read or listen to

the lecture and then you present all the information back to the teacher. The core assumption held by "absolute knowers" is that knowledge exists in an absolute form. Two reasoning patterns were evident in absolute knowing, namely receiving and mastery:

- The receiving pattern, tends to be used more by women than men. A central characteristic of this pattern is its internal approach. "I like to sit and listen; just take notes from the overhead projector. The material is right here, if you have a problem you just ask the educator. You hear it, you see it and you just write it down."

- The mastery pattern, tends to be used more often by men than women. They prefer an active approach to learning, are critical of instructors, expecting interactions with peers and instructors that help them master the material. Absolute knowing corresponds to the formal mode of learning cited by Collis and Biggs (cf. 3.4.4.3).

The Absolute Knowledge Approach tends to undergo metamorphosis passing through other approaches in learning until the Contextual Knowing Approach is harnessed. Contextual 'knowers' look at all aspects of a situation or issue, seek out expert advice in that particular context and integrate their own and others' views in deciding what to think. The Contextual Knowing Approach is more likely to be used by learners who have already completed their initial qualification (graduated) at a tertiary institution. (This corresponds to the post-formal mode of learning described by Collis and Biggs in 3.4.4.3).

In order to enrol for the Post-graduate Diploma in Mental Health learners would already have attained a basic medical degree (M.B.,Ch.B. or equivalent, as recognised by the South African Health Professions Council). Hopefully the learner will be able to cognitively use the Contextual Knowing Approach or the Post-formal Mode of learning to integrate new knowledge with practical expertise gleaned from daily management of patients with psychiatric conditions to enhance their learning experiences (West & West 1987:151).

The learners enrolled for the Post-graduate Diploma in Mental Health will be expected to use the extended abstract response when formulating and acquiring their learning outcomes, as individuals or during group work, according to the SAQA regulations. During the evaluation process, learners will gain extra points for being able to formulate their answers in this manner.

3.4.2 The neurobiological basis of learning

Neurologically there are three types of learning, which use different circuits within the brain: motor, emotional and cognitive learning. Only cognitive learning and it's role in education will be discussed.

The cerebral cortex of the human brain consists of some ten thousand million neurons and ten times as many glial cells. It is made up of small subunits, or modules, that are in essence a form of 'computer chip'. Each module is genetically determined at the time of primitive cell division in the germinal matrix. There are many millions of modules and

each can be considered to form a basic learning unit consisting of a physical means of permanent memory storage together with a switch system. Many of these modules have specified anatomical connections and are pre-programmed with a type of operational programme or learning strategy committing the module to serve a preset function.

The brain does not reach full maturity until the third decade of life. There is a rapid phase of development in the first four years after birth, during which the weight of the brain increases by about 1000 grammes from its weight at birth. Development of dendritic connections, synaptic stabilization, myelination, formation of Nissl substance (rough endoplasmic reticulum) and maturation of association pathways follow an orderly, predetermined sequence.

3.4.2.1 *The brain as an organ of learning*

Much as a computer disk must be formatted to arrange the memories in a retrievable form at specified addresses, the cerebral cortex is formulated with learning at specific predetermined addresses, and this learning is classified and retrieved by language. As mentioned previously, the cerebral cortex is made up of millions of modules each with a built-in programme allowing learning to proceed in a set way at a predetermined rate, and that the cerebral cortex is formatted like a computer disk, with preset addresses learning specific tasks. These learning modules have a preset hard-wiring and software system enabling them to function in a specific modality; to collect and store a defined data set.

The four basic functions of the frontal lobe are: to plan the future, to check for the presence of danger, to inhibit basic drives and to focus attention. This lobe is thought to be important in planning for the future; it contains current working memory and it allows us to 'say to ourselves'. It provides a devil's advocate, seeing the danger or worst consequences of planned actions, and so provides the higher (moral conducts) of basic drives to prevent unwarranted behaviour. It has to produce a plan of action in problem solving. The frontal lobe also has to do with sustaining attention, with the initiation of activity and with drive through curiosity. Without this lobe, adult patients tend to be inactive, without initiative, apathetic and unmotivated. Children with frontal lobe dysfunction cannot concentrate on one function for long and are easily distracted.

3.4.2.2 *The role of the Temporal Lobe*

Diseases of the temporal lobes are particularly associated with learning disability (Brown & Minns 1999:41). The temporal lobe is a vital junction of cognitive, emotional and autonomic functions as well as being essential for memory function.

The region of the temporal lobe known as the transverse gyri of Heschl are thought to be responsible for auditory discrimination, for example distinguishing sounds with linguistic meaning such as colour and collar, from those with an emotional connotation such as tenderness, anger and sarcasm.

A region called the planum temporale also forms part of the auditory association area. It is considered to be the anatomical basis of speech, in particular the site of the word store – the lexicon – of language (Brown & Minns 1999:42).

3.4.2.3 ***Memory***

Brown and Minns (1999:42) regard memory as absolutely basic to learning. If we cannot store new memories, we cannot store anything new. Complex strategies such as the classification and storage of related memories must be transformed into *concepts*, thus making it possible for the individual to understand and to reason.

3.4.2.3.1 *Explicit and Implicit Memory*

Explicit memory encodes information about autographical knowledge as well as factual knowledge. It is also known as declarative memory (memories that can be reported verbally). The stored information of explicit memory is the result of processing by our perceptual apparatus. Once stored, it can be recalled deliberately. However, later recall is not merely a faithful reproduction of the original stored information but rather a modified representation of past experience in which the sensory information is used as clues to reconstruct the past event in a newly formed later recall. Two types of declarative (explicit) are described: Semantic and Episodic memory (Yudofsky & Hales 2002:589). Semantic memory refers to the acquisition of factual information about the world (Levenson 2005:6). Typically semantic memories cannot be fixed as having been acquired at a specific time.

For example, although most people know that Shakespeare is the author of *Hamlet* few can recall where they first acquired this information.

Episodic memory refers to recording and conscious recollection of personal experiences (Levenson 2005:6). Semantic memory is required for episodic memory, but in most cases the spatial and temporal context of events and other associated features such as the emotions associated with life events and the specific details that encompass life events are also included. Episodic memory encompasses personal or autobiographical memories as well as memories for public events.

Declarative (explicit) memory is dependent on the integrity of the hippocampus and its related brain structures (Spitzer 1999:200). Implicit or non-declarative memory has an automatic, or *reflex* quality, and may be strongly associated with motor learning. The formation and recall of an implicit memory are not dependent on cognition, but rather are automatic, without deliberate effort. Yudofsky and Hales (2002:598) describe three types of non-declarative memory:

- Procedural memory

  The term procedural memory is typically applied to tasks that assess the acquisition of motor or cognitive skills (Levenson 2005:6). One can describe procedural memory as "knowing how" as opposed to declarative memory's "knowing that". The brain areas that mediate procedural memory have not yet been identified. It is thought to be non-dependent on the

parahippocampal structures but the basal ganglia may be involved.

- Simple conditioning and simple associative learning.
  This will not be discussed as the acquisition of knowledge relies on far more complex procedures (Spitzer 1999:200).

- Priming
  Some investigators have suggested that distinct memory systems may underlie performance on priming tasks. Schacter (1987: 502) defines priming as the facilitated identification of perceptual objects from reduced cues as a consequence of prior exposure to those objects. In a typical priming task, the subject studies some material but is not told that he or she will be expected to recall it. For example, the subject may be given a list of words and asked to identify those that contain a particular letter or make some judgment about the words (perhaps the degree of pleasantness). A key feature of the subsequent retrieval task is that it is also implicit. For example, in one typical retrieval task, the subject is given the first three letters of words (perhaps word stems) and is asked to generate words that begin with those stems as quickly as possible. Half of the word stems are the beginnings of words to which the subject was previously exposed, whereas the other half-correspond to new words. In this experiment, the subject will generate words more rapidly for stems of previously studied words. In addition, this priming experiment includes an explicit recall component, usually a recognition task in which the subject is given a list of words

containing both previously studied and new words. Typically, the subject's ability to discriminate the 'old' from the 'new' words is quite poor, thus demonstrating that exposure to the words was not sufficient for retrieval in a standard explicit recall task. The studied material includes words, shapes and sounds. The mode of exposure of the studied list has also been extensively varied and these studies have provided insight into the memory processes underlying the priming. An important feature of the subject's initial exposure to the list is the 'level of processing'. A distinction can be made between instructions that call attention to the perceptual features of the items (for example their shape and constituent letters) and those that require a deeper or more conceptual level of processing (for example making judgments about whether words belong to specific categories).

In general, the more the mode of study is perceptual in nature, a quality some call "data driven", the better the priming. This is of value in curriculum development where the learner should be assisted to master certain information by gaining deeper and relevant insight concerning the topic rather than just being able to regurgitate certain facts using rote learning (semantic learning). Schacter, (1987:203) describes this type of priming as an expression of *perceptual representation systems* - a group of domain-specific subsystems that process and represent information about the form and structure, but not the meaning or other associative properties of words and objects. Perceptual representation systems are thought to involve the brain areas

responsible for the initial perception and processing of information without much reliance on the hippocampal systems.

3.4.2.3.2 *Working memory*

Working memory is typically viewed as distinct from the declarative and non-declarative memory systems. Short-term or labile memory endures for seconds or minutes and is regarded by Brown and Minns (1999:43) as being the equivalent of RAM (random access memory) in computer terms. It is the memory necessary for acquiring new data by perception from the environment. It is the memory into which we bring previously stored memories from the cerebral cortex. Material must be brought into short-term memory before it can be processed by recognition or reasoning. It can be seen as a repository for briefly holding onto information such as telephone numbers or the name of a newly met person (Yudofsky & Hales 2002:600). It is also important in tasks that require mental manipulation of information such as multi step arithmetic problems. It enters consciousness only when held in short-term memory and is closely related to consciousness. It probably relies on oscillating circuits in the reticular formation or on modification of synapses. Short-term memory is often used by psychologists as synonymous with immediate memory (Lishman 2002:28). Lishman (2002:28) describes the immediate memory span (or ultra short-term memory) as being reflected in the reproduction of material such as brief digit sequences which fall within the span of attention (cf. 3.4.2.3.5).

Paying attention holds the current content of consciousness, while distraction allows the loss of current thoughts. Interest holds the

attention and so maintains the content of consciousness, which can then be processed by reasoning. The content of short-term memory lasts only a few minutes, even with rehearsal, after which it is forgotten if it is not transferred to long-term stores. Just as the memory in a pocket calculator or RAM in a computer is lost when switched off, so short-term memory is lost with sleep, electro convulsive therapy, anaesthesia or distraction.

Long-term, or stable memory endures for days, years or even decades and can be compared to the hard-disk memory in computer terms. It is the memory required to demonstrate a learned behaviour over longer periods of time. It hold all our significant personal information (data) and also holds it in sequence, so giving us our concept of time. Unlike short-term memory it is hard to change or displace. Storage of memories must be sequential, since sequence gives us our concept of time of past and present (Brown & Minns 1999:44).

3.4.2.3.3 *'Search' and 'Save'*

Brown & Minns (1999:44) loosely define the word search as the recalling of old memories. Material is drawn from long-term memory stores into short-term memory by a 'search' command via the frontal lobe and the reticular formation. If this process is faulty the result is difficulty in recall in *RE-MEMBERING.* This process must be different from the activation of the medial temporal lobe structures required to memorize, that is, save new memories, since recall of past stored memories is normal after bilateral medial temporal lobectomy. Faulty searching is also seen as someone becomes older; they have difficulty

in remembering names but not concepts and yet after a few minutes the recall is perfect. This concept shows that the store is still there, it is the recall that is faulty. In searching the cerebral cortex for stored memories that form part of a concept, the brain is *associative,* not *logical.* Hereby all parts of the cortex are searched for a recognisable component of the concept and the brain does not go through every step of a mathematical, logical programme as occurs in a computer. One wonders how the brain searches through multiple memory stores located in the cerebral cortex so rapidly. Eccles (1979:19) demonstrated that the apical dendrite of a neuron contains a structure known as a cartridge, which can turn a neuron on or off, so that all the neurons in a module are switched on; then any pattern of surface stimulation that they have previously met and for which they have a memory trace or protein would be signalled by the neuron firing.

3.4.2.3.4 *Saving new memories*

Brown and Minns (1999:44) explain how new material can be placed from short-term memory and conscious perception or reasoning into long-term memory stores if the anterior temporal lobe and specifically the hippocampus (the brain's equivalent of the 'save' command on a computer), are intact. The memory system within the temporal lobe is quite extensive. The hippocampal formation includes the hippocampus, the dentate gyrus, the subiculum and the parahippocampal cortices. The dendate gyrus consists of small, dense granule cells while the hippocampus contains large pyramidal cells. There are also GABAergic basket cells, which inhibit the hipocampal pyramidal cells. The hippocampus is divided into three parts – CA1, CA2 and CA3 (Brown &

Minns 1999: 44). Bilateral loss of pyramidal cells in CA1 appears to be specifically involved in memory loss. Afferents to the hippocampus come mainly from the entorhinal cortex, which in turn is connected with nearly every association area in the neocortex (permanent memory stores) and septal nuclei (attention and consciousness). The acetylcholinergic fibres of these nuclei produce a long-lasting excitation of hippocampal pyramidal cells. One of these nuclei, the basal nucleus of Meynert is always affected in Alzheimer's disease.

Efferent fibres project back to the parahippocampal cortex, hypothalamus, mamillary bodies and cingulate cortex. The complete circuit required from the temporal lobe involves the fornix, which arises in the subiculum, the indusium griseum along with the mamillary bodies and the medial dorsal nucleus of the thalamus. Memory loss found in chronic alcoholism and post-traumatic Wernicke's encephalopathy is linked to lesions of the mamillary bodies and the medial thalamus. There is still uncertainty whether the seat of memory is the hippocampus itself, or the adjacent bundle of white matter, the temporal stem. Studies of the neurotransmitter choline acetyltransferase, essential for memory and deficient in Alzheimer's disease (and also Down Syndrome), suggest that the basis of memory is a primary grey matter processing unit in the hippocampal formation. Brown and Minns (1999:45) postulate that the amydala/hippocampal complex on the left (brain) relates to verbal memory and the right side relates to spatial memory. If one side is damaged or removed, the opposite side can take over; if both sides are damaged, the long-term storage of any new memories is severely disrupted.

3.4.2.3.5 *Attention*

Attention according to Brown and Minns (1999:50) is the willed or voluntary selection of a topic to hold within consciousness, utilizing short-term memory in order to allow mental processing (thinking). Attention is the focusing of conscious awareness upon a particular motor activity – especially while it is being learned a specific sensory input or perception, or memories and concepts retrieved from long-term memory stores into short-term memory.

Attention is accompanied by the rejection of simultaneous and unwanted sensory stimuli, which are said to be 'gated out' – for example environmental noise as distinct from speech sounds and visual stimuli other than those relevant to the task at hand. If such thought processes are not gated out they enter conscious awareness and interfere with the thought processes, so that one may 'lose the train of thought' – one is distracted and this clears short-term memory. Attention is also lost (a secondary attention deficit arises) when the material is boring, irrelevant or anxiety-provoking and likewise attention is sustained when the material is interesting and excites curiosity. Perhaps this is one of the challenges curriculum planners face, to ensure that the material is stimulating. It is thought that the intra-laminar thalamic nuclei and the prefrontal lobes are important in the maintenance of attention (Brown & Minns 1999:51).

3.4.3 Emotional and psychological factors affecting adult learners

Gravett (2005:10) explains that adult learners often seek education in order to address problems, challenges or needs arising from their life roles.

As all the learners in the Post-graduate Diploma in Mental Health will be medical doctors, a summary of emotional/psychological factors affecting doctors is presented. Aziz (2004:29) collates stress factors affecting doctors in different parts of the world. Although doctors are not a homogenous group, recurring themes included:

- Excessive number of hours worked and work overload
- Inadequate time spent with patients
- Uncertainty (regarding diagnosis and management of patients)
- Being "on call" and night work
- Team conflicts
- Increasing criticism, expectation and demands from the public
- Sleep loss and sleep disruption
- Dealing with violent patients
- Work encroaching into personal time spent with families, and
- Omnipresence of illness and death.

In a South African context, Peltzer, Mashego and Mabeba (2003:275) also cite conflict with colleagues not doing their work and stressful working conditions as factors that affect doctors negatively.

These risk factors may often lead to:

- Compromised physical and mental wellbeing resulting in "burnout".
- Increased incidence of depressive and somatic anxiety symptoms; also higher suicide rates compared to other professionals and the general population.
- Marital and family relationships being negatively affected, and
- Increased alcohol consumption.

(Aziz 2004:29; Peltzer *et al.* 2003:275; White, O'Connor & Garrett 1997:330).

Many of these issues shouldl be addressed during the presentation of the programme.

3.4.4 Types of learning

There are three separate neuroanatomical circuits in the brain, subserving motor, emotional and cognitive learning. New behaviour can arise purely as a result of neuro-anatomical maturation or as an effect of environmental experience.

Although Brown and Minns (1999:52) differentiate several categories of learning including reflex behaviour, pre-programmed behaviour, conditioned behaviour and true learned behaviour including motor, emotional and cognitive learning only cognitive learning will be discussed.

3.4.4.1 *Cognitive learning*

Cognition (from *con ,*with, + *cognito,* knowledge or understanding) as explained by Brown and Minns (1999:59) with the development of understanding we are able to say 'I know'; I have knowledge, that is , I possess a collection of acquired data on that subject that I can group and bring together into short-term memory and consciousness to form a concept, so that I can understand. Hensyl (1990:325) gives a broader definition of cognition in Stedman's Medical Dictionary, as the generic term embracing the quality of knowing, which includes perceiving, recognising, conceiving, judging, sensing, reasoning and imaging.

The basis of understanding is the formation of concepts, that is, a set of linked memories on the same topic stored at different addresses in the cerebral cortex: this allows the whole brain to function as a unit. This formation of concepts requires some form of language. Words (the lexicon) are localized, but inner language as implied by, for example, understanding or comprehension, requires all parts of the brain.

The individual memories that form a concept are not stored in the same place, for example an orange (as a concept). The phonetic sound sequence, smell, taste, colour, size, texture, written spelling (graphemic sequence) and facts – that it is a citrus fruit, that it contains vitamin C, that there are Jaffas and blood oranges, that they come from Israel – are all memories that are stored in different parts of the brain. The time when a particular memory component of a concept was initially laid down from first perception may also differ by fifty years or more: it would take a long time if a whole lifetime of individual memories had to

be sifted through to extract one fact. A memory in isolation may only be retrieved by chance. Brown & Minns (1999:59) relate that in the Library of Congress in the United States of America with its millions of books, if one takes a book off one shelf and places it on the shelf below, it is the same as stealing the book, as it would be irretrievable at the wrong coded address. The same is true in the brain: excellent hardware with abundant but unclassified data is of little use without a language and an operations strategy to say what to do with the data – without such a strategy we would have to return to the cerebral sponge concept of 'store everything and let it sort itself out'.

This is not to say that when we developed a concept and understanding we do not 'self-programme' and generate our own software systems for further development of the data through reasoning and imagination. The human brain is not 'logical' like an ordinary computer, which runs through all its information in a pre-set mathematical routine dictated by the software, but is associative, that is, the whole brain scans a wide field looking for relevant data to light up.

This image triggers the corresponding concept so that the other components of the concept are retrieved, from all the different addresses in the cerebral cortex, into short-term memory. One *RE-COGNISES* the object and can say 'I understand what that is; I have previous knowledge'. If the orange were square, blue, or tasted like a peach, the incongruity with the previous existing concept would cause us to recognise a dis-concordance and make us unsure whether we understood what the object was.

Thought is the current content of consciousness, so if I am thinking about an orange, then using the analogy with a computer, this section corresponds to that section of RAM which we are currently processing (thinking about). I can process or compute these thoughts by verbal reasoning. This computation occurs in the central processing unit of my reticular formation while these thoughts are held in short-term memory, making them 'conscious'. I can compare an apple with an orange (an easy process) or socialism with communism (a narrow, more highly abstract concept), or the substantia nigra with the locus coeruleus (a barely existing concept, so my understanding is limited). One must have multiple stored facts, that is, knowledge about a subject, in order to form a concept. The more individual memories there are – the more components to the concept – the greater the understanding. Hopefully this approach will apply in curriculum planning and development especially with regard to Outcomes–based Learning.

Verbal reasoning consists in comparing each individual component of the two concepts – for example size, shape, smell, colour – to see if they are similar or different. As a result of this reasoning I can reach a decision: the two concepts are similar or very different. These mental abilities or processes of perception, recognition, understanding, verbal reasoning and decision making are the basis of the mind (mental processes) and are what we attempt to assess in learners during formal evaluation, (or what is formally tested during psychometric evaluation of intelligence). Brown and Minns (1999:60) explain that the way in which memories acquired at different times in our lives and stored in different parts of the brain are classified into concepts depends upon a structured symbol system we call language. Although this language is

usually based upon words, other systematised symbol systems – such as those for chemistry, electronic circuitry, music, algebra – are also languages allowing memories to be grouped into concepts and allowing the person to understand and reason. One cannot reason until one has formed concepts and one cannot form concepts without some basic factual knowledge. This is often forgotten in medical education where teachers may try to teach clinical reasoning before the basic lingua franca of anatomy, physiology and pathology has been remembered.

3.4.4.2 *Describing the development and structure of learning*

Killen and Hattingh (2004:73) state that demonstrations of learning depend on the learner's understanding. Understanding may be regarded as the ability to provide explanations, or the ability to think logically, or the ability to solve unfamiliar problems, or the ability to re-interpret objective knowledge, or the ability to view things from different perspectives – to mention a few.

3.4.4.3 *The modes of cognitive learning*

Collis (1992:28) suggests that modes of cognitive functioning progress from sensor-motor through iconic, concrete-symbolic and formal to post-formal. Each mode represents a distinct (measurable) advance in development of cognition and learning competence which enables the learner to deal with a different form of knowledge. The form of knowledge in the sensori-motor mode is usually described as *tacit knowledge - knowing how* to perform a skilled act without necessarily being able to describe the act or explain why it is being done in a

particular way. From the perspective of teaching and assessment, two things should be noted about this mode of cognitive functioning: it forms the basis for progression to the next mode (iconic) and it encompasses a wide range of different levels of tacit knowledge. For example, both the knowledge underpinning very simple skills performed by young children and the knowledge underpinning more complex activities (such as hitting a golf ball) all require tacit knowledge. These modes can be described as:

- *The iconic mode*. This is the stage of development during which learners gain and later fully develop the capacity to form internal pictures, images or 'icons' and to use words to represent real objects and to facilitate thought. Capacity for this form of thought commences at about 18 months of age and it allows the learner to use signifiers (words, images) to manipulate ideas and to communicate orally. Development continues within this mode when, for example, communication reaches adult level in terms of its structure and sophistication. Iconic thinking facilitates the development of intuitive knowledge that enables learners to do things (such as object qualification) correctly, but does not enable them to explain why. Further maturity within this mode of thinking facilitates quite sophisticated activities such as art appreciation and problem solving in areas such as mathematics and science – when 'the "solution" to the problem is imaged in this mode and then established to the satisfaction of the colleagues by evidence and argument in a later-developed mode, usually formal' (Collis 1992: 28).

- *The concrete – symbolic mode* is so-named because it allows the learner to interpret the concrete world through symbolic systems. It represents an important development in the abstraction involved in thinking. Mental representations are now in terms of concepts rather than icons and the logical relationships between concepts allow learners to manipulate them. This mode of cognition is possible from about six years of age. Because learners can now deal with symbolic systems, such as those used in language, mathematics and music, they can now think about events and objects from the environment in symbolic ways. For example the learner can use geometric diagrams to represent physical objects and events.

  Learning in the concrete-symbolic mode leads to the development of *declarative knowledge* – the ability to give symbolic descriptions of the concrete world. Mastery of the symbol systems involved in writing, computational mathematics, drawing and reading maps, reading musical scores and so on provides learners with a powerful tool for controlling their interactions with the environment and other people. Collis (1992:29) claimed 'the mastery of these symbol systems and their application to reality, must be regarded as a major task to be achieved during the years of compulsory schooling'. Most importantly, learners must come to understand 'there is a logic and order between the symbols they are using [such as grammatical rules in language or mathematical symbols in an equation] that allows the symbols to be manipulated independently of the aspect of the real world that they are representing at that point in time'. Manipulation of the symbols can

lead to more appropriate symbolic representations and to a deeper understanding of the real world. 'Ability to function efficiently in the skills of this mode is crucial to operating effectively within our society because it is the mode in which the cognitive aspects of everyday living are conducted' (Collis & Biggs 1986:189). If learners are to develop intellectually in the concrete symbolic mode (and higher modes), teachers must actively cultivate the learner's intellectual skills rather than just impart knowledge. Likewise, teachers need to assess their learners' intellectual skills, not just their capacity to memorise information.

- *The formal mode* involves the manipulation of theoretical (abstract) constructs, and is therefore concerned with *theoretical knowledge.* Thinking can now involve hypothesis formulation and prepositional reasoning – the learner can now consider possibilities as well as realities. Development in this mode is usually context-specific – a learner may be capable of formal operation in mathematics but not in music for example. This mode usually starts at the age of sixteen and is a commonly expected level for successful university entrance. It is expected that development in this mode will continue through university and that a high level of functioning in this mode in the student's major study areas is a minimum passing standard in a Bachelor's degree and at this level learners should be able to demonstrate their understanding of a discipline well enough to work within it (Collis & Biggs 1986:189).

- *The post-formal mode*. Development in the post-formal mode is very content-specific and few learners will reach this stage – those

who do will probably not reach it until adulthood. Collis and Biggs (1986:189) suggest that 'individuals who aspire to the post-formal mode must have an overview of their discipline such that they can challenge its basic tenets and conduct research to advance understanding in the area'. This is the form of cognition that we usually expect of post-graduate students.

3.4.5 Modes of delivery for adult learners

3.4.5.1 Definitions relating to E-learning

The following definitions relate to E-learning:

- **E-learning**

  E-learning can be defined as: Education via the Internet, network or standalone computer. Network enables the transfer of skills and knowledge. E-learning applications and processes include web-based learning, computer-based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intranet/extranet, audio or videotape, satellite TV and CD-ROM (Google 2004:p1 of 1). The University of the Free State's Centre for Higher Education Studies and Development defines E-learning as 'the use of various technological tools that are either Web-based, Web-distributed or Web-capable for the purposes of education'.

- **Distance education**

  In 1990 Moore described distance education as all arrangements for providing instruction through print or electronic communications

media to persons engaged in planned learning in a place or time different from that of the instructor(s). In 1997, Moore and Kearsley refined the definition to specify that the learning is planned and includes "organisational and administrative arrangements" (Maguire 2005:1). Mcharg, Goding, Caldarone, De Bere and Mclachlan (2006:258) describe how a virtual learning environment (VLE) where learning can be facilitated in two different localities can be established. Students also have access to online medical journals.

- **Asynchronous learning**

  The learner(s) and instructor are separated by time and space – using a variety of technical media to support the teaching and learning (Maguire 2005:1).

- **Online distance learning (ODL)**

  Norman, Van der Vleuten and Newble (2002:586) describe the origins of distance learning. In the first half of the 20th century distance education took the form of correspondence courses, which ultimately collapsed under the weight of economic drive for profitability. In the second half of the century, open universities took a more comprehensive approach to distance education and by incorporating electronic technologies, created a second wave of enthusiasm for distance education.

At the end of the 20th century, starting in 1998 (PriceWaterhouseCoopers 2004:p1 of 1), the year of educational

enlightenment, distance education had once again become a burgeoning enterprise which will continue to expand for some time.

Advantages of distance education to faculty, students and school:

- In an online environment there is greater interaction between faculty and student.

- There is an increased ability to reach a greater number of learners resulting in increased diversification and globalization.

- The needs of non-traditional students can be met, for example students with responsibilities such as career and family demands which keep them from taking traditional daytime college courses.

- Traditional students who wish to learn in an online environment.

- Distance education provides a new stream of revenue without the needs of additional on-campus facilities such as residence halls and classroom space (Maguire 2005:2).

- Distance learning allows students to learn at their own pace (D'Andrea & Gosling 2005:130; Rogerson 2003:1).

Suzanne Levy (2004:3) states boldly "the challenge to colleges in the 21st century is not to decide why they should have an online distance

learning program, but to decide how to design and implement such a program".

O'Leary and O'Leary (2006:31) describe it (E-learning) as a rapidly emerging Web application. New technologies are tools with multiple capabilities; it is misleading to make assertions like "Microcomputers will empower (sic) students" because it is only one way in which computers might be used. Any given instructional strategy can be supported by a number of contrasting technologies (old and new), just as any given technology might support different instructional strategies (Battles, Crowder, Mille, Sadler, Mohl & McIntire 1997:347; Podrug 2003:202). Payne (2004:231) suggests "good practice" and "best practice" in curriculum development and course design can be based on serious thinking about cognitive development, without neglecting the acquisition of information, skills and theoretical understandings.

The classroom has been almost entirely discipline-centred and the mode of presentation didactic, focusing chiefly on information transmission. Some of this has unfortunately carried over into electronically mediated education. Notar, Wilson and Ross (2002:642) caution that emerging research informs us that for teachers to make the most of new technologies, especially in the case of high-level cognitive skills, they must become facilitators, collaborators and guides who make instruction learner-centred. D'Andrea and Gosling (2005:130) differentiate between a technologically based approach to teaching and learning compared to a technologically mediated approach. The former is seen as an overarching paradigm for teaching

and learning whereas the latter is more about teaching and learning methods including e-learning.

Online teaching (using the Internet and the World Wide Web-www), requires an evaluation of how learning takes place. Significant learning is marked by transformation in ways of thinking and in the making of meaning (Harden 1998:190). According to Dewey and the constructivists, the necessary conditions for significant learning should be in place. The acquisition of the habits and skills of critical thinking include substantial opportunities for students to be active, interactive and reflexive (Payne 2004:232). The online environment is increasingly capable of supporting these conditions. The requirement that students have the opportunity to be genuinely interactive implies a social context in which knowledge is constructed (Jones, Ǿstbyte & Clarke 2000:72; Raubenheimer 2003:23).

As aspects of a social learning context, both teacher-student and peer-to-peer interactions (Kropiunigg, Pucher & Weckenmann 2002:334) are significant, serving as a model of tone and focus. Students also need time to reflect about new information, events, and new experiences, to think about them, to interpret them and compare them to current understandings and to evaluate their own learning (Briscoe, Byrne, Hicks, Care, Williams & Jones 1987:15),(cf. Magolda's Epistemological Reflection Model 3.4.1).

The conditions for significant learning can be created in a computer-mediated environment, but using Information Technology (IT) to facilitate good educational practices is labour-intensive. Payne

(2004:235) elucidates that "teaching" must be understood as embracing both design and implementation of an educational environment, with clear objectives and with carefully considered means for attaining them (Bisoux 2003:29). The concept of *scaffolding* can inform course design, but as a strategy for supporting students in performing tasks that they would not yet be able to accomplish independently, requires continuous, on-the-ground fine-tuning of means and materials (Broudo, White, Rodenburg, Arsenau, Chalmers, Wright, Mizgala & Lirenman 1997:321). Cavanaugh (2005:p1 of 9) explains that although online teaching of a course can be more time-consuming compared to traditional instruction, the additional time spent is found to be largely from increased student contact and individualised instruction and not from the use of technology per se.

ODL requires the teacher to become a mentor and model, rather than a judge or merely the purveyor of information. The power to control, which is inherent in the act of designing, as well as in the facilitator's role must be exercised judiciously, if the conditions of effective learning are to be realised.

3.4.5.2 *Planning, before implementing E-learning*

Although the first online class was offered in 1994, Levy (2004:p1 of 20) states that by 1998, 51% of the institutions of higher learning in the United States of America included a plan for information technology in their strategic plan. Levy (2004:p2 of 20) warns that knowing what makes ODL successful and having considered ODL when developing a strategic plan is essential in order to avoid unnecessary costs, wasted

time, confusion, frustration and stress for those involved in ODL. A successful ODL programme needs to focus not on computers and networking in the technology infrastructure that simply support the educational process, but on six distinct areas that are part of the total educational system:

3.4.5.2.1 *Vision and plans*

According to Bucholtz (1997:1) when college faculty, staff and administration start with a vision, it is necessary for them to understand that this vision will result in a change in the organisational structure. Administrators have the potential to greatly affect the effectiveness of a programme by securing resources, influencing potential participants, supporting the changes and implementing processes that will overcome the barriers that affect instructors and students. Cassell (2002:5) warns that distant learning programmes may be too easily accredited by accreditation agencies. Some programmes lack effective learning experiences (Pritchard 2003: 848) and there is some evidence that people getting credit are not the same ones that completed the course requirements. Administrators should ensure the programme is not open to abuse.

3.4.5.2.2 *Curriculum*

Planning for ODL usually focuses on budget and personnel planning, not on critical pedagogic issues. ODL is more than a teaching mode or method; it is a distinct and coherent field of education. The technology infrastructure should not be built without considering the academic and

educational requirements of an ODL programme (Hesketh, Stephen, Laidlaw & Binnie 2001:33). Petersen (1999:385) cautions that many instructors do not wish to change their style of instruction.

3.4.5.2.3 *Staff training and support*

The rapid evolution of knowledge requires innovative development in curriculum and faculties need greater flexibility and support as they teach their courses (Biggs 1998:200). Effective ODL requires the instructor to not only have the knowledge of the content area, but also have interpersonal skills to effectively communicate with their students online (Brown & Wall 2003:325).

Despite the obvious advantages of making courses easily accessible to students through the Internet, many instructors and institutions are reluctant to make the move to ODL. The instructors are reluctant for many reasons:

- Perceived increase in the time it takes to develop and deliver online courses (Curry & Smith 2005:316).
- The lack of technical and administrative support available to them.
- Concern about copyright and intellectual property issues (cf. 3.4.5.3).
- Concern about the quality of online courses.
- Concern about incentives and obstacles to teaching online.
- Resistance to being told what to do by administrators.
- Inadequate training for the instructors who are being expected

to write and teach these online courses.

- When administrators try to compare the effectiveness and cost benefit of ODL to traditional on-campus courses.

The University of the Free State has the facilities and support staff to enable staff to present online courses at the Centre for Higher Education Studies and Development (CHESD). In this study, depending on the recommendations of the Delphi Panel, the Post-graduate Diploma in Mental Health may be presented in an asynchronous, web-based online distance format.

Toohey and Watson (2001:552) give 12 tips for choosing web teaching software:

- Explore what web-based teaching has to offer.
- Decide how the software will be used.
- Find out the particular requirements of the users.
- Try out the online technical support provided by the software developers.
- Join the user groups and ask questions about the capabilities of each package.
- Consider what training support may be needed for teachers.
- Find out what help or support students require.
- Consider student access to computer facilities.
- Check what system the neighbours are using.
- Whichever package you choose, build in the cost of providing assistance with instructional design for teachers developing online courses.

- Plan for obsolescence.

3.4.5.2.4 *Student services*

Attention needs to be given to organisational structures, especially those pertaining to servicing students. If students are expected to be successful, they need access to student services (Hartley, Gill, Walters, Bryant & Carter 2001:12). ODL is not just about teaching and learning, it is about giving students who are not able to come to campus an experience equivalent to the on-campus student by providing the same types of student services online that are available to on-campus students (Bacon & Jacovich 2001:p1 of 7; Merkel 1999:p11 of 15).

Dennis Bancroft, Director of Oscail, the National Distance Education Centre in Dublin, Ireland, when interviewed by Savrock (2001), identified student support as one of three critical areas (the others being curriculum and technology) needed to maintain a successful ODL programme (Levy 2004:p7 of 20).

3.4.5.2.5 *Student training and support*

Students who are not prepared for the online environment can have a negative impact on other students and the instructor in the classroom. Students' attitudes to the course can be improved by their experience of teaching (McParland, Noble, Livingstone & McManus 2003:447). Covington, Petherbridge and Warren (2005:p7 of 11) suggest that student needs can be assessed by inviting students to complete a

questionnaire in order to understand their skills, comfort levels and attitudes to the course.

3.4.5.3 *Copyright and Intellectual property*

Copyright law seems straightforward enough: another cannot reproduce copyrighted works (Levy 2004:p8 of 20). Copyright can be defined as "….the exclusive right in relation to work embodying intellectual content (i.e. the product of the intellect) to do or to authorise others to do certain acts in relation to that work…acts [which] represent…. the manners in which that work can be exploited for personal gain or profit" (PASA 2005:p1 of 9).

There is no such thing as an International Copyright that will automatically protect an author's writing throughout the world (Tysver 2005:p4 of 7). Protection against unauthorised use in a particular country basically depends on the national laws of that country.

Copyright law is a major law that affects higher educational institutions. This law allows the owners of a copyright absolute domain for the life of the author plus 50 years, (as opposed to the European Union and USA's 70 years). The copyright holder has the right to reproduce the copyrighted work in any format; to prepare derivative works; to distribute copies of copyrighted work to the public by sale, rent, lease, or gift: to perform the copyrighted work publicly; and to display the copyrighted work publicly.

In the university setting however, the doctrine of fair use applies. Fair use allows copyrighted materials to be used without express permission of the copyright holder in an educational setting, provided that use does not impair the marketability of the work, that only a portion of the original work is used and it is not a critical portion, that credit is given to the author, and in the case of a performance, it is part of a systematic instructional activity related to the teaching content and is transmitted for reception in a classroom.

The issues of copyright, fair use and work for hire are all being reconsidered in this era of ODL. Instructors have been accustomed to the idea that they "own" their own work, even if they did not own it legally. Traditionally, when instructors changed colleges, they got to take their lecture notes too. They could give away their lecture notes freely. Given actual copyright law, though a part-time instructor can use the same lecture notes when teaching at two different institutions, a full-time instructor legally may not. This also applies to online courses; they belong to the institution when a full-time instructor creates them. As courses are being put online, thereby becoming marketable, institutions are beginning to claim their rights to the copyright. Full-time instructors have no legal authority to keep the class material they write unless they negotiate for that right.

The doctrine of fair use is also challenging to online instructors. In the past, instructors could copy and distribute articles, provided that the articles were less than 2500 words or 10% of the original work. Therefore, Levy (2004:p9 of 20) admonishes: establishing a

copyright/intellectual rights policy is necessary to deal with issues before problems occur.

3.4.5.4 *Designing distance-learning programmes in a medical setting*

Distance education, where the learner is at a distance from the teacher, as distinct from the traditional classroom and apprenticeship model where both are in close proximity (Harden 1988:140), is playing an increasing role in medical education, particularly in post-graduate education and in continuing professional development (Cook & Dupras 2004:599; Johnson, Dutton, Biffra & Black 2006:1403; Laidlaw, Harden, Robertson & Hesketh 2003:182). Designing learning resource material, however, is not easy and requires expertise in the content of the subject area to be studied, in education and instructional design, and technically in the format in which the programme is to be rendered (Laidlaw 1987:139). Wong, Greenhalgh, Russell, Boynton & Toon (2003:1020) have certain recommendations, in query form, concerning 10 overlapping areas that should be adhered to before placing a course on the web:

- Is there a market for an online course in this subject area?
- What are the aims and learning outcomes of the course?
- Which software platform should we use?
- Who will develop the course, and what training and support will they need?
- How do we write high quality study materials?

- What design features can we use to promote learning?
- What are the technical and administrative challenges of delivering a web-based course?
- How can we evaluate our course and improve quality?
- How can we mainstream our course within our institution?
- How can we make our course financially viable?

Concerning the writing of high-quality materials Wong *et al*. (2003:1021) suggest the following staff roles to help attend to subject content, pedagogy, graphic design and technical delivery as much of the teaching is centred around these issues:

- Programme Director with responsibility for strategy, budget, academic standards and procedures, and liaison with central committees and external bodies.
- Director of Operations with responsibility for day-to-day running of the programme, supervision of staff and personnel issues.
- Technical Director with responsibility for technical design, hardware and software development, and supervision and training of other staff in technical matters.
- Graphic Designer with responsibility for layout of material on web pages.
- Module Writers who must be provided with appropriate academic and technical backup for developing course materials. They should also be proficient in the five domains of education, administration, research, written communication and professional academic skills.

- Module Tutors with responsibility for delivering the course material once it is written.
- Personal Tutors with pastoral responsibility for individual students.
- Technical Support Officer for day-to-day maintenance of the course website and provision of a helpdesk facility.
- Programme Administrator to deal with student administration and course enquiries, and to liaise with appropriate central university departments involved with marketing, administration and student support.
- Secretarial/personal assistance for senior staff.

3.4.5.5 *Mobile learning (M-learning)*

For over a billion people, the mobile phone (or cellphone) is an essential part of everyday life. Jones and Marsden (2005:8) continue explaining that the statistics associated with the uptake and use of mobile phones are staggering. Mobile ownership outstrips personal computer ownership dramatically, despite the technology being relatively new. According to Jones and Marsden (2005:14), mobile phones started to offer access to web-like information using a variety of innovations. So too, like all computing devices, their processors became faster and faster and their onboard storage capacities ever vaster. Meanwhile as phones became more like PDAs (Personal Digital Assistants), handhelds gained wireless communication card slots, so users could communicate with each other, placing calls and sending text messages as well as connecting wirelessly with communication services.

3.4.5.6 *The handheld computer in an educational setting*

Numerous studies in the literature point to the potential of handheld technologies as learning tools (Leach *et al.* 2005:3). PDAs are perceived as 'effective instructional tools', with the potential to have a positive effect on pupil learning. Key benefits are seen to be increased time using technology, increased motivation and increased collaboration and communication. The 'anytime, anywhere' access to learning resources is an important advantage of the handheld computer, enabling adult learners to fit study time around other activities. Pownell and Bailey (2000:3) outline six functions for educational leaders that handheld computers can offer:

- Organising and planning.
- Reference information; timely access to important information.
  Many authors have emphasized the importance of access and use of continuing medical information for doctors (Harrison & Hogg 2003:885 ; Poole 2003:238; Zimitat 2001:117).
- Gathering and Analysing - supports decision making through analysis of data (Taylor, Anthony, Lavallee & Taylor 2006:283).
- Learning and self-improvement (supports life-long learning of current information and techniques).
- Communication (with study leader).
- Teaming and Collaborating (including sharing organisational documents, data bases and schedules).

Although the advantages of M-learning are still to be fully exploited the handheld computer is considered to be a device that will ultimately replace the lap-top computer. The researcher agrees with Backstein and Reznick (2003:1067) who predict: as medical educators we need to move quickly to develop foci of excellence, resisting duplication of effort, and challenging ourselves to capitalise on an academic spirit that fosters sharing and the pushing back of new technological frontiers.

3.5 EXAMPLES OF EXISTING CURRICULA IN MENTAL HEALTH IN OTHER REGIONS OF THE WORLD

Several curricula in Mental Health in different parts of the world are reviewed, for example from Australasia, Europe and North America, but no post-graduate curriculum in Mental Health for African countries could be found outside the Republic of South Africa.

3.5.1 Australasia – The University of Otago Post-graduate Diploma in Mental Health (New Zealand)

The Christchurch School of Medicine and Health Sciences, University of Otago's Curriculum for the Post-graduate Diploma in Mental Health (PG Dip MH) is a "well–oiled" programme that appears to be well organized, very comprehensive and probably has been refined and streamlined over several years in operation. The programme caters for medical practitioners and other health professionals such as nurses and psychologists who wish to further their studies. The programme is well articulated and flexible allowing learners to progress in their own

specific fields of interest. (Of note – the School of Medicine and Health Sciences also has many other post-graduate programmes running). The convenors of the curriculum also have the liberty to decide which papers (modules) will not be presented in a given academic year.

Limitations of this programme can be summarized as follows: The courses are area-bound, where learners have to be present at a specific location at a specific time. This could prevent certain potential candidates from enrolling for the course if they cannot have time off to attend lectures. Only a few modules make use of electronic learning (e-learning). The programme would probably be improved if it was adjusted to include the benefits of e-learning, for example more 'chat room' sessions. The curriculum could easily be adjusted to the Southern African context with its own set of cultural phenomena. Also in South Africa/Southern Africa with its paucity of psychiatrists more emphasis would need to be placed on the appropriate recognition and treatment of common psychopathology, with less teaching in psychotherapy. Although in many modules learners are encouraged to think critically, one gains the impression that the traditional didactic styles are utilised rather the modern outcomes-based approach.

3.5.2 Europe: University of Maastricht MSc in Mental Health (The Netherlands)

One gets the impression the programme has not yet been finalised, and therefore the paucity of content information. This programme attempts to offer training in Mental Health according to the Bologna Declaration of 1999 where the European Ministers of Education agreed to

uniformity in tertiary education. 29 European countries have agreed to restructure their training of students in tertiary institutions. According to this declaration, all learners will be exposed to two phases of education. The first phase (known as the bachelor or undergraduate phase) takes three years and learners receive a bachelor diploma. The second phase (known as the graduate or master phase), leads to the Master's Diploma. There seems to be much uncertainty whether medical practitioners would be allowed to enrol for this Master's Diploma in Mental Health.

3.5.3 North America: McMaster University- Program For North American Mobility In Higher Education (Canada)

This programme is funded co-operatively by the governments of Canada, the United States and Mexico for promoting a student-centred North American dimension to education and training. The Department of Psychiatry at McMaster University in partnership with other universities (from all three countries) has developed an innovative public mental health curriculum.

The purpose of the programme is to improve the quality of human resource development in the area of public mental health (in North America), by developing leaders who have an understanding and personal experience of the policy, legislation, funding and delivery of issues of public mental health at a national and international level. The programme also planned to develop an innovative curriculum, teaching materials, methods and modules which would be made available to university mental health training programmes in each of the three

countries. There is uncertainty if the programme caters exclusively for doctors or whether entry level is open to other disciplines too. This programme is very dynamic and highly specialised. The Department of Psychiatry also offers courses for registrars and advanced training for psychiatrists at post-doctoral level.

3.6 CONCLUSION

Many aspects of Programme and Curriculum Design have been discussed in this chapter. The researcher has endeavoured to assimilate many factors that are important when planning a new curriculum. Several traditional curricula were considered and compared to a more modern approach, where Outcomes–based Learning can be utilised. Several existing curricula in Mental Health from different parts of the world were studied and analysed.

The neurophysiology of human cognitive learning has been described, especially how it relates to the more mature students who have more advanced methods of facilitating their own learning process and education.

The merits and practical implementation of distance education using E-learning and newer technological developments in programme and curriculum development were also discussed in this chapter.

Although computer science progresses in leaps and bounds, providing more innovative ideas for new tools in education, the fundamental

needs for effective curriculum planning and design remain. As medical (and other scientific) expertise continues to expand, so too the need to impart this knowledge to learners. Medical educators should have the wisdom to know how to teach others effectively in the 21st century.

The programme for the development of a Post-graduate Diploma in Mental Health will hopefully play a part in disseminating knowledge in Psychiatry to medical practitioners in South Africa. The methods used to determine the contents of this framework will be discussed in chapter 4.

CHAPTER 4

RESEARCH DESIGN, METHODS AND TECHNIQUES

4.1 INTRODUCTION

Teaching Psychiatry as a subject in medical schools has a long tradition. The knowledge of the subject is linked to the current understanding of research in Psychiatry and clinical experience and expertise. George Santayana (2006:p3 of 5) said: "Those who cannot learn from history are doomed to repeat it".

When designing a programme to teach post-graduate Psychiatry to medical doctors a course may fade into oblivion (become obsolete), if the basic content is irrelevant to the needs of the learners. If one, however, applies the principles that made Psychiatry so relevant in the German-speaking countries of Europe, namely to find a balance between research and clinical practice one is less likely to end up with "scientific data - bearing no relevance" as happened in Victorian England (Shorter 1997:90), (cf. 2.2.4).

To ensure the framework envisaged for the purpose of developing a Post-graduate Diploma Programme in Mental Health contained the type of learning material needed by general practitioners in primary health care, use was made of the Delphi Technique.

4.2 RESEARCH DESIGN

Two main paradigms, quantitative and qualitative research approaches, (Landman 1988:73), were used in this study. The quantitative approach was used to answer questions related to relationships among variables with the purpose of explaining, predicting and controlling phenomena, while the qualitative approach was used to answer questions about the nature of phenomena with the purpose of describing and understanding the phenomena from the participant's point of view (Leedy 1997:104).

The research was based on a phenomenological preparation, namely the literature review to provide reliable data for understanding the phenomenon (Verma & Beard 1981:187). The phenomenology here served the purpose of ensuring sufficient background knowledge on the subject, in addition to generating a number of criteria to be used together with criteria which were identified as being of importance. The researcher's own prior experience of working in primary care settings and also as specialist frequently receiving patient referrals from doctors working in this milieu also contributed to the appropriateness of these criteria. By listening to doctors referring patients and reading their referral letters, the researcher was able to form an opinion about the level of interest and expertise these doctors had in Psychiatry. A scientific approach was, however, needed to determine and test the criteria needed for the framework.

The terms 'qualitative' and 'quantitative' were frequently used to identify different methods or approaches to research. Henning, Van Rensburg and Smit (2004:3) provide an overview of the two

approaches in the following description: "The distinction between the qualitative paradigm and the better known quantitative paradigm lies in this quest for understanding and for in-depth inquiry. In a quantitative study, the focus will be on control of all the components in the actions and representations of the participants – the variables will be controlled and the study will be guided with an acute focus on how variables are related… In a qualitative study the 'variables' are usually not controlled because it is precisely this freedom and natural development of action and representation we wish to capture".

Alternatively, both approaches could be defined in other ways: Babbie and Mouton (2001:53) suggest that the qualitative research paradigm refers to "the generic research approach in social research according to which research has its starting point as the insider perspective on social action". Babbie and Mouton (2001:149) also suggest another definition: "Studies that are usually qualitative in nature which aim to provide an in-depth description of a group of people or community. Such descriptions are embedded in the life-worlds of the actors being studied and produce insider perspectives of the actors and their practices".

In another article, Babbie and Mouton (2001:49) state that, when referring to the quantitative paradigm, there are a number of related themes in mind which would include an emphasis on the quantification of constructs, in other words assigning numbers to the perceived qualities of things. Variables play a central role in describing and analysing human behaviour (also known as variable analysis), while a central role is afforded to control for sources of error to the research process. McMillan and Schumacher (2001:165) state that designing

quantitative research involves choosing subjects, data collection techniques, for example questionnaires, observations and interviews, as well as procedures for gathering and collating the data. Procedures for implementing treatments should follow. Together these components form the research design of the study. McMillan and Schumacher (2001:15) summarise the difference between the two approaches by using the following statement: "Quantitative research presents statistical results represented with numbers; qualitative research presents data as a narration with words".

According to Robson (1993:20), a research problem can be addressed by using more than one approach, an aspect which may have substantial advantages. The two approaches were used to complement each other, to provide a better understanding of the research problem, as well as to enhance the interpretability of the research findings.

4.3 THE LITERATURE REVIEW

Neuman (1997:89) is of the opinion that a literature review is based on the assumption that knowledge accumulates and that we learn and build on what others have done.

Neuman (1997:89) cites four goals of a literature review:

- To demonstrate a familiarity with a body of knowledge and establish credibility.

- To show the path of prior research and how a current project is linked to it.
- To integrate and summarise what is known in an area.
- To learn from others and stimulate new ideas.

Singleton and Straits (1999:544) regard the aim of a literature review as one of contextualising the problem against related theory and research, as well as to ensure that the researcher is sufficiently knowledgeable about the topic to be able to investigate it in an informed manner.

The focus of the literature study was twofold. The first objective was a historical review; to trace the development of the teaching of Psychiatry and to discover how current theory and practice of Psychiatry being taught in medical schools in South Africa has evolved over many centuries. These findings were described in Chapter 2.

The second objective was a theoretical review of the literature pertaining to curriculum development and planning. Chapter 3 of this study described different methods of curriculum planning and different types of technology that may be utilised in a modern teaching programme in the 21st century. The appropriate legislative and university (University of the Free State) regulations for the programme were also scrutinised to ensure the programme would be eligible for implementation and approval (cf. 6.6). The literature regarding the learning process especially in human adults was also perused.

4.4 THE DELPHI STUDY

The Delphi Technique is a method for the collection of opinion on a particular topic (De Villiers, De Villiers & Kent 2005:639). It is based on the premise that 'pooled intelligence' enhances individual judgement and collective opinion of experts (Linstone & Turoff 1979:3; Murry & Hammons, 1995:426). The method was devised in the early 1950s by Helmer and Dalkey as a tool for determining military priorities.

The Delphi Technique is named after the oracle on the island of Delphi in Greece, which was believed to accurately predict the future (Clayton, 1997:337; Murry & Hammons, 1995:426). According to Smit and De J Cronje (2002:163), the Delphi Technique can be used to finalise decisions which need to be made by experts.

The Delphi Technique rests on two assumptions, firstly group decisions (made by experts in the fields of study) are more valid than those made by individuals. Secondly, during direct interpersonal contact domineering members of the group may affect consensus reached by the group or there may be group bias involved (Murry & Hammons 1995:426). Since the decision-making is rarely left to an individual, the success, credibility and validity of the process is increased (Clayton 1997:373). According to Critcher and Gladstone (1998:432), the Delphi Technique allows a wide range of experts from different backgrounds to participate in the communication process. Furthermore, as in the case of this research study, these experts may be widely separated geographically.

The main characteristics of the Delphi technique are anonymity, expert input (Clayton 1997:377), physical separation, iteration, as the process takes place through a number of rounds during which a new questionnaire – containing feedback from the previous round – is compiled (Woudenberg 1991:133), statistical analysis of the responses, which allows each participant to see where his/her opinion lies when compared to the rest of the group (Clayton 1997:385), and controlled feedback which entails that the participants' responses after each round are analysed and each respondent receives feedback during the next round. Feedback is completely anonymous and is a democratic process, as each panellist has an opportunity to change and/or amend his/her previous opinion (Goodman 1987:730). Subsequently, the Delphi Technique not only provides quantitative information about the subject of study, but also qualitative information, as definitions and solutions to problems – related to the topic under discussion – are provided by the participants. This adds substance to Critcher and Gladstone's (1998: 433) statement that the "Delphi straddles the divide between qualitative and quantitative methodologies", making it particularly true.

Linstone and Turoff (1979:7) identify six phases in the Delphi process:

- Formulation of ideas,
- Exposing the options,
- Determining initial positions on the issues,
- Exploring and obtaining the reasons for disagreement,
- Evaluating the underlying reasons and
- The re-evaluation of the options.

The Delphi Technique was used in this study for the following reasons (Critcher & Gladstone 1998:432; Linstone & Turoff 1979:4; Murry & Hammons 1995:426):

- It was a fast and cost-effective method of gathering expert opinions.
- Difficulties and problems with a face-to-face discussion were overcome through using the Delphi process.
- The study allowed for a range of experts from various backgrounds to participate equally in the process.
- As the research had the aim of designing a framework, the Delphi process lent itself to exploration of the topic.
- Participants could use their own time to carefully consider their responses.
- Both quantitative and qualitative approaches were needed for the study.

Therefore the Delphi Technique was seen as a viable option for the study.

4.4.1 The Delphi Questionnaire

A letter requesting participation was formulated in which prospective Delphi experts could be invited to form part of the study panel (cf. Appendix A).

The Delphi questionnaire was compiled using information that had been obtained from the literature and the researcher's own prior experience

in the field (cf. Appendix B). Examples of the literature survey being used for statements in the questionnaire are:

- Section C was based on the curriculum used by the University of Otago: Diploma in Mental Health (cf. 3.5.1).
- Parts of Section C such as main statement 8C relates to 2.2.4, while 8D relates to 2.3.
- In Section D, the main statements 27 A to BB relate to 3.4.5.1. and 3.4.5.2 as described in Chapter 3 of this thesis.

The Delphi questionnaire consisted of five sections, namely:

Section A: Crucial Exit Level Outcomes (Main Statements 1A – 4)
Section B: Format of the Programme and Content of the Modules (Main Statements 5A – 6)
Section C: Contents of the Programme (Main Statements 7A – 18)
Section D: Education Methodology and Modes of Delivery (Main Statements 19A – 28)
Section E: Student Evaluation (Main Statements 29A – 30)

290 statements were grouped together under the Main Statements in sections A to E (cf. Appendix B). The content of each section was clearly stated. Participants were instructed to not only choose from a number of alternatives but also to make evaluations based on clearly defined criteria. Participants were also instructed to indicate the importance of each statement using the following scale:

1 = Essential

2 = Useful

3 = Unnecessary

Each section allowed space at the end of the questions for participants to write comments on the specific section.

4.4.1.1 *The pilot study*

A biostatistician from the Department of Biostatistics at the UFS, a staff member of the Department of Psychiatry in the Faculty of Health Sciences (UFS) and the supervisors of this research project were asked to scrutinise the Delphi study questionnaire and help to make it more 'user-friendly'.

Four experts, a retired professor in Family Medicine, a professor of Higher Education Studies and two authorities in electronic learning, also piloted the study questionnaire.

Minor changes were implemented according to the suggestions of the latter group. These recommendations by the expert in Higher Education Studies included:

- The omission of six statements in Section D (20: Outcomes-based Education) as these statements were self-explanatory.
- One of the statements, (20 Q), in Section D was rephrased.
- The omission of three questions in Section D relating to 'stakeholders' as they do not apply to the study.

- In Section D, statement 22 T, an example of student resources was added.
- In Section D, statement 22X 'every four years' was changed to 'regularly'.
- In Section D, the order in which statements 23 L and 23 M were stated was swapped, as the content of L follows that of M.
- In Section D, concerning statements 27 H and 27 I, the word 'online' was added to 'module'.
- In Section D, statement 27 T the word 'updated' was substituted for the word 'replaced'.

The expert in Family Medicine:

- Recommended the deletion of repetition in Section C, statement 7 K.
- Suggested 'nosology', 'pervasive disorders' and 'elimination disorders' be defined.
- Suggested an example of other courses be given in Section C statement 9 I.
- Commented on the word 'stakeholders' in Section C statements 21 H – J. These questions were deleted as they do not apply to the study.
- The contents of Section E statements 29 I and L were complex. These questions were further subdivided to avoid confusion in decision-making.

The experts in E-learning proposed:

- In Section A statement 3 the words 'adhered to' replaced values 'attained'.

The completed Delphi questionnaire appears as Appendix B.

4.4.1.2 *The participants and the Delphi process*

For the purposes of the Delphi Technique, respondents were selected from the fields of Psychiatry, Family Medicine (including Community Medicine), E-Learning, Medical Education and Programme Development.

In addition they had to be experts in their field who were also actively involved in mental health care and/or education of learners at tertiary level. Landman's stratified method of sampling (1988:92) served as a useful model in order to divide the population (people involved in mental health care and training) into subgroups. By using the literature review as a basis, certain subgroups could be identified:

- Experts in Psychiatry
- Experts in medical education
- Experts in electronic learning
- Experts in primary health care management
- Experts in government policy on health care.

The rationale for the categories of experts selected was:

- **PSYCHIATRY** featured very strongly in the programme content. Experts gave advice regarding the themes that should be included in the teaching modules and which themes should be avoided in order to help to narrow the field. They also ensured that the context of the programme was relevant, that it had the necessary depth and that the most common/important conditions were included in the programme. They would also know if any similar programmes were already being conducted in South Africa.

- **FAMILY/COMMUNITY MEDICINE:** The expert gave advice regarding the psychiatric needs of the community, especially at primary health care level. The expert was in a position to know if there was a demand for the programme. As a majority of the learners were medical officers or general practitioners, the experts could advise on the particular needs of this group of doctors, as well as the academic level which the learners would be able to cope with. In addition this expert could indicate whether or not part-time learners would be able to cope with the work load of the programme. An expert in Community Medicine was in a position to provide the government's perspective on primary care.

- **MEDICAL EDUCATION AND PROGRAMME DEVELOPMENT:** Experts advised on the presentation of learning content in the programme, using stimulating and innovative methods. They

also gave advice how to examine learners. The level of expertise was on a par with international medical education.

- **E-LEARNING:** The expert has a thorough knowledge of the electronic medium and psychology/Psychiatry gave advice concerning various aspects of the presentation and content of the programme. The expert ensured that the programme was not pedagogically or technically compromised.

Random sampling did not seem to be an option in this case, as panellists with specific expertise and experience were required to participate in the Delphi process. Purposive sampling, where the available samples who had satisfied specific criteria as indicated in the literature review (cf. Landman 1988:91), was a more viable option. Twelve experts identified in this manner were invited to participate in the study. The experts resided in different parts of South Africa. This context was important as the proposed framework was designed to cater for the post-graduate training needs in Mental Health of medical doctors working in South Africa and had to be relevant to this environment. Using the examples of diversity in the literature, certain criteria were used as a basis in which to select the experts (cf. Linstone & Turoff 1979:23; Murry & Hammons 1995:428; Williams & Webb 1994:185):

- Experience and expertise in Mental Health
- A Post-graduate Degree such as M.Med, M.A or Ph.D.
- Knowledge of Primary Health Care
- Knowledge and experience of tertiary education.

Fifteen people were invited as they represented a heterogeneous sample group, due to the fact that they came from different education stratifications (Clayton 1997:378). Three potential experts declined the request to participate in the study.

The sample was selected from various government and private sectors in South Africa. Four experts were Heads of psychiatric departments in different parts of South Africa. One expert was jointly employed by two psychiatric departments, while four other experts were involved in private psychiatric practice. One expert was a head of a Family Medicine Department (Rural Medicine). One expert was involved Medical Education. Another was involved in Psychology and E-learning. The expert in Community Medicine was also a Director of Health in Local Government.

Consent to participate in the study was obtained through personal and electronic communication. All participants in the Delphi process were asked to sign informed consent before participating in the study (cf. Appendix A).

4.4.2 The Analysis of the Data

Round 1 of the Delphi questionnaire was sent to the experts on 6 October 2006.

After all the responses of the panel were received for Round 1, the data was analysed and summarised (cf. Appendix C). The results of Round 1 and important comments were sent to the experts.

These inputs were combined and used as a template to compile the questionnaire for Round 2 of the Delphi process in the study. The format of the questionnaire for Round 2 was changed to accommodate all the information obtained from Round 1.

Dajani, Sincoff and Talley (1979:83) state consensus was assumed to have been achieved when a certain percentage (80%, in this study) of responses fall within a prescribed range for the value being estimated.

Two rows were allocated to each statement in which consensus had not been reached in Round 1 (cf. Appendix D). The upper row reflected how the experts had voted in Round 1, and their personal choice was indicated individually.

A number of the statements achieved consensus, but also received comments advising changes. Subsequently the panel was given another opportunity to rate these edited and/or revised statements. Statements achieving consensus without suggested changes did not require a re-rating. This ensured that panellists would not change their opinions on statements they had previously had consensus on.

Round 2 of the questionnaire, accompanied by a covering letter and attached as Appendix D was electronically transmitted to the panel on 12-14 January 2007. The panel was requested to complete the questionnaire and return it to the researcher. If the questionnaire was not returned after 10 working days, the matter was followed up in a

manner similar to Round 1. The results and comments of Round 2 were communicated to the experts (cf. Appendix E).

The same procedure was followed to compile the questionnaire for Round 3. The table format of the questionnaire was maintained. In this round, ratings were required for statements where consensus was not achieved after the previous rounds of the Delphi process. Adjustments to the statements, as recommended by the panel, were made and indicated on the questionnaire in bold print. Statements with changes suggested by the panel and achieving consensus after Round 2 were not re-rated in Round 3. No new statements were added in the Round 3 questionnaire.

On 3 March 2007, a covering letter and the Round 3 questionnaire (Appendix F) were transmitted electronically to the members of the panel. Hard copies were also mailed to the experts. They were asked to complete and return the questionnaire at their earliest convenience. The results and comments of Round 3 were also sent to the experts (cf. Appendix G).

A final report of the Delphi study was transmitted electronically to all the members of the panel. This report (see Table 5.1) contained the final outcome of every item in the questionnaire, including the round in which the item was excluded from the study, whether consensus or stability (defined by Linstone and Turoff (1979:277) as when movement of the opinion of the group as a whole stabilize), was reached, and included the different votes of the panellists on the 3-point scale. The responses to the open-ended, categorised questions were also

indicated for rounds 1 and 2, (those questions had all been excluded after Round 2), but the responses to the open-ended questions were not included again, since the participants had already received feedback on these questions during the preceding rounds.

4.5 CONCLUSION

The research design and methods have been discussed. The way in which the Delphi Technique was conducted has been explained. The results of the responses given by the Delphi panellists and the use of the Delphi Technique as a measuring instrument will be discussed in Chapter 5.

CHAPTER 5

FINDINGS OF THE RESEARCH

5.1 INTRODUCTION

The results and findings of the 12 sets (three questionnaires per expert) of Delphi questionnaires are reported in this Chapter. The results are reported according to the stages in which the study took place.

5.2 DESCRIPTION AND DISCUSSION OF THE DELPHI STUDY

The study necessitated three rounds before the Delphi process could be ended. Each round is discussed separately. First a description of the measuring instrument will be provided, followed by an analysis of the responses. This will be followed by a short summative discussion of the findings of Rounds I and 2 respectively (cf. Appendices C + E). A summative discussion will be given on Round 3, the final round (cf. Table 5.1).

5.2.1 First round of the Delphi study

5.2.1.1 *The measuring instrument*

A letter (Appendix B) accompanied the Delphi questionnaire (Appendix B) in the first round of the Delphi study. The letter also contained

information relevant to the structure of the questionnaire as well as the procedure normally followed in the Delphi process. Instructions on how to complete the questionnaire were also included.

Delphi participants were clearly instructed to evaluate each statement in respect of its importance on a three-point scale. These points were defined as follows and in the following manner:

1 = Essential (this criterion must definitely be included in the framework)
2 = Useful (it does not matter whether this criterion is included or not – but it may be included in the framework)
3 = Unnecessary (this criterion must definitely be excluded from the framework).

The layout of the Delphi questionnaire will be discussed per section and will only be done once in the following paragraphs, as the basic structure of the questionnaire stayed constant through all the rounds (cf. comments in Rounds 2 and 3).

SECTION A of the Delphi questionnaire (cf. Appendix B), relating to Outcomes-based Education, dealt with crucial exit level outcomes. Thus on completion of the programme the student was expected to have gained certain knowledge and skills, while having adhered to certain values. This constituted the headings used in Section A.

This section was divided into three subsections which collectively contained 34 statements. Place was allocated next to each statement

for participants to give their comments. The fourth subsection was an open-ended section in which the participants could add other statements or write additional comments (cf. Appendix B).

SECTION B of the Delphi questionnaire dealt with the format of the programme and content of the modules and contained two subsections. The first subsection reflected a basic approach to formatting the content of a programme and contained 18 statements.

Place was allocated after each statement for the participants to provide their comments. The second subsection was an open-ended section in which the participants could add other statements or write additional comments.

SECTION C of the Delphi questionnaire dealt with the basic layout and content of the programme of the first (and second) academic years. This section was divided up into 12 subsections; four for the first academic year, seven for the second academic year and the twelfth subsection was an open-ended section in which the participants could write their statements or add comments. Section C contained 90 statements (n= 90).

SECTION D of the Delphi questionnaire (cf. Appendix B) dealt with education methodology and modes of delivery and was divided into 10 subsections containing various statements (n = 114), included under each subsection. Place was allocated after each statement for the participants to give their comments. The twelfth subsection was open-

ended, making provision for participants to add other statements or write additional comments.

SECTION E of the Delphi questionnaire (cf. Appendix B) dealt with student assessment during both academic years. This section was divided into two subsections; one which included various subsections (n = 22) and one open-ended subsection in which the participants could add other statements or write additional comments. Participants could also write comments next to the statements. The sections A - E constitute the five sections which were incorporated in the Delphi questionnaire.

5.2.1.2 Analysis of responses in Round 1

The responses of Round 1 of the Delphi study were analysed manually by the researcher and controlled by the supervisors. An evaluation was calculated for each statement and an indication was given of the frequency of responses for each point on the scale.

According to Dajani *et al.* (1979:83) consensus is assumed to have been achieved when a certain percentage of responses fall within a prescribed range for the value being estimated. The aim of the Delphi process is to reach a level of consensus among the expert panel members on a specific statement.

For the purpose of this study, consensus was defined as having been reached when 80% of the participants' votes fell within the same bracket (1, 2 or 3) on the scale; therefore in practical terms, when 10

or more of the votes for a specific statement fell in the same point on the scale. Where consensus was reached for a specific statement in the first round, it was excluded from the questionnaire in Round 2.

Stability is described as the natural tendency for opinions of experts to centralise (Linstone & Turoff 1979:277). Stability can therefore be declared when movement of the opinion of the group has reached stability.

5.2.1.3 *Summative discussion of the findings of Round 1 of the Delphi study*

There was 100% response rate to the Delphi questionnaire, as all 12 experts completed and returned the questionnaire. Consensus was reached on 48% of the Round 1 questionnaire containing 290 statements.

A report concerning the results of Round 1 and an accompanying letter was sent to the participants a week after it had been completed. All the statements where consensus had been reached were shadowed (48% of the statements). Useful comments made by the participants were also listed (cf. Appendix C).

During the first round certain comments were made by the participants. Where appropriate the researcher wrote answers in bold letters to give clarity (cf. Appendix C).

5.2.2 Second round of Delphi study

5.2.2.1 *The measuring instrument*

Round 2 of the study was sent out in January 2007 with an accompanying letter (see appendix D) to the participants. The letter stated the purpose of the questionnaire and the instructions on how to complete the second round.

Each statement listed in the questionnaire contained an extra row. The number of participants who had selected a specific option in the previous round for that statement was reported, for example in statement 10 I, nine participants chose option 1 (essential for the framework), one chose option 2 (useful) and the remaining person chose option three (unnecessary) (cf. Appendix D). Twelve different Round 2 questionnaires were customised, one for each participant, in the sense that an asterisk was noted for that particular respondent's response to each particular statement in the previous round. Thus if a respondent had selected option 1 (essential) in statement 10 I, the row for 10 I would be reported as being 9* 2 1. This was done to ensure each participant easily remembered what they had indicated for that particular statement in Round 1. Or in table form:

	Essential	**Useful**	**Unnecessary**	comments
Round 1	**9***	**2**	**1**	
Round 2				

This example should be interpreted in the following manner: As far as the statement was concerned, 75% (9 out of 12) of the participants indicated *essential* as their preference, ~ 17% (16,6) indicated *useful* as their preference, while the other 8% indicated *unnecessary* as their choice.

As an appendix the Delphi questionnaire requiring completion for Round 2 is included in this thesis (cf. Appendix D). All statements where consensus was reached in Round 1 were subsequently excluded from the Round 2 questionnaire. None of the original statements were changed.

5.2.2.2 *Analysis of responses of Round 2*

The Round 2 Delphi study responses were analysed manually, by indicating the frequency of responses on each point of the scale for each statement.

5.2.2.3 *Summative discussion of the findings of Round 2 of the Delphi study*

All 12 experts completed Round 2; 100% of the participants responded. After Round 2 a 69% point of consensus was reached on all the statements. In Appendix E the results are reported, including the comments made by the participants. Similarly (as in Round 1), the statements where consensus was reached were shadowed. The participants were informed of the results of Round 2 of the Delphi study

within one week of the researcher having received the last completed Round 2 questionnaire.

5.2.3 Third round of the Delphi study

5.2.3.1 *The measuring instrument*

The Round 3 questionnaire was sent out accompanied by a letter (Appendix F). The purpose of this round was to attempt to reach consensus on the remaining statements.

Once again each participant's questionnaire was individualised, indicating their personal vote for each specific statement in Round 2 and how it correlated with the other votes for the same statement.

The participants were afforded an opportunity to change their choice for each specific statement in Round 2 (where consensus had not been reached) or they could abide by their decision concerning the statement. If the participants chose to stick to their previous decision for a statement (where consensus had not been reached after Round 3), stability could be declared for the statement. The participants were invited once again to make comments.

5.2.3.2 *Analysis of responses of Round 3*

The responses of the third round were analysed manually (as in the previous rounds), by determining the frequency of responses for each point of the scale for a particular statement.

5.2.3.3 *Summative discussion of the findings of Round 3 (final round) of the Delphi study*

100% of the participants completed Round 3, (as for the other rounds). After Round 1 consensus was reached on 48% of the statements. This increased to 69% in Round 2 and 89% in Round 3.

The statements where consensus was obtained in Round 3 are shaded (cf. Appendix G). The statements in which consensus was reached and deemed as essential (voted as option 1) will be included in the framework for the curriculum in Mental Health (see Chapter 6). There were, however, certain cases where consensus was obtained for option 2 and this will also be included in the framework and noted as such.

With the exception of 1 statement (19B), nowhere else in the study was consensus reached on option 3. The 31 statements where stability rather than consensus was reached, are also indicated in Table 5.1. The number of participants indicating a specific point scale will also be indicated.

Table 5.1 The Results of the Delphi Questionnaire after Round 3

(Main statements 4, 6, 18, 28 and 30 have been omitted as they do not contain results. The written comments suggested by the Delphi experts are not recorded in this table.)

SECTION A CRUCIAL EXIT LEVEL OUTCOMES
This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH). **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

1. On completion of the PGDipMH, the student should have gained the following knowledge:					
		Essential	**Useful**	**Unnecessary**	Results
A	The ability to classify the various common types of psychopathology				**CONSENSUS ROUND 1 (11 1 0)*** ***11 experts indicated 1;** **1 indicated 2;** **0 indicated 3.**
B	Current theories on the known aetiology of mental conditions				**CONSENSUS ROUND 2 (10 2 0)**

C	Current theories on the pathophysiology of common mental conditions				**CONSENSUS ROUND 2 (10 2 0)**
D	Current theories on the psychopharmacology used to manage common mental conditions				**CONSENSUS ROUND 1 (10 2 0)**
E	An appreciation of the effect of the patients' physical environment on their conditions				**CONSENSUS ROUND 1 (10 2 0)**
F	An appreciation of the effect of the patients' cultural environment on their conditions				**CONSENSUS ROUND 2 (12 0 0)**
G	Comprehend the importance of patient confidentiality				**CONSENSUS ROUND 1 (12 0 0)**
H	Know the interpersonal dynamics involved in a multi-disciplinary health team approach				**CONSENSUS ROUND 2 (12 0 0)**
I	The role of risk factors in Mental Health				**CONSENSUS ROUND 1 (10 2 0)**
J	An understanding of research methods				**CONSENSUS ROUND 1 (0 10 2)**
K	Current theories relating to the prevention of psycho-pathology (in people)				**CONSENSUS ROUND 3 (12 0 0)**

L	Cost-effective utilisation of special investigations in Psychiatry				**CONSENSUS ROUND 2 (11 1 0)**
M	Appropriate utilisation of new technology in Psychiatry				**STABILITY AFTER 3 ROUNDS (4 8 0)**
N	An understanding of legal issues in Psychiatry				**CONSENSUS ROUND 1 (10 2 0)**
O	Knowledge of effective counselling skills				**CONSENSUS ROUND 1 (10 2 0)**

2. On completion of the PGDipMH, the student should have gained the following skills:

		Essential	**Useful**	**Unnecessary**	Results
A	The ability to identify most common forms of psycho-pathology				**CONSENSUS ROUND 1 (11 1 0)**
B	The ability to conduct a thorough mental state examination				**CONSENSUS ROUND 1 (12 0 0)**
C	The ability to diagnose common mental conditions				**CONSENSUS ROUND 1 (12 0 0)**
D	The ability to manage common mental conditions				**CONSENSUS ROUND 1 (12 0 0)**
E	The ability to refer patients appropriately for further				**CONSENSUS ROUND 1 (11 1 0)**

	management				
F	Be able to demonstrate cultural sensitivity to all patients				**CONSENSUS ROUND 2 (10 2 0)**
G	Be able to function as an integral part of a multidisciplinary health care team				**CONSENSUS ROUND 1 (12 0 0)**
H	Be able to effectively counsel a patient				**CONSENSUS ROUND1 (10 2 0)**
I	Be able to communicate using basic computer skills				**STABILITY AFTER 3 ROUNDS (8 4 0)**

3. On completion of the PGDipMH, the student should have adhered to the following values:					
		Essential	**Useful**	**Unnecessary**	Results
A	The importance of patient confidentiality				**CONSENSUS ROUND 1 (12 0 0)**
B	The importance of multi-disciplinary health care inter-ventions				**CONSENSUS ROUND 1 (12 0 0)**
C	A respect for the rights of mental health care users				**CONSENSUS ROUND 1 (12 0 0)**
D	Empathy for mental health care users (patients)				**CONSENSUS ROUND 1 (12 0 0)**

E	Empathy for the families of mental health care users				**CONSENSUS ROUND 1 (12 0 0)**
F	Appreciation that the patient is more important than the disease				**CONSENSUS ROUND 1 (12 0 0)**
G	A positive approach to self-directed life-long learning				**CONSENSUS ROUND 2 (10 2 0)**
H	A willingness to participate in self- evaluation				**CONSENSUS ROUND 2 (10 1 1)**
I	A willingness to participate in peer evaluation				**CONSENSUS ROUND 3 (12 0 0)**
J	A positive attitude with regard to continuing professional development				**CONSENSUS ROUND 2 (10 2 0)**

SECTION B

FORMAT OF THE PROGRAMME CONTENT OF THE MODULES

This section deals with the basic layout and content of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary

5. The following should be considered for the format of the Programme content of the modules:

		Essential	**Useful**	**Unnecessary**	Results

A	The programme should be taught over a two year period				**STABILITY AFTER 3 ROUNDS (9 2 1)**
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200)				**STABILITY AFTER 3 ROUNDS (7 5 0)**
C	The second academic year should contain **THREE** modules (Notional hours = 600)				**STABILITY AFTER 3 ROUNDS (6 6 0)**
D	The second academic year should contain a research project				**STABILITY AFTER 3 ROUNDS (1 4 7)**
E	Students should be required to pass the first academic year before proceeding to the second academic year				**CONSENSUS ROUND 3 (10 2 0)**
F	Students who do not wish to enrol for the second academic year, but who have successfully passed the first year, should receive a certificate				**STABILITY AFTER 3 ROUNDS (2 3 7)**
G	The second academic year should contain **SIX** modules, from which learners are required to choose **TWO** modules				**CONSENSUS ROUND 2 (1 10 1)**

H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year. (Students may begin this project in the first academic year)				**STABILITY AFTER 3 ROUNDS (4 6 2)**
I	Students will be assessed using tutorials and worksheets				**CONSENSUS ROUND 3 (12 0 0)**
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion)				**CONSENSUS ROUND 3 (10 2 0)**
K	Students will also be evaluated according to their contribution to the chat room discussion				**CONSENSUS ROUND 3 (10 2 0)**
L	There should be a restriction on the number of students who are allowed to enrol for each academic year				**CONSENSUS ROUND 3 (10 0 2)**

M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme				**CONSENSUS ROUND 3 (10 0 2)**
N	Learners should be encouraged to present appropriate case studies in their wards/practice when leading chat room sessions				**CONSENSUS ROUND 2 (12 0 0)**
O	The academic standard of subject material used in the programme should be closer to MMed(Psych) level than final year M.B.,Ch.B. level				**CONSENSUS ROUND 3 (10 2 0)**
P	Where possible, teaching should be directed towards practical situations in wards/practice (rather than philosophical theories)				**CONSENSUS ROUND 1 (11 1 0)**
Q	Where applicable, teaching should be directed towards rural, primary care settings				**CONSENSUS ROUND 3 (11 1 0)**
R	Where applicable cultural phenomena should also be discussed				**CONSENSUS ROUND 1 (11 1 0)**

SECTION C CONTENTS OF THE PROGRAMME					
This section deals with the basic layout and content of the programme of the first academic year. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**					
7. THE CONTENT OF THE MODULE 1: Introduction to Psychiatry. The content of the module will include:					
		Essential	**Useful**	**Unnecessary**	Results
A	This module should take the form of face-to-face contact sessions where students are required to be present at the UFS for two working days				**CONSENSUS ROUND 2 (11 1 0)**
B	Basic neuro-anatomy will be discussed using anatomic models				**CONSENSUS ROUND 2 (10 2 0)**
C	Basic neurophysiology will also be presented and discussed				**CONSENSUS ROUND 2 (10 2 0)**

D	The basic common psychiatric evaluation will be demonstrated and discussed in a tertiary setting				**CONSENSUS ROUND 2 (10 1 1)**
E	Four case studies using patients with common chronic psychiatric conditions will be presented by the academic staff				**CONSENSUS ROUND 2 (11 1 0)**
F	Discussion in case studies will also include symptomatology of the conditions under discussion				**CONSENSUS ROUND 1 (10 2 0)**
G	Discussion in case studies will include neuropathology of the conditions under discussion				**CONSENSUS ROUND 2 (10 2 0)**
H	Discussion in case studies will include management of the conditions under discussion				**CONSENSUS ROUND 1 (12 0 0)**
I	Discussion in case studies will include prognosis of the conditions under discussion				**CONSENSUS ROUND 1 (11 1 0)**
J	Students will be given a written clinical case report with specific questions relating to the case. Answers have to be e-mailed to the Department within 7 working days				**CONSENSUS ROUND 2 (10 2 0)**

K	Students will be evaluated according to their ability to integrate knowledge				**CONSENSUS ROUND 1 (11 1 0)**
L	The new Mental Health Care Act should also be discussed				**CONSENSUS ROUND 1 (12 0 0)**

8. CONTENT OF MODULE 2: CHRONIC PSYCHIATRIC CONDITIONS – (Part 1)					
This module features **CHRONIC PSYCHIATRIC CONDITIONS (Part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:					
		Essential	**Useful**	**Unnecessary**	Results
A	The basic known neuron-pathology of schizophrenia				**CONSENSUS ROUND 2 (10 2 0)**
B	The sub-types of schizophrenia				**CONSENSUS ROUND 3 (10 2 0)**
C	The history of nosology of schizophrenia				**STABILITY AFTER 3 ROUNDS (8 3 1)**
D	The pharmacology of treatment in schizophrenia				**CONSENSUS ROUND 1 (12 0 0)**
E	The complications of pharmacological treatment in schizophrenia				**CONSENSUS ROUND 1 (12 0 0)**

F	The importance of early recognition and treatment in prodromal schizophrenia				**CONSENSUS ROUND 1 (12 0 0)**
G	The role of cannabis (and other substances) in early diagnosis and treatment of schizophrenia				**CONSENSUS ROUND 1 (11 1 0)**
H	About psychosis secondary to general medical conditions				**CONSENSUS ROUND 1 (11 0 0)**
I	How to diagnose and treat schizo-affective disorder				**CONSENSUS ROUND 2 (10 1 1)**
J	How to differentiate schizophrenia from acute delirium				**CONSENSUS ROUND 1 (11 1 0)**
K	How to recognise culture bound conditions				**CONSENSUS ROUND 1 (12 0 0)**
L	How to recognise delusional disorders				**CONSENSUS ROUND 1 (11 1 0)**
M	How to recognise "Group A" Personality Disorders: Paranoid, Schizoid and Schizotypal Personality Disorders				**CONSENSUS ROUND 2 (10 2 0)**

9. CONTENT OF MODULE 3: COMMON PSYCHIATRIC CONDITIONS (Part 2)

This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part two) – MOOD DISORDERS.**

On completing the module the learner should know how to:

		Essential	Useful	Unnecessary	Results
A	Understand the differences between Bipolar Disorders and Depressive Disorders (including subtypes)				**CONSENSUS ROUND1 (12 0 0)**
B	Treat the conditions mentioned in 9A				**CONSENSUS ROUND 2 (10 2 0)**
C	Manage complications of treatment				**CONSENSUS ROUND 1 (11 1 0)**
D	Recognise patients at risk of committing suicide				**CONSENSUS ROUND 1 (12 0 0)**
E	Differentiate the phases of grief				**CONSENSUS ROUND 2 (11 1 0)**
F	Differentiate Mood Disorders secondary to General Medical Conditions				**CONSENSUS ROUND 1 (11 1 0)**
	Explain the meaning of Adjustment Disorders				**CONSENSUS ROUND 1 (10 2 0)**
H	Apply the principles of Cognitive Behaviour Therapy				**STABILITY AFTER 3 ROUNDS (9 3 0)**

10. CONTENT OF MODULE 4: COMMON PSYCHIATRIC CONDITIONS (Part 3)					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – Part 3 – ANXIETY DISORDERS** On completion of the module the learner should be able to:					
		Essential	**Useful**	**Unnecessary**	Results
A	Explain **Generalized Anxiety Disorder**				**CONSENSUS ROUND 1 (11 0 1)**
B	Explain **Obsessive Compulsive Disorder**				**CONSENSUS ROUND 1 (10 2 0)**
C	Explain **Post Traumatic Stress Disorder**				**CONSENSUS ROUND 1 (11 1 0)**
D	Explain **Panic Disorder**				**CONSENSUS ROUND 1 (11 1 0)**
E	Explain **Social Anxiety Disorder**				**CONSENSUS ROUND 1 (10 2 0)**
F	Treat the conditions mentioned in 10 A to E and have a knowledge of complications of treatment (pharmacotherapy)				**CONSENSUS ROUND 1 (11 1 0)**
G	Understand the concept of **co-morbidity** relating to anxiety disorders and depressive disorders				**CONSENSUS ROUND 1 (11 1 0)**

H	Have a working knowledge of **non-pharmacological treatment** of anxiety disorders				**CONSENSUS ROUND 2 (11 1 0)**
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds**				**CONSENSUS ROUND 3 (11 1 0)**
J	Know the **differential diagnosis of anxiety disorders**				**CONSENSUS ROUND 1 (11 1 0)**
K	How to recognise Avoidant, Dependent, and Obsessive Personality Disorders				**CONSENSUS ROUND 3 (12 0 0)**

11. THE SECOND ACADEMIC YEAR and MODULE 5: CHILD PSYCHIATRY - (Part 1)

The programme in year two will contain six modules. Students will have the option of selecting three modules.

Module 5 = Child Psychiatry Part 1

Module 6 = Child Psychiatry Part 2 (only for learners who have completed module 5).

Module 7 = Addiction Disorders

Module 8 = Forensic Psychiatry

Module 9 = Geriatric Psychiatry

Module 10 =Introduction to Psychotherapy

Students will also be required to complete a research project.

On completion of **Module 5 (CHILD PSYCHIATRY - Part 1)** the learner should:					
		Essential	**Useful**	**Unnecessary**	Results
A	Have an understanding of **normal development in humans** (Neuro-developmental and behavioural changes from conception to adulthood				**CONSENSUS ROUND 2 (11 1 0)**
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism)				**CONSENSUS ROUND 3 (11 1 0)**
C	Understand **Disruptive Disorders** in children				**CONSENSUS ROUND 1 (11 1 0)**
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis)				**CONSENSUS ROUND 3 (11 1 0)**
E	Have a working knowledge of **Intellectual Disability** (Mental retardation)				**CONSENSUS ROUND 1 (10 2 0)**
F	Be able to manage **victims of 'abuse'** (physical, sexual, emotional) at primary health care level				**CONSENSUS ROUND 1 (12 0 0)**

12. MODULE 6 – CHILD PSYCHIATRY (Part 2)					
On completion of this module, learners should:					
		Essential	**Useful**	**Unnecessary**	Results
A	Have a working knowledge of **Depressive disorders in children**				**CONSENSUS ROUND 1 (11 1 0)**
B	Have a working knowledge of **anxiety disorders in children**				**CONSENSUS ROUND 1 (11 1 O)**
C	Understand issues facing **adolescents** (including exposure to illicit substances)				**CONSENSUS ROUND 1 (11 1 0)**
D	Have a working knowledge of **eating disorders**				**CONSENSUS ROUND 1 (10 2 0)**
E	Be able to **counsel parents and families in crisis**				**CONSENSUS ROUND 1 (12 0 0)**

13. MODULE 7 – FORENSIC PSYCHIATRY					
Learners who complete this module should be able to:					
		Essential	**Useful**	**Unnecessary**	Results
A	Understand **the rights of patients** and the n**ew Mental Health Care Act**				**CONSENSUS ROUND 1 (11 1 0)**
B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)**				**CONSENSUS ROUND 3 (10 2 0)**
C	Understand the **Law on Sterilization and abortion**				**STABILITY AFTER 3 ROUNDS (9 3 0)**
D	Understand **ethical issues** relating to Psychiatry				**CONSENSUS ROUND 1 (11 1 0)**
E	Be able to advise families regarding legal issues i.e. if and when patients are no longer able to manage their own affairs				**CONSENSUS ROUND 2 (11 1 0)**
F	Know how **intoxication with substances affects criminal responsibility**				**CONSENSUS ROUND 3 (12 0 0)**
G	Know how to recognize Anti-social and Borderline Personality Disorders				**CONSENSUS ROUND 2 (10 2 0)**

14. MODULE 8 - ADDICTION DISORDERS					
Learners completing this module should:					
		Essential	**Useful**	**Unnecessary**	Results
A	Have a working knowledge of the effects of **ethanol (alcohol)** in humans				**CONSENSUS ROUND 1 (11 1 0)**
B	Be able to manage patients with **acute alcohol withdrawal**				**CONSENSUS ROUND 1 (12 0 0)**
C	Understand **chronic alcohol dependence**				**CONSENSUS ROUND 1 (11 1 0)**
D	Have a working knowledge of the terms **use** and **abuse**				**CONSENSUS ROUND 1 (11 1 0)**
E	Have a working knowledge of **illicit drugs/substances** commonly available in South Africa				**CONSENSUS ROUND 1 (11 1 0)**
F	Be able to manage patients with signs and symptoms of **acute withdrawal** from a substance until the patient can be managed at secondary/tertiary level				**CONSENSUS ROUND 1 (12 0 0)**

G	Be able to explain how substances affect **criminal accountability**				**CONSENSUS ROUND 2 (11 1 0)**
H	Have a working knowledge of **drug-substitution therapy**				**CONSENSUS ROUND 1 (10 2 0)**
I	Be able to recognize and manage **co-morbid psychiatric conditions**				**CONSENSUS ROUND 1 (10 2 0)**

15. MODULE 9 - GERIATRIC PSYCHIATRY					
After completing this module learners should:					
		Essential	**Useful**	**Unnecessary**	Results
A	Understand the **psycho-pathology of the aging brain**				**CONSENSUS ROUND 2 (11 1 0)**
B	Have a working knowledge of **dementia**				**CONSENSUS ROUND 1 (12 0 0)**
C	Understand **pharmaco-therapy in the elderly**				**CONSENSUS ROUND 1 (12 0 0)**
D	Be able **to counsel families** of elderly patients				**CONSENSUS ROUND 1 (10 2 0)**
E	Know how to manage the process of having a patient placed under curatorship (legal implications)				**CONSENSUS ROUND 2 (10 2 0)**

16. MODULE 10 - INTRODUCTION TO COGNITIVE BEHAVIOURAL THERAPY					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Results
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)**				**STABILITY (9 2 1)**
B	Be able to understand the principles of CBT				**CONSENSUS ROUND 3 (11 1 0)**
C	Be able to **apply CBT** in counselling patients having **depressive disorders**				**CONSENSUS ROUND 1 (10 2 0)**
D	Be able to **apply CBT** in patients having **anxiety disorders**				**CONSENSUS ROUND 1 (12 0 0)**
E	Be able to **counsel patients** who have recently been **acutely traumatised**				**CONSENSUS ROUND 1 (10 2 0)**
F	Be able to manage patients with **suicidal ideation**				**CONSENSUS ROUND1 (10 2 0)**
G	Have a working knowledge of **personality disorders.** Learners should be able to identify these disorders and know when to refer patients				**CONSENSUS ROUND 1 (10 2 0)**

17. MODULE 11 - THE RESEARCH PROJECT

Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.

		Essential	Useful	Unnecessary	Results
A	The research project forms an integral part of the Post-graduate Programme in Mental Health				**STABILITY AFTER 3 ROUNDS (4 2 7)**
B	A tutor will be available to assist the learner				**CONSENSUS ROUND 2 (11 0 1)**
C	Learners will also be able to make use of a biostatistician				**CONSENSUS ROUND 3 (10 2 0)**
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS				**CONSENSUS ROUND 3 (11 0 1)**
E	Results of the Research should be published in an **accredited Medical Journal**				**STABILITY AFTER 3 ROUNDS (0 9 3)**
F	If the research project is not completed the learner will not be awarded the qualification				**STABILITY AFTER 3 ROUNDS (1 2 9)**

SECTION D
EDUCATION METHODOLOGY AND MODES OF DELIVERY

This section deals with methodology and modes of delivery of the programme.

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X.

Only mark one option.

19. POLICIES AND PROCEDURES FOR PROGRAMME APPROVAL

In the **development** of an educational programme in Mental Health:

		Essential	Useful	Unnecessary	Results
A	A Postgraduate Programme in Mental Health should be implemented at the National Qualification framework level 7 (post-graduate diploma level)				**CONSENSUS ROUND 1 (11 1 0)**
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework				**CONSENSUS ROUND 3 (0 2 10)**

	level 8 (master's degree level)				
C	The Department of Education and the Department of Health should support the educational programme (Post-graduate Programme in Mental Health)				**CONSENSUS ROUND 1 (11 1 0)**
D	The pharmaceutical industry should be approached for financial assistance (sponsor-ship), in order to support the Post-graduate Programme in Mental Health				**CONSENSUS ROUND 3 (1 10 1)**
E	The Post-graduate Programme in Mental Health should be offered as a structured, formally registered SAQA approved programme pegged at the appropriate level				**CONSENSUS ROUND 1 (10 2 0)**
F	The Post-graduate Pro-gramme in Mental Health should be offered as an informal short course programme				**CONSENSUS ROUND 3 (0 12 0)**
G	The Post-graduate Pro-gramme in Mental Health should contain modules which may serve as credit bearing short courses				**CONSENSUS ROUND 3 (11 1 0)**

H	The Post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes				**STABILITY AFTER 3 ROUNDS (9 3 0)**
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses (e.g. M. Med. Fam)				**CONSENSUS ROUND 3 (2 10 0)**

20. OUTCOMES-BASED EDUCATION

In developing an education programme for the Post-graduate Programme in Mental Health, the following should be considered:

		Essential	**Useful**	**Unnecessary**	Results
A	Evaluation procedures are consistent				**CONSENSUS ROUND 1 (11 1 0)**
B	Evaluation procedures are interrelated				**CONSENSUS ROUND 2 (11 1 0)**
C	Regular review of the course to eliminate ineffective sections				**CONSENSUS ROUND 1 (11 1 0)**

D	Evaluation of the materials to eliminate ineffective materials				**CONSENSUS ROUND 1 (11 1 0)**
E	Orientation from "What I (as a lecturer) must cover" is changed to "What a student should be able to do" as a consequence of instruction				**CONSENSUS ROUND 1 (12 0 0)**
F	Self-evaluation by the students should be encouraged to ensure they know what is expected of them				**CONSENSUS ROUND 1 (10 2 0)**
G	Efficient student learning is facilitated by providing direction				**CONSENSUS ROUND 1 (12 0 0)**
H	Efficient student learning is facilitated by identifying instructional priorities				**CONSENSUS ROUND 1 (10 2 0)**
I	Demonstrations (of knowledge gained) must be of high quality e.g. chat room contributions				**CONSENSUS ROUND 1 (10 2 0)**
J	Demonstrations must show evidence of significant learning				**CONSENSUS ROUND 1 (11 1 0)**
K	A portfolio should form part of demonstrations of knowledge gained by each student				**CONSENSUS ROUND 2 (11 1 0)**

L	The outcomes must be significant				**CONSENSUS ROUND 2 (10 2 0)**
M	The outcomes must be clear				**CONSENSUS ROUND 1 (10 2 0)**
N	The outcomes must be concise				**CONSENSUS ROUND 1 (10 2 0)**
O	Demonstrations must occur in some ”own context” (performance setting)				**CONSENSUS ROUND 2 (11 1 0)**

21. CURRICULUM PLANNING, DEVELOPMENT AND DESIGN					
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:					
		Essential	**Useful**	**Unnecessary**	Results
A	The curriculum develop-mental process should be sensitive to the academic setting of the project				**CONSENSUS ROUND 3 (12 0 0)**
B	The curriculum develop-mental process should be sensitive to the capabilities of the students for whom the programme is designed				**CONSENSUS ROUND 2 (10 2 0)**

C	The curriculum develop-mental process should be sensitive to the interests of the students for whom the programme is designed				**CONSENSUS ROUND 3 (10 2 0)**
D	The curriculum should be sensitive to the priorities of the students for whom the programme is designed				**CONSENSUS ROUND 2 (11 1 0)**
E	The development of the programme should require a detailed knowledge and appreciation of the discipline				**CONSENSUS ROUND 1 (10 2 0)**
F	The development of the programme should require an understanding of the resources available to the faculty and educators involved				**CONSENSUS ROUND 1 (10 2 0)**
G	The development of the programme should require an understanding of the options available to the faculty and educators involved				**CONSENSUS ROUND 1 (10 2 0)**
H	The programme should have a rationale (or mission statement) to explain why the programme exists				**CONSENSUS ROUND 1 (10 2 0)**

I	The overall programme aims must be clearly stated, in order to explain what the programme will achieve				**CONSENSUS ROUND 1 (11 1 0)**
J	Outcome statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the programme				**CONSENSUS ROUND 1 (11 1 0)**
K	Content statements must be provided to indicate what areas of knowledge will comprise the student learning				**CONSENSUS ROUND 1 (12 0 0)**
L	Teaching guidelines must be provided in order to indicate how long the learning activities will be organized				**CONSENSUS ROUND 1 (10 2 0)**

22. IMPLEMENTING AND EVALUATING THE CURRICULUM					
Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Results

A	There must be a demonstrable need for the programme				**CONSENSUS ROUND 1 (10 2 0)**
B	The academic area must be stable in terms of the knowledge comprising the programme				**CONSENSUS ROUND 2 (11 1 0)**
C	The academic area must be well defined in terms of the knowledge comprising the programme				**CONSENSUS ROUND 1 (11 1 0)**
D	There must be clear potential for success of the programme				**CONSENSUS ROUND 1 (10 2 0)**
E	The department/institution providing the programme must have the necessary resources available				**CONSENSUS ROUND 1 (12 0 0)**
F	Any social and political factors that may negatively impact the provision of the programme should be considered				**CONSENSUS ROUND 1 (12 0 0)**
G	A needs assessment should be considered in terms of the programme objectives				**CONSENSUS ROUND 1 (11 1 0)**
H	The aims/exit level outcomes of the curriculum should be stated				**CONSENSUS ROUND 1 (12 0 0)**

I	There should be a clear rationale and justification for the provision of the programme				**CONSENSUS ROUND 1 (12 0 0)**
M	Assessment criteria and procedures must be clearly stated				**CONSENSUS ROUND 1 (10 2 0)**
N	The context and community in which the programme resides should be articulated				**CONSENSUS ROUND 2 (10 2 0)**
O	The entry and admission criteria for the programme must be adequately described				**CONSENSUS ROUND 1 (11 1 0)**
P	The form of instruction should be appropriate to the learners' needs				**CONSENSUS ROUND 1 (11 1 0)**
Q	The programme should allow for individual differences in students				**STABILITY AFTER 3 ROUNDS (8 4 0)**
R	The programme should allow for individual differences in learning methods				**STABILITY AFTER 3 ROUNDS (7 5 0)**
S	Provision must be made for adequate availability of student materials				**CONSENSUS ROUND 2 (12 0 0)**
T	Provision must be made for adequate availability of student resources. E.g. computers				**CONSENSUS ROUND 1 (10 2 0)**

U	Provision must be made for adequate availability of student facilities				**CONSENSUS ROUND 1 (10 2 0)**
V	There should be provision for pilot testing of the proposed programme prior to final implementation				**CONSENSUS ROUND 3 (11 1 0)**
W	Criteria must be available for evaluation of all aspects of the programme for purposes of quality assurance				**CONSENSUS ROUND 2 (10 2 0)**
X	Quality Assurance Processes should assess the Post-graduate Programme in Mental Health regularly				**CONSENSUS ROUND 1 (11 1 0)**
Y	There must be evidence of significant groups (subject specialists) involved through-out the development of the proposed programme curriculum				**CONSENSUS ROUND 1 (11 0 1)**

23. STUDENT ASSESSMENT

In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:

		Essential	Useful	Unnecessary	Results
A	The emphasis should be shifted away from the input or content aspect of programmes toward the objective assessment of the performance of learners in terms of clearly stated outcomes				**CONSENSUS ROUND 2 (10 2 0)**
B	The ultimate outcome (end point) for each and every person learning in a particular programme should be equivalent and clearly stated				**CONSENSUS ROUND 2 (10 2 0)**
C	The assessment must be objective and verifiable				**CONSENSUS ROUND 2 (12 0 0)**
D	The responsibilities learners are expected to assume to monitor their own learning must be defined				**CONSENSUS ROUND 1 (10 2 0)**
E	The assessment criteria for each of the abilities/skills that have been developed should be defined				**CONSENSUS ROUND 1 (11 1 0)**

F	An assessment taskforce is established, which will include an assessment expert				**CONSENSUS ROUND 3 (11 1 0)**
G	There is the establishment of a systematic assessment programme, which will aim to ensure uniformity of assessment across all subjects/modules				**CONSENSUS ROUND 2 (10 2 0)**
H	There is an integrated method of assessment covering all aspects of the learning programme				**CONSENSUS ROUND 1 (11 1 0)**
I	Standardised multi-modal methods of learner assessment should be used				**CONSENSUS ROUND 1 (10 1 1)**
J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors				**CONSENSUS ROUND 3 (11 1 0)**
K	The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected				**CONSENSUS ROUND 2 (10 2 0)**
L	Moderation of learner assessment takes place to ensure that the required level, standard, appropriate-				**CONSENSUS ROUND 1 (11 1 0)**

	ness and fairness is observed				
M	All forms of assessment are conducted by appropriately trained moderators with specific expertise in the learning area				**CONSENSUS ROUND 1 (10 2 0)**

24. FORMAL LECTURES					
		Essential	**Useful**	**Unnecessary**	Results
A	There is a place for formal lectures as a means of content delivery to students				**STABILITY AFTER 3 ROUNDS (6 6 0)**
B	The content of formal lectures should be geared to the practical needs of medical practitioners working in primary health settings				**CONSENSUS ROUND 1 (11 1 0)**
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE)				**CONSENSUS ROUND 3 (12 0 0)**
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic				**CONSENSUS ROUND 3 (11 1 0)**

E	Formal lectures can be used to present the core content of the programme				**CONSENSUS ROUND 2 (10 2 0)**
F	Powerpoint presentations and video-clips should be used where appropriate to enhance the lecture				**CONSENSUS ROUND 1 (10 2 0)**
G	Copies of hand-outs should be made available at a website for students to access after the lecture				**CONSENSUS ROUND 2 (10 2 0)**
H	Copies of illustrations should be made available at a website for students to access after the lecture				**CONSENSUS ROUND 2 (10 2 0)**
I	The content of the lecture should be available for students to access using Podcasting				**STABILITY AFTER 3 ROUNDS (9 3 0)**
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture				**CONSENSUS ROUND 3 (11 1 0)**
K	Formal lectures containing core knowledge on the topic need to be revised regularly				**CONSENSUS ROUND 1 (11 1 0)**
L	Peer review on content of core knowledge is important				**CONSENSUS ROUND 1 (12 0 0)**

M	Constructive feedback on the content of he lecture from students should be encouraged				**CONSENSUS ROUND 1 (11 1 0)**

25. SMALL GROUP SESSIONS					
Whether in the format of face-to-face interaction, or on-line distance "chat rooms", small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Results
A	Familiarise students with an adult approach to learning				**CONSENSUS ROUND 2 (11 1 0)**
B	Encourage students to take responsibility for their own learning				**CONSENSUS ROUND 1 (11 1 0)**
C	Promote deeper under-standing of the topic				**CONSENSUS ROUND 1 (11 1 0)**
D	Encourage problem-solving skills				**CONSENSUS ROUND 2 (11 1 0)**
E	Encourage participation (Some students may be based in remote areas with little contact with other doctors)				**CONSENSUS ROUND 1 (11 1 0)**
F	Students should also be evaluated on the content of their contributions to small				**STABILITY AFTER 3 ROUNDS (9 3 0)**

	group interactions				
G	Each small group session should be facilitated by both a tutor and a co-tutor				**STABILITY AFTER 3 ROUNDS (8 4 0)**
H	Syndicate groups (without a tutor and co-tutor) should be used				**CONSENSUS ROUND 3 (1 10 1)**

26. PATIENT - CENTRED LEARNING					
As students will be frequently exposed to patients with mental illness, either in in-patient settings or out-patient wards (or in private practice), the use of ward-based teaching in the programme:					
		Essential	**Useful**	**Unnecessary**	Results
A	Should be considered, where learners will be asked to link a certain psychiatric condition (under discussion), with a particular patient(s)				**CONSENSUS ROUND 2 (10 2 0)**
B	Learners may be asked to detect specific symptomato-logy in certain patients and report to their tutor or group				**CONSENSUS ROUND 2 (10 2 0)**
C	Learners may relate the effect of certain medications on a patient (efficacy or side-effects)				**CONSENSUS ROUND 2 (11 1 0)**

D	Learners may have a platform in which to discuss problem patients with tutors and/or the group and so increase their knowledge of the topic				**CONSENSUS ROUND 1 (11 1 0)**
E	Learners can be instructed to write up case-studies of certain common psychiatric conditions and include this work in their portfolios (which will be assessed at a later date)				**CONSENSUS ROUND 2 (12 0 0)**
F	Each learner in the group will have an opportunity to present a patient (in their own practice) with specific complaints. This will serve as a learning exercise				**CONSENSUS ROUND 1 (11 1 0)**

27. ONLINE DISTANCE LEARNING

Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:

		Essential	**Useful**	**Unnecessary**	Results

A	In the 21st century ODL is….				**CONSENSUS ROUND 2 (10 2 0)**
B	ODL allows for greater interaction between tutor and learner				**CONSENSUS ROUND 3 (10 2 0)**
C	ODL meets the needs of non-traditional learners				**CONSENSUS ROUND 3 (11 1 0)**
D	ODL allows learners to work at their own pace				**STABILITY AFTER 3 ROUNDS (7 5 0)**
E	Administrators of the university/ Institution presenting the programme need to be favourably inclined towards ODL				**CONSENSUS ROUND 1 (11 1 0)**
F	ODL calls for a change in academic and educational requirements (compared to presenting traditional curricula)				**CONSENSUS ROUND 2 (10 2 0)**
G	The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility				**CONSENSUS ROUND 2 (12 0 0)**
H	The rapid evolution of knowledge requires the staff facilitating the online module to have greater support from medical experts				**CONSENSUS ROUND 1 (10 2 0)**

I	The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff				**CONSENSUS ROUND 2 (10 2 0)**
J	Instructors need more allocated time to develop online courses				**CONSENSUS ROUND 3 (11 1 0)**
K	Instructors need more allocated time to deliver online courses				**CONSENSUS ROUND 3 (11 1 0)**
L	Additional technical staff are needed for ODL				**CONSENSUS ROUND 2 (10 2 0)**
M	Additional administrative staff are needed for ODL				**STABILITY AFTER 3 ROUNDS (9 2 1)**
N	Copyright laws and intellectual property rights should be adhered to				**CONSENSUS ROUND 1 (10 2 0)**
O	Instructors should ensure the quality of ODL remains high				**CONSENSUS ROUND 1 (11 1 0)**
P	Instructors should be taught how to manage possible obstacles they may encounter when teaching online				**CONSENSUS ROUND 1 (10 2 0)**
Q	The software used to present the Post-graduate Pro-gramme in Mental Health should be of the same type				**CONSENSUS ROUND 2 (11 1 0)**

	as used by the UFS (in other programmes)				
R	A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken				**CONSENSUS ROUND 2 (10 2 0)**
S	ODL courses should be revised regularly				**CONSENSUS ROUND 2 (10 2 0)**
T	ODL courses should be updated when the software becomes obsolete				**CONSENSUS ROUND 1 (10 2 0)**
U	Learner training and support (in computer matters) plays an integral part of the programme				**CONSENSUS ROUND 2 (10 1 1)**
V	Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable				**CONSENSUS ROUND 1 (11 1 0)**
X	A graphic designer should take responsibility for the layout of material on web pages				**CONSENSUS ROUND 3 (2 10 0)**
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent)				**STABILITY AFTER 3 ROUNDS (7 5 0)**

Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms)				**STABILITY AFTER 3 ROUNDS (3 9 0)**
A A	Students should be encouraged to make use of Mobile learning				**CONSENSUS ROUND 3 (2 10 0)**
B B	Students should be encouraged to make use of blogs				**CONSENSUS ROUND 3 (2 10 0)**

SECTION E STUDENT EVALUATION					
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one.**					
29. STUDENT ASSESSMENT					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Results
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online				**STABILITY AFTER 3 ROUNDS (5 7 0)**

B	Learners will have seven working days to return their "homework" online				**STABILITY AFTER 3 ROUNDS (6 6 0)**
C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic				**STABILITY AFTER 3 ROUNDS (2 9 1)**
D	If the tutorial is not successfully completed students will have three days to make corrections				**STABILITY AFTER 3 ROUNDS (3 9 0)**
E	Students will be assessed according to their contributions to the chat room sessions				**CONSENSUS ROUND 3 (0 12 0)**
F	The case studies for each module will also be assessed				**CONSENSUS ROUND 1 (10 2 0)**
G	Students who wish to exit the course after year one will have to pass an oral examination in order to receive a Short Learning Programme certificate				**CONSENSUS ROUND 2 (10 2 0)**
H	The oral examination will consist of a case presentation (30 minutes) related to the subject material in modules 1-4				**CONSENSUS ROUND 2 (11 1 0)**

I	The allocation of weightings for year one module marks is as follows: Tutorials (first attempt) 45%				**CONSENSUS ROUND 2** **(2 10 0)**
J	The allocation of weightings for year one module marks includes: case-studies = 45%				**CONSENSUS ROUND 2** **(2 10 0)**
K	The allocation for year one module marks includes chat room contributions = 10%				**CONSENSUS ROUND 3** **(2 10 0)**
L	The learner must have 50% or more to continue to the second academic year				**CONSENSUS ROUND 1** **(10 1 1)**
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				**CONSENSUS ROUND 3** **(11 1 0)**
N	The weightings for the second academic year will be as follows: Tutorials (first attempt) 25%				**CONSENSUS ROUND 2** **(1 11 0)**
O	The weightings for the second academic year will include case-studies = 25%				**CONSENSUS ROUND 2** **(2 10 0)**
P	The weightings for the second academic year will include chat room contributions = 10%				**CONSENSUS ROUND 2** **(1 11 0)**

Q	The weightings for the second academic year will include a research project = 40%				**STABILITY AFTER 3 ROUNDS (3 1 8)**
R	Learners who do not have an average mark of at least 50 % will not be allowed to attend the final oral examination				**CONSENSUS ROUND 1 (11 1 0)**
S	The final oral examination (30 minutes) should take the form of a case presentation				**CONSENSUS ROUND 1 (10 2 0)**
T	Students obtaining 50% or more will be awarded a qualification				**CONSENSUS ROUND 1 (10 2 0)**
U	Examiners of the oral examinations will be psychiatrists and psycho-logists (UFS staff)				**CONSENSUS ROUND 2 (12 0 0)**
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists				**STABILITY AFTER 3 ROUNDS (8 3 1)**

5.3 INTERPRETATION OF THE FINDINGS OF THE DELPHI STUDY

The findings mentioned in Table 5.1 will now be discussed. The order of the statements has been changed in order to facilitate discussion.

In any dynamic Outcomes-based Education programme, crucial exit level outcomes should be clearly stated regarding the knowledge and skills the students (or learners) should have gained, as well as the values they need to adhere to. The Delphi panel agreed with this principle as reflected in statement:

Outcome statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the programme (21J)

Where consensus was reached on a statement (option 1), the statement is printed in bold letters, unless otherwise stated, where the statement is given in brackets.

5.3.1 The Academic area of the Programme

By way of introduction, the following statements are essential:

- **The academic area must be stable in terms of the knowledge comprising the programme** (22B) and
- **The academic programme area must be well defined in terms of the knowledge comprising the programme** (22C)

5.3.2 The knowledge learners should acquire through the Programme

On completion of the Post-graduate Diploma in Mental Health (PGDipMH), the student should essentially have gained the following **knowledge**:

- **The ability to classify the various common types of psychopathology** (1A).
- **Current theories on the known aetiology of mental conditions** (1B).
- **Current theories on the pathophysiology of common mental conditions** (1C).
- **Current theories on the psychopharmacology used to manage common mental conditions** (1D).
- **An appreciation of the effect of the patients' physical environment on their conditions** (1E).
- **An appreciation of the effect of the patients' cultural environment on their conditions** (1F).
- **A comprehension of the importance of patient confidentiality** (1G).
- **The interpersonal dynamics involved in a multi-disciplinary health team approach** (1H).
- **The role of risk factors in Mental Health** (1I).
- **Current theories relating to the prevention of psychopathology (in humans)** (1J).
- **The cost-effective utilisation of special investigations in Psychiatry** (1K) and

- **An understanding of legal issues in Psychiatry** (1N).
- Although there was consensus on the role of appropriate utilisation of new technology in Psychiatry, this knowledge was seen as being useful rather than essential (1M).

5.3.3 The skills learners should acquire through the Programme:

On completion of the PGDipMH students should essentially have gained the following **skills**:

- **The ability to identify most common forms of pychopathology** (2A).
- **The ability to conduct a thorough mental state examination** (2B).
- **The ability to diagnose common mental conditions** (2C).
- **The ability to manage common mental conditions** (2D).
- **The ability to refer patients appropriately for further management** (2E).
- **The ability to demonstrate cultural sensitivity to all patients** (2F).
- **The ability to function as an integral part of a multi-disciplinary health care team** (2G).
- **The ability to effectively counsel patients** (2H).
- The panel did not regard basic computer skills as important (no consensus reached) (2I).

5.3.4 Contents of the Programme:

These parts of Section A can be linked to parts of Section C: THE CONTENTS OF THE PROGRAMME.

MODULE 1 – INTRODUCTION TO PSYCHIATRY

- **During this two day seminar students would receive formal face-to-face formal tuition** (7A).
- **Basic neuroanatomy will be presented using anatomic models** (7B).
- **Basic neurophysiology will also be presented** (7C).
- **The evaluation of basic common psychiatric conditions will be presented in a tertiary setting** (7D). The context, however, will have to be geared towards the primary health care settings
- **Four case studies using patients with common chronic (or acute) conditions will be presented (with the consent of the patients involved)** (7E).
- **The symptomatology of the conditions under discussion will also be dealt with** (7F).
- **The management of these conditions will also be discussed** (7H).
- **A specific case report will be given to students. Students will be required to answer specific questions by e-mail to the Department of Psychiatry within seven working days** (7J).

- **Students will be evaluated according to their ability to integrate knowledge** (7K).
- **Students should have a working knowledge of the Mental Health Care Act** (7L).

MODULE 2 - CHRONIC PSYCHIATRIC CONDITIONS (Part 1)

Tuition for this module and all the other modules except module 1 will be presented using the Online Distance Learning (ODL) format.

The following conditions will be discussed in this Module:

SCHIZOPHRENIA
On completing the module the student should know:

- **The basic known neuropathology of Schizophrenia** (8A).
- **The sub-types of Schizophrenia** (8B).
- **The pharmacology of treatment in Schizophrenia** (8D).
- **The complications of pharmacological treatment (in Schizophrenia)** (8E).
- **The importance of early recognition and treatment in prodromal Schizophrenia** (8F).
- **The role of cannabis (and other substances) in early diagnosis and treatment of Schizophrenia** (8G).
- **About psychosis secondary to general medical conditions** (8H).

No consensus was reached regarding the inclusion of statement 8C the History of the Nosology of Schizophrenia. This topic was seen as either essential or useful by a majority of the experts.

MODULE 3 – CHRONIC COMMON PSYCHIATRIC DISORDERS (Part 2)

MOOD DISORDERS

On completing the module the student should know how to:

- **Understand the differences between Bipolar Disorders and Depressive Disorders (including subtypes)** (9A).
- **Treat the conditions mentioned in 9A** (9B).
- **Manage the complications of treatment** (9C).
- **Recognise patients at risk of committing suicide** (9D).
- **Differentiate the phases of grief** (9E).
- **Differentiate Mood Disorders secondary to general medical conditions** (9F).
- **Explain the meaning of Adjustment Disorders** (9G).

MODULE 4 – CHRONIC COMMON PSYCHIARTRIC DISORDERS (Part 3)

ANXIETY DISORDERS

On completing the module the learner should be able to:

- **Explain Generalized Anxiety Disorder** (10A).
- **Explain Obsessive Compulsive Disorder (**10B).
- **Explain Post Traumatic Stress Disorder** (10C).
- **Explain Panic Disorder** (10D).
- **Explain Social Anxiety Disorder** (10E).
- **Treat the conditions mentioned in 10 A to E and have a knowledge of complications of treatment (Pharmaco-therapy)** (10F).
- **Understand the concept of co-morbidity relating to Anxiety Disorders and Depressive Disorders** (10G).
- **Have a working knowledge of non-pharmacological treatment of Anxiety Disorders** (10H).
- **Be able to decide if a patient with Anxiety Disorder and Co-morbid Depression will possibly qualify for impairment on psychiatric grounds** (10I). The final decision will be made by a psychiatrist.
- **Know the differential diagnosis of Anxiety Disorders** (10J).
- **Know how to recognise Avoidant, Dependent and Obsessive Personality Disorders** (10K).

MODULE 5 - CHILD PSYCHIATRY (Part 1)

On completion of the module the student should:

- **Have an understanding of normal development in the human brain** (11A). This refers to the neuro-developmental and behavioural changes from conception to adulthood.
- **Have a basic knowledge of Pervasive Disorders in children (for example Autism)** (11B).
- **Understand Disruptive Disorders in children** (11C).
- **Have an understanding of approaches in treatment for Elimination Disorders (enuresis and encopresis)** (11D).
- **Have a working knowledge of Intellectual Disability (Mental Retardation)** (11E).
- **Be able to manage victims of abuse (physical, sexual, emotional) at primary health care level** (11F).

MODULE 6 – CHILD PSYCHIATRY (Part 2)

On completion of the module the student should:

- **Have a working knowledge of Depressive Disorders in children** (12A).
- **Have a working knowledge of Anxiety Disorders in children** (12B).
- **Understand issues facing adolescents (including exposure to illicit substances)** (12C).
- **Have a working knowledge of Eating Disorders** (12D).
- **Be able to counsel parents and families in crisis** (12E).

MODULE 7 – FORENSIC PSYCHIATRY

Students who complete this module should be able to:

- **Understand the rights of patients and the Mental Health Care Act** (13A).
- **Understand the concepts of Trialability and Criminal Responsibility. Section 77 and 78 of Criminal Procedure Act** (13B).
- **Understand ethical issues relating to Psychiatry** (13D).
- **Be able to advise families regarding legal issues, i.e. if and when patients are no longer able to manage their own affairs** (13E).
- **Know how intoxication with substances affects Criminal Responsibility** (13F).
- **Know how to recognise Antisocial and Borderline Personality Disorders** (13G).
- No consensus was reached on the inclusion of the Law on Sterilization in the Module (13C). A majority of experts regarded the inclusion of this law as either essential or useful. This statement will be included in the programme.

MODULE 8 – ADDICTION DISORDERS

Students completing this module should:

- **Have a working knowledge of the effects of ethanol (alcohol) in humans** (14A).

- **Be able to manage patients with acute alcohol withdrawal** (14B).
- **Understand chronic alcohol dependence** (14C).
- **Have a working knowledge of the terms use and abuse** (14D).
- **Have a working knowledge of illicit drugs/substances commonly available in South Africa** (14E).
- **Be able to manage patients with signs and symptoms of acute withdrawal from a substance until the patient can be managed at secondary/tertiary level** (14F).
- **Be able to explain how substances affect criminal responsibility** (14G).
- **Have a working knowledge of drug-substitution therapy** (14H).
- **Be able to recognise and manage co-morbid psychiatric conditions** (14I).

MODULE 9 – GERIATRIC PSYCHIATRY

After completing this module students should:

- **Understand the psychopathology of the aging brain** (15A).
- **Have a working knowledge of dementia** (15B).
- **Understand pharmacotherapy in the elderly** (15C).
- **Be able to counsel families of elderly patients** (15D).
- **Know how to manage the process of having a patient placed under curatorship (legal implications)** (15E).

MODULE 10 – INTRODUCTION TO COGNITIVE BEHAVIOUR THERAPY

After completing this module students should:

- **Be able to understand the principles of Cognitive Behaviour Therapy (CBT)** (16B).
- **Be able to apply CBT in counselling patients having Depressive Disorders** (16C).
- **Be able to apply CBT in patients having Anxiety Disorders** (16D).
- **Be able to counsel patients who have been acutely traumatised** (16E).
- **Be able to manage patients with suicidal ideation** (16F).
- **Have a working knowledge of personality disorders** (16G).
- Although consensus was not reached concerning (16A) – A knowledge of the origins of CBT – most experts thought this knowledge was either essential or useful to be included in the programme.

On completion of the PGDipMH students should have adhered to the following values concerning patients:

- **The importance of patient confidentiality** (3A).
- **The importance of multidisciplinary health care interventions** (3B).
- **A respect for the rights of mental health care users** (3C).
- **Empathy for mental health care users** (3D).
- **Empathy for the families of mental health care users** (3E).

- **An appreciation for the fact that the patient is more important than the disease** (3F).

5.3.5 Values learners should adhere to

On completion of the PGDipMH should have adhered to the following values concerning themselves as learners:

- **A positive approach to self-directed life long learning** (3G).
- **A willingness to participate in self-evaluation** (3H).
- **A willingness to participate in peer evaluation** (3I).
- **A positive attitude regarding continuing professional development** (3J).

5.3.6 A research project

A practical exercise that could be utilised to help develop these values stated in statements (3G) to (3J) would be to include the undertaking of a compulsory research project in the programme as part of the requirements needed before qualifying. However, the completion of a successful research project is not generally regarded as being a minimum requirement for post-graduate diplomas but is certainly necessary for master's degrees (cf. 3.2.4). This sentiment was also reflected in the Delphi study. Although consensus was not reached, a majority of experts thought the research project was unnecessary, statement (17A). Should the research project have been included in the programme, there was consensus for the following:

- **Students would have the use of a tutor to assist them** (17B).
- **Students would be able to consult a biostatistician** (17C).
- **Protocols for their research projects would have to be approved by the Ethics Committee of the UFS** (17D).

5.3.7 The Format of the Programme

The following factors are important when planning the **format** of the programme:

- Although consensus was not reached on the time frame for the course (5A), a majority of experts agreed that a two year period was either essential or useful.
- Although consensus was not reached on the amount of modules to be presented in the first academic year (5B), all the experts felt four modules were either essential or useful**.**
- Although consensus was not reached on the amount of modules to be presented in the second academic year (5C), 50% of the experts indicated three modules as being essential, while the remainder said three were useful.
- There was enough consensus to suggest it was useful for students to be allow to choose three modules from a list of six modules to be presented in the second academic year (cf. 5G).
- As stated in Section 5.3.1 the overall feeling was that a research project (5D) would not be a requirement for the PGDipMH.

- **Students should be required to pass the first academic year before proceeding to the second year** (5E).
- There was no consensus on the awarding of a certificate to students who successfully passed the first academic year, but who did not wish to proceed to the second academic year (5F). The majority of experts felt this was unnecessary. However, in 5.4.4.2 statement (29G), the experts agreed that the statement "**students who wish to exit the course after one year will have to pass an oral examination in order to receive a Short Learning Course Certificate"**, was essential to the programme. The same sentiment was also reflected in (29M).
- **The second academic year should contain six modules, of which learners should choose three modules** (5G).
- Concerning the research project (5H) it should not form part of the programme – (cf. 5.3.1).
- **Students will be assessed using tutorials and worksheets** (5I).
- **Each tutorial will also contain a chat room session (60 - 90 minutes)** (5J). Students will be given turns to lead the topic under discussion and all learners will be required to contribute to the discussion.
- **Students will be evaluated according to their contribution to the chat room discussion** (5K) (cf. 29E described in 5.4.4.2).
- **There should be a restriction on the number of students who are allowed to enrol for each academic year** (5L). The literature cautions that ODL classes should not be too large.

- **Only medical practitioners registered with the South African Health Professions Council will be accepted for enrolment in the programme** (5M). There was a suggestion that allied medical professionals also be allowed to enrol for the programme.
- **Learners should be encouraged to present appropriate case-studies from their wards/practice when leading chat room sessions** (5N).
- **The academic standard of subject material used in the programme should be closer to M.Med (Psych) level than to MBchB level** (5O).
- **Where possible, teaching should be directed towards practical situations in wards/practice (rather than philosophical theories)** (5P).
- **Where applicable, teaching should be directed towards rural, primary care settings** (5Q).
- **Where applicable, cultural phenomena should also be discussed** (5R).

5.3.8 Aspects of the framework relating to OBE

The following factors relating to Outcomes-based Education are essential:

- **Evaluation procedures should be consistent** (20A).
- **Evaluation procedures should be interrelated** (20B).
- **There should be regular review of the programme to eliminate ineffective parts** (20C).

- **There should be evaluation of the materials to eliminate ineffective materials** (20D).
- **A change in orientation from "what I (as a lecturer) must cover" to "what a student should be able to do" as a consequence of instruction** (20E).
- **Self-evaluation by students should be encouraged, to ensure they know what is expected of them** (20F).
- **Facilitation of efficient student learning by providing direction** (20G).
- **Facilitation of efficient student learning by identifying instructional priorities** (20H).
- **Demonstration (of knowledge gained) must be of high quality e.g. chat room contributions** (20I).
- **Demonstrations must show evidence of significant learning** (20J).
- **A portfolio should form part of the demonstrations of knowledge gained by the student** (20K).
- **Outcomes (of learning) should be significant** (20L).
- **Outcomes should be clear** (2OM).
- **Outcomes should be concise** (20N).
- **Demonstrations of learning must occur in some "own context" (performance setting)** (20O).

5.3.9 Student assessment

In developing an educational programme in Mental Health, recognition must be taken of mechanisms for student assessment in order to ensure that:

- **The emphasis is shifted away from the input or content aspect of the programme towards the objective assessment of the performance of learners in terms of clearly stated outcomes** (23A).
- **The ultimate outcome (end point) for each and every person learning in a particular programme is equivalent and clearly stated** (23B).
- **The assessment is objective and verifiable** (23C).
- **The responsibilities learners are expected to assume to monitor their own learning are defined** (23D).
- **The assessment criteria for each of the abilities/skills that have been developed are defined** (23E).
- **An assessment taskforce is established, which will include an assessment expert** (23F).
- **There is the establishment of a systematic assessment programme, which will aim to ensure uniformity of assessment across all subjects/modules** (23G).
- **There is an integrated method of assessment covering all aspects of the learning programme** (23H).
- **Standardised multi-modal methods of learner assessment are used** (23I).
- **Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors** (23J).
- **The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected** (23K).

- **Moderation of learner assessment takes place to ensure that the required level, standard, appropriateness and fairness is observed** (23L).
- **All forms of assessment are conducted by appropriately trained moderators with specific expertise in the learning area** (23M).

5.3.10 Formal lectures

No specific consensus was reached by the Delphi Experts regarding the use of formal lectures as a form of content delivery to students, statement (24A). Six experts considered formal lectures essential to the programme while the other half conceded formal lectures were useful for the programme. However, there was consensus on the next statements showing inadvertently that formal lectures are essential to the programme.

- **The content of formal lectures should be geared to the practical needs of medical practitioners working in primary health settings** (24B).
- **Formal lectures can be used to facilitate OBE** (24C).
- **By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic** (24D).
- **Formal lectures can be used to present the core content of the programme** (24E).
- **Powerpoint presentations and video-clips should be used where appropriate to enhance the lecture** (24F).

- **Copies of hand-outs should be made available at a website for students to access after the lecture** (24G).
- **Copies of illustrations should be made available at a website for students to access after the lecture** (24H).
- No consensus was reached regarding the availability of lectures using Podcasting (24I). However, the Delphi Experts did consider using Podcasting essential or useful.
- **Copies of the Powerpoint slides should be available at a website for students to access after the lecture** (24J).
- **Formal lectures containing core knowledge on the topic need to be revised regularly** (24K).
- **Peer review on the content of core knowledge is important** (24L).
- **Constructive feedback on the content of the lecture from students should be encouraged** (24M).

5.3.11 Patient-centred learning

As students are frequently exposed to patients with mental illness, either during in-patient settings or out-patient wards (or in private practice), there is a place for ward–based teaching in the programme.

- **Patient-centred learning should be considered, where learners will be required to link a certain psychiatric condition (under discussion), with a particular patient(s)** (26A).

- **Learners may be asked to detect specific symtomatology in certain patients and report to their tutor or group** (26B).
- **Learners may relate the effect of certain medications on a patient (efficacy or side-effects)** (26C).
- **Learners may have a platform allowing them to discuss problem patients with their tutors and/or the group and so increase their knowledge of the topic** (26D).
- **Learners can be instructed to write up case-studies of certain common psychiatric conditions and include this work in their portfolios (to be assessed at a later date)** (26E).
- **Each learner will have an opportunity to present a patient (from their practice) with specific complaints. This will also serve as a learning exercise** (26F).

5.4 ADDITIONAL ASPECTS CONCERNING THE INTERFACE BETWEEN THE PROGRAMME AND THE ADULT LEARNER

This concerns aspects of the Framework where the patient and OBE do not feature directly in the programme.

5.4.1 Curriculum planning, Development and Design

Before constructing a curriculum, the following factors should be considered:

- **The curriculum development process should be sensitive to the academic setting of the project** (21A).
- **The curriculum developmental process should be sensitive to the capabilities of the students for whom the programme is designed** (21B).
- **The curriculum developmental process should be sensitive to the interests of the students for whom the programme is designed** (21C).
- **The curriculum should be sensitive to the priorities of the students for whom the programme is designed** (21D).
- **The development of the programme should require a detailed knowledge and appreciation of the discipline** (21E).
- **The development of the programme should require an understanding of the resources available to the faculty and educators involved** (21F).
- **The development of the programme should require an understanding of the options available to the faculty and educators involved** (21G).
- **The programme should have a rationale (or mission statement) to explain why the programme exists** (21H).
- **The overall programme aims must be clearly stated, in order to explain what the programme will achieve** (21I).
- **Outcomes statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the programme** (21J).

- **Content statements must be provided to indicate what areas of knowledge will comprise the student learning** (21K).
- **Teaching guidelines must be provided to in order to indicate how long the learning activities will be organised** (21L).

5.4.2 Online Distance Learning (ODL)

With the exception of Module 1, all the other modules in the curriculum will be presented using ODL.

ODL should be considered as a practical method of facilitating the teaching of Psychiatry in a Primary Health Care setting because:

- **In the 21st century ODL is essential** (27A).
- **ODL allows for greater interaction between tutor and learner** (27B).
- **ODL meets the needs of non-traditional learners** (27C).
- No consensus was reached concerning ODL allowing learners to work at their own pace (27D). The experts, however, did regard this advantage to be essential or useful.
- **Administrators of the university presenting the programme need to be favourably inclined towards ODL** (27E).
- **ODL calls for a change in academic and educational requirements (compared to traditional curricula)** (27F).

- **The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility** (27G).
- **The rapid evolution of knowledge requires the staff facilitating the online module to have greater support from medical experts** (27H).
- **The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff** (27I).
- **Instructors need more allocated time to develop online courses** (27J).
- **Instructors need more allocated time to deliver online courses** (27K).
- **Additional technical staff are needed for ODL** (27L).
- Although no consensus was reached regarding the need for additional administrative staff for ODL (27M), most Delphi Experts regarded this as being essential or useful.
- **Copyright laws and intellectual property rights should be adhered to** (27N).
- **Instructors should ensure the quality of ODL remains high** (27O).
- **Instructors should be taught how to manage possible obstacles they may encounter when teaching online** (27P).
- **The software used to present the PGDipMH should be of the same type as used by the UFS (in other programmes)** (27Q).

- **A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken** (27R).
- **ODL courses should be revised regularly** (27S).
- **ODL courses should be updated when the software becomes obsolete** (27T).
- **Learner training and support (in computer matters) plays an integral part of the programme** (27U).
- **Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable** (27V).
- **A graphic designer should take responsibility for the layout of material on web pages –** Consensus was reached that the services of a graphic designer were seen as useful (option 2), rather than essential for the programme (27X).
- No consensus was reached concerning the use of 'video-clips' to demonstrate certain signs and symptoms in consenting patients (27Y). Likewise no consensus was reached concerning the use of simulated patients (actors demonstrating certain signs and symptoms) (27Z). The Delphi Experts did, however, agree that the use of 'video-clips' or simulated patients was essential or useful for the programme.
- **Students should be encouraged to make use of mobile learning** (27AA).
- **Students should be encouraged to make use of blogs** (27BB).

5.4.3 Small Group Sessions

Whether in the format of face-to-face interaction, or online distance 'chat rooms', small groups can be important to:

- **Familiarise students with an adult approach to learning** (25A).
- **Encourage students to take responsibility for their own learning** (25B).
- **Promote deeper understanding of the topic** (25C).
- **Encourage problem-solving skills** (25D).
- **Encourage participation. (Some students may be based in remote areas with little contact with other doctors)** (25E).
- Concerning the evaluation of students based on the content of their contributions to the small group (25F), the Delphi Experts regarded this as essential or useful. Likewise the Delphi Experts regarded the facilitation of small group sessions using a tutor and co-tutor (25G) as either essential or useful.
- **Syndicate groups (without a tutor or co-tutor) should be used** (25H). Consensus was reached on the usefulness of these groups, (option 2).

5.4.4 Evaluation

Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to implementing and evaluating the curriculum.

5.4.4.1 *Implementation and Evaluation of the Curriculum*

- **There must be a demonstrable need for the programme** (22A).
- **The academic area must be stable in terms of the knowledge comprising the programme** (22B).
- **The academic area must be well defined in terms of knowledge comprising the programme** (22C).
- **There must be clear potential for success of the programme** (22D).
- **The department/institution presenting the programme must have the necessary resources available** (22E).
- **Any social and political factors that may negatively impact the provision of the programme should be considered** (22F).
- **A needs assessment should be considered in terms of the programme objectives** (22G).
- **The aims/exit level outcomes of the curriculum should be stated** (22H).
- **There should be a clear rationale and justification for the provision of the programme** (22I).
- **Assessment criteria and procedures must be clearly stated** (22M).
- **The context and community in which the programme resides should be articulated** (22N).
- **The entry and admission criteria for the programme must be adequately described** (22O).

- **The form of instruction should be appropriate to the learners' needs** (22P).
- No consensus was reached concerning the programme making allowances for individual differences in students or their learning methods (20Q). The Delphi Experts, however, regarded both aspects as essential or useful.
- **Provision must be made for adequate availability of student materials** (22S).
- **Provision must be made for adequate availability of student resources such as computers** (22T).
- **Provision must be made for adequate availability of student facilities** (22U).
- **There should be provision for pilot testing of the proposed programme prior to final implementation** (22V).
- **Criteria must be available for evaluation of all aspects of the programme for purposes of quality assurance** (22W).
- **Quality Assurances Processes should assess the Post-graduate Programme in Mental Health regularly** (22X).
- **There must be evidence of significant groups (subject specialists) involved throughout the development of the proposed programme** (22Y).

5.4.4.2 *Student Assessment*

Consensus was not reached on the following statements:

- After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online (29A).

- Learners will have seven working days to return their 'homework' online (27B).
- If the tutorial is successfully completed (>70% of answers correct), the student will be asked to form part of the chat room session (27C). If the tutorial is not successfully completed students will have three working days to make corrections. (If >70% of the homework is now correct students will be allowed to form part of the chat room session on the topic). The rationale for the 70% boundary was to ensure students had a working knowledge of the topic, and did not participate in the chat room session unprepared.

The Delphi Experts did, however, regard these statements as being essential, or useful:

- **Students will be assessed according to their contributions to the chat room sessions** (29E). The panel regarded this as useful to the programme, (option 2).
- **The case-studies of each module will be assessed** (29F).
- **Students who wish to exit the course after one year will have to pass an oral examination in order to receive a Short Learning Programme Certificate** (29G) (cf. 5F 5.3.7).
- **The oral examination will consist of a case presentation (30 minutes) relating to subject material in modules 1 – 4** (29H).
- **The allocation of weightings for year one module marks is as follows:**

  Tutorials (first attempt) = 45% (29I).

Case-studies = 45% (29J).

Chat room contributions = 10% (29K).

The panel regards these three statements as being useful

- **The learner must have 50% or more to continue to the second academic year** (29L).
- **Those who wish to exit after the first academic year must have at least a 50% module mark on average and at least 50% in the oral examination to obtain the Short Learning Programme Certificate (in Mental Health)** (29M).
- **The weightings for the second academic year will be as follows:**

  Tutorials (first attempt) = 25% (29N).

  Case-studies = 25% (29O).

  Chat room contributions = 10% (29P).

  The panel regarded these three statements as being useful to the programme.
- No consensus was reached by the panel concerning the awarding of marks for the research project. A majority regarded it as being unnecessary.
- **Learners who do not have an average mark of at least 50% will not be allowed to attend the final oral examination** (29R).
- **The final oral examination (30 minutes) should take the form of a case presentation** (29S).
- **Students obtaining 50% or more will be awarded a qualification** (29T).
- **Examiners of the oral examinations will be psychiatrists and psychologists (UFS staff)** (29U).

- There was no consensus regarding examiners at the oral examinations being requested to examine on behalf of the South African College of Psychiatrists (29V). A majority of the panel regarded this as essential or useful. This issue will be dealt with in direct consultation with the College in order to get a viable solution.

5.5 CONCLUSION

The findings of the research project, the Delphi study were described in this chapter. Of the 290 statements compiled and presented in the Delphi Questionnaire consensus was reached on 259 (89,3%). Of these 259 statements consensus was reached on option 1 in 249 statements (96,1% deemed essential for the framework). In the remaining 10 statements consensus was reached on option 2 (deemed useful for the framework) in nine statements and once for option 3.

The fact that there was a 100% response rate in all three rounds by the Delphi Experts and that consensus was reached on 89% of the statements counts favourably for the study.

In the following chapter, Chapter 6, the development of a framework for the Post-graduate Programme in Mental Health will be discussed.

CHAPTER 6

DISCUSSION OF THE FRAMEWORK OF THE PROGRAMME FOR THE POST-GRADUATE DIPLOMA IN MENTAL HEALTH

"Remember that there is often no 'someone else' who will do this for you – 'they' are 'us'; it is medical educationalists as well as technologists who are undertaking the work." Ellaway 2007: 589.

6.1 INTRODUCTION

As a means of assisting doctors working at primary health care level in South Africa to become more effective in diagnosing and managing psychiatric conditions, the researcher aspired to design a post-graduate programme for medical doctors who desired tuition in order to prepare themselves to pass the Diploma in Mental Health.

Chapter 1 dealt with the orientation and introduction to the study, whilst chapter 2 considered the path that teaching of Psychiatry in South Africa has progressed.

Chapter 3 reviewed the factors necessary to develop a curriculum and reviewed similar programmes in other parts of the world. In chapter 4 a description was given of the research design, methods, and techniques and chapter 5 described these results. This chapter relates to the development of the Framework of the Programme for the Post-graduate

Diploma in Mental Health. The Framework will ultimately be constructed in six phases (I to VI), which are described in this chapter.

6.2 PREMISES UTILISED IN DEVELOPING A FRAMEWORK FOR THE POST-GRADUATE DIPLOMA IN MENTAL HEALTH

During the initial stage of the study the researcher realised that there was no programme offering tuition for doctors wishing to receive post-graduate training in Mental Health at diploma level. The researcher knew that in recent times a wealth of new technology has become available, making it possible for the medical practitioners to learn in their own environment without the disruption of having to spend too much time away from their practices. (The researcher is of the opinion that most postgraduate medical diplomas utilising the 'face-to-face' teaching mode necessitate the learner to use approximately five weeks of leave away from their place of work, excluding travelling time to and from the institution offering the diploma).

The main challenge in the study was to find a viable bridge to link two widely differing domains namely Mental Health Care and E-learning. The bridge had to be 'user-friendly' without compromising standards in education or subject content. The bridge also had to have certain characteristics or points of departure (cf. Table 6.1).

As no such bridge exists the researcher endeavoured to assemble a framework. The process of this framework construction can be subdivided into six phases namely:

Phase I: IDENTIFICATION OF THE INDIVIDUAL NEEDS OF THE DOCTOR AS LEARNER AND THE MENTAL HEALTH CARE USER (PATIENT)

Phase II: THE CONTENT OF THE PROGRAMME

Phase III: THE DESCRIPTION OF THE MODE OF DELIVERY THROUGH WHICH THE PROGRAMME WILL BE PRESENTED

Phase IV: THE USE OF BLENDED LEARNING TO CONSOLIDATE DIFFERENT PARTS OF THE PROGRAMME IN MENTAL HEALTH

Phase V: APPROVAL AND IMPLEMENTATION OF THE PROGRAMME

Phase VI: FINAL ACCREDITATION AND ACCEPTANCE OF THE PROGRAMME.

Certain points of departure form an integral part of the process (cf. Table 6.1).

Table 6.1 Points of departure

- There had to be a need for the Programme (cf. 3.3.6).
- The Programme had to be cost-effective and feasible.
- The standards of the candidates' learning had to be relevant.
- The content of tuition had to be relevant to the Mental Health needs of the community at primary health care level.
- The mission and goals of the Faculty of Medicine UFS had to be recognized.
- The mission and goals of the South African College of Medicine had to be recognized (cf 2.5.1)
- The scientific character needed to be maintained in the context of the discipline (Psychiatry) and student expectations.

- The need for tuition for potential candidates who are employed on a full-time basis and are not able to attend classes during the traditional office hours(cf.3.4.5.1)
- The content and context of the curriculum were to be considered.
- The methods and modes of education were to be taken into consideration.
- Modern technology was to be utilised in teaching.
- Vertical development was to be accommodated.
- Credits were to be accumulated.
- The particular needs and circumstances of the students should be taken into account.
- The standards and scope of education required by SAQA and the College of Medicine (Psychiatry) for students to pass the Diploma in Mental Health should be maintained.

[Compiled by the researcher, Nichol (2007) as part of the Ph.D. research project.]

Using a literature study and the researcher's own experience it became apparent that four role-players could be identified as being essential to the gestalt of the study namely the student/learner, OBE, patients and their environment and the Programme. As an integral part of the study, they form the backbone of the framework. The interaction of these role-players is portrayed schematically in Figure 6.1.

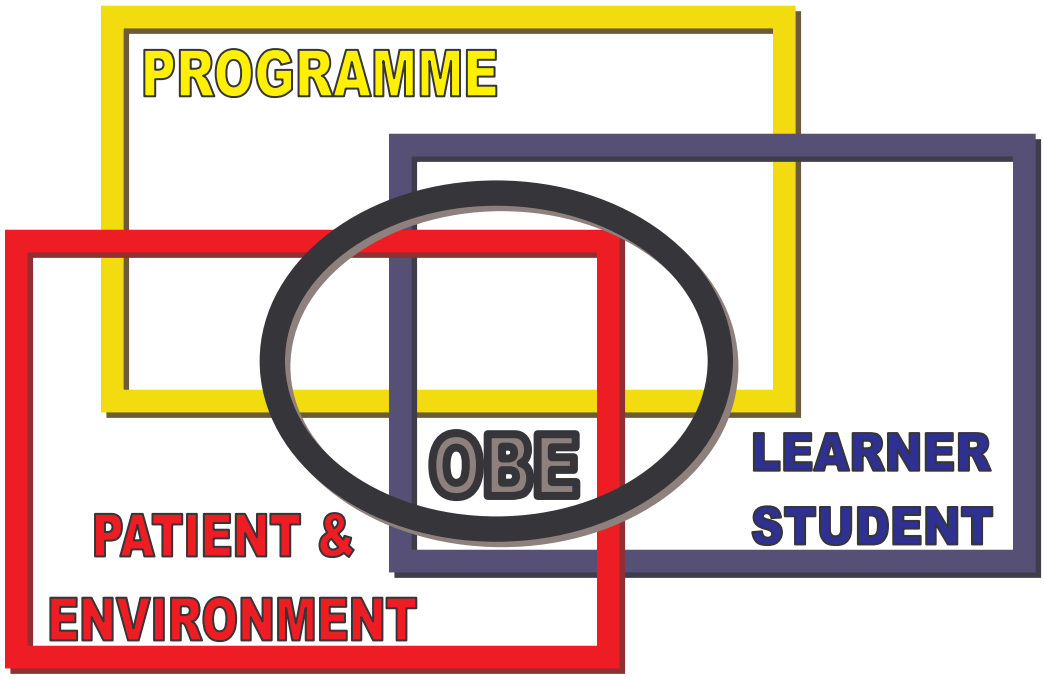


Figure 6.1 The interface between the role players in the framework. [This schematic representation was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.3 PHASE I: IDENTIFICATION OF THE INDIVIDUAL NEEDS OF THE DOCTOR AS LEARNER AND THE MENTAL HEALTH CARE USER (PATIENT)

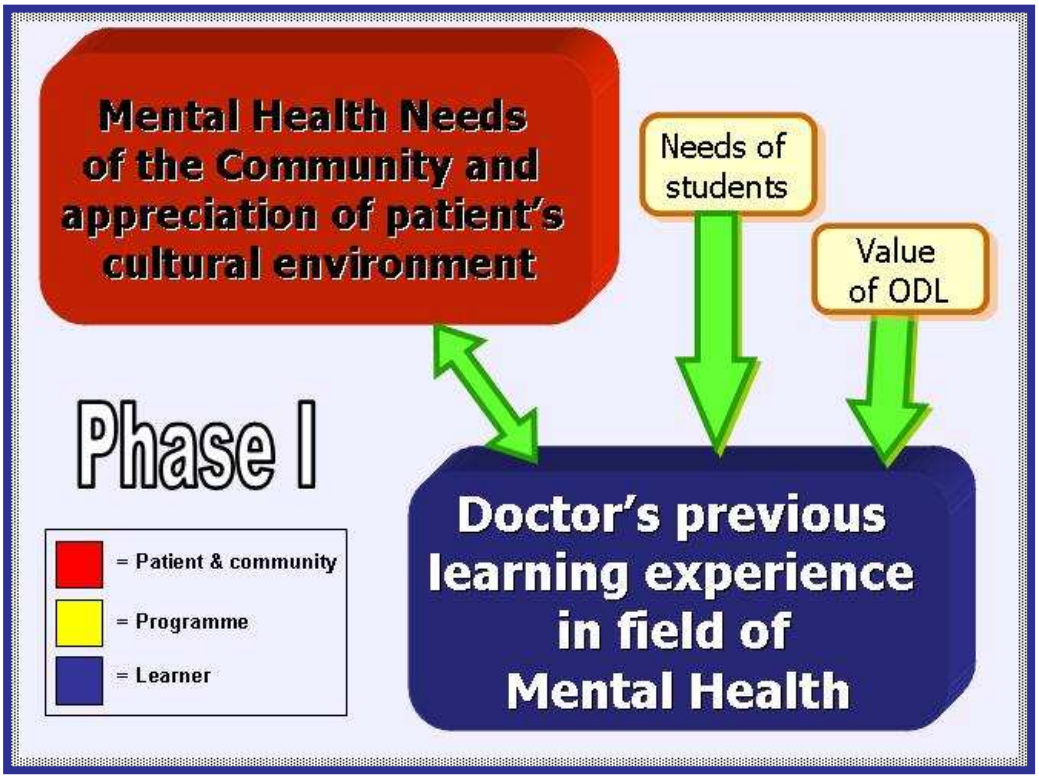


Figure 6.2 Factors influencing the doctor as learner and the patient in the community [This illustration was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.3.1. The Adult learner

The first premise relates to the characteristics and needs of adult learners (cf. Table 6.2., sections 3.4.1 and 3.4.4.3) where the Contextual Knowing Approach or the Post Formal Mode of learning is discussed in relation to post-graduate students. These will be the students who plan to receive tuition to equip themselves to successfully

pass examinations (meet the requirements of the University of the Free State and the College of Medicine) in order to receive the Post-graduate Diploma in Mental Health. Although all doctors received training in Psychiatry as undergraduate students, most would recognise a personal need to enhance their knowledge of Mental Health especially if they are frequently managing patients with psychological and/or psychiatric issues. The emotional and psychological factors affecting doctors were also discussed in section 3.4.3

Table 6.2 Specific professional characteristics (and inadvertent needs) of the doctor in the community

- Often overworked due to a shortage of doctors, especially in rural areas of South(ern) Africa (cf. 1.1).
- Some doctors inadequately trained in under-graduate Psychiatry – leads to avoidance of psychiatric patients or inadequate care.
- Difficulty making accurate diagnoses.
- Ignorance regarding referral of patients to secondary/tertiary levels of care (or to psychologists).
- Ignorance regarding the stipulations of the new Mental Health Care Act and the rights of mental health care users.
- Ignorance regarding continuation or cessation of disability grants for patients. (If grants continued unnecessarily, further drain on community resources. If stopped unnecessarily, resultant increased suffering of patients and their dependents.
- Logistical challenges (time/financial or family responsibilities); difficulty attending post-graduate diploma courses presented in the traditional manner.

[This summary was compiled by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.3.2 The Application of the recommendations of the Delphi Study affecting students

On completion of the PGDipMH students should have adhered to the following values (cf. statements 3A- J) concerning patients:

- The importance of patient confidentiality.
- The importance of multidisciplinary health care interventions.
- A respect of the rights of mental health care users.
- Empathy for mental health care users and their families.
- An appreciation of the fact that the patient is more important than the disease.

On completion of the PGDipMH the students should have adhered to the following values concerning themselves as learners:

- A positive approach to self-directed life long learning.
- A willingness to participate in self-evaluation.
- A willingness to participate in peer evaluation.
- A positive attitude regarding continuing professional development.

The needs of the student should be considered when planning, developing and designing a curriculum (cf. Fig 6.2). The curriculum developmental process should therefore be sensitive to the capabilities,

interests and priorities of the students for whom the programme is designed (cf.5.4.1 - statements 21B-D).

Online Distance Learning (ODL) would be useful to meet the needs of non-traditional learners (cf. section 5.4.2 – statement 27C and Fig. 6.2).

Students should be encouraged to make use of mobile learning, for example having DSM IV on flash cards, or blogs, to learn from each other in an informal manner. (cf. 5.4.2.- statements 27AA and 27BB).

Students would form part of group sessions (cf. section 5.4.3) in either face-to-face contact sessions or online distance chat rooms. The value of this approach is to:

- Familiarise students with an adult approach to learning.
- Encourage students to take responsibility for their own learning.
- Promote deeper understanding of the topic under discussion.
- Encourage problem-solving skills.
- Encourage participation as some doctors live and work in remote regions of South(ern) Africa.

Students would be assessed accordingly using tutorials, chat room contributions, case-studies and oral examinations (cf. 5.4.4.2 – statements 29 E – U). Student assessment will be discussed in more detail in 6.5.3.

6.3.3 The Mental Health Care User

The study of Mental Health Care including Psychiatry cannot be isolated and regarded as a separate entity from the patient (also known as the Mental Health Care User in South Africa (cf. Fig 6.3).

Patients have certain needs which should be addressed in the Programme (cf. 3.3.6). A comprehensive knowledge of psychiatric illness is essential. This entails not only the knowledge of psychopathology and management of psychiatric conditions in Primary Health Care conditions but should also include methods relating to primary prevention of mental illness in patients (which also affects their families). This leads to the third premise of formulating a comprehensive programme to better empower students to be more effective in managing and preventing mental illness.

Table 6.3 Mental Health needs of the community

• Recognition of psychiatric conditions.
• Maintenance treatment of chronic conditions (including psychosocial rehabilitation).
• Prevention of conditions (alcohol, suicide).
• Crisis management (trauma).
• Adequate referral of patients.

[This summary was compiled by the researcher, Nichol (2007) as part of the Ph.D. research project.]

These needs have been compromised due to lack of person power as described in Chapter 1(cf. 1.1), leading to:

- under-detection of conditions.
- loss of employment and
- increase in common crime, linked to psychiatric morbidity.
- drain on social services.
- disability/incapacity grants.
- increased demands for logistics relating to repeated readmissions of patients who could have been managed at primary health care level.
- increased work load for mental health care workers in the region.

6.3.4 Patient-Centred Learning

The students will also be encouraged to make use of patient-centred learning (cf. 5.3.1 – statements 1E – G; 5.3. 8 – statements 26A – F). Learners will be required to link certain conditions (under discussion) with particular patients in the practices or hospitals where the learners serve the community. While using consenting patients as "study material", students would have to detect certain symptoms, which they will discuss with their tutors or the group without violating patient confidentiality. They would also describe the efficacy or side-effect profile of the medications the patients receive. Patients who were perhaps difficult to manage will benefit from 'tertiary level consultations', and students will gain more knowledge on the topic. Students will be required to write case reports concerning patients with certain conditions and include this work in their portfolios to be assessed at predetermined dates. Students would also have to appreciate the effects of the patients' physical and cultural environment on their (the patients') conditions (cf. 2.1).

6.4 PHASE II - THE CONTENT OF THE PROGRAMME

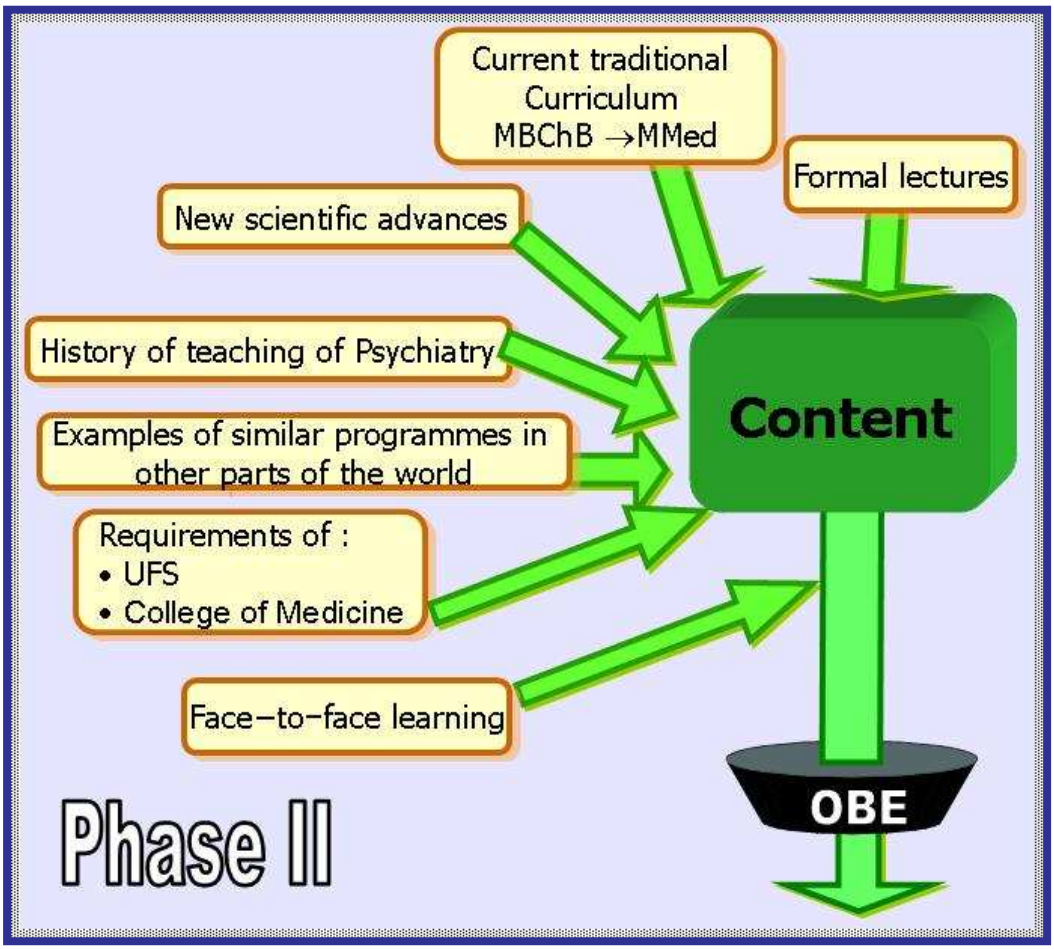


Figure 6.3 The factors influencing the content of the programme [This illustration was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

As seen in Figure 6.3, the selection of information which was included in statement form to be tested by the Delphi study Experts was influenced by:

- Traditional curricula in the M.B.,Ch.B. and M.Med. Psychiatry programmes.
- The history of the teaching of Psychiatry (cf. Chapter 2).

- New scientific advances in Psychiatry(cf. 2.3)
- Examples of other programmes in different parts of the world (cf 3.5).
- The requirements of the UFS.
- The requirements of the College of Medicine in South Africa (cf. 3.2.4).

The content matter of the Programme, as recommended by the Delphi Experts will be incorporated into the Programme in such a way that the objectives of SAQA are not violated.

The content of the Programme is best summarised by statement 21J: Outcome statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the Programme.

6.4.1 The knowledge and skills learners should acquire through the Programme

The academic area must be stable and well defined (cf. statements 22B and 22C) in terms of the knowledge contained in the Programme. In line with certain crucial level outcomes of the study (cf. Section A of the questionnaire), on completion of PGDipMH, the student should have gained the following knowledge:

- The ability to classify the various common types of psychopathology.
- Current theories on the known aetiology of mental conditions.

- Current theories on the pathophysiology of common mental conditions (conditions commonly encountered in psychiatric practice).
- Current theories on the psychopharmacology used to manage common mental conditions (cf. 2.3).
- An appreciation of the effect of the patients' physical environment on their conditions.
- An appreciation of the effect of the patients' cultural environment on their conditions (cf.2.1).
- A comprehension of the importance of patient confidentiality.
- The interpersonal dynamics involved in a multidisciplinary health team approach (cf.2.1).
- The role of risk factors in Mental Health.
- Current theories relating to the prevention of psychopathology (in humans).
- The cost-effective utilisation of special investigations in Psychiatry and an understanding of legal issues in Psychiatry.

Although there was consensus on the role of appropriate utilisation of new technology in Psychiatry, this knowledge was seen as being useful rather than essential.

On completion of the PGDipMH, students should essentially have gained the following skills:

- The ability to identify most common forms of pychopathology.
- The ability to conduct a thorough mental state examination.
- The ability to diagnose and manage common mental conditions.

- The ability to refer patients appropriately for further management.
- The ability to demonstrate cultural sensitivity to all patients (cf. 2.1).
- The ability to function as an integral part of a multidisciplinary health care team (cf. 2.1).
- The ability to effectively counsel patients.

The knowledge and skill content students are expected to gain is directly linked to the ten modules forming part of Section C: THE CONTENTS OF THE PROGRAMME which contains the Statements 7- 17.

6.4.1.1 *Content of Module 1*

MODULE 1 – INTRODUCTION TO PSYCHIATRY

During this two day seminar students would receive formal face to face formal tuition. This tuition will be intense and will articulate on the learners' undergraduate knowledge. Additional material for in-depth study will be made available.

- Basic neuroanatomy will be presented using anatomic models.
- Basic neurophysiology will also be presented.
- The evaluation of basic common psychiatric conditions will be presented in a tertiary setting. The context however will have be geared towards the primary health care settings.
- Four case-studies using patients with common chronic (or acute) conditions will be presented (with the consent of the patients involved).

- The symptomatology of the conditions and their management will also be discussed.
- A specific case report will be given to students. Students will be required to answer specific questions by e-mail to the Department of Psychiatry within seven working days.
- Students will be evaluated according to their ability to integrate knowledge.
- Students should have a working knowledge of the Mental Health Care Act.

6.4.1.2 *Content of Module 2*

MODULE 2 – CHRONIC COMMON PSYCHIATRIC CONDITIONS (Part 1)
(conditions often encountered in psychiatric clinics such as schizophrenia)

Tuition for this Module and all the other Modules except Module 1 will be presented using the Online Distance Learning (ODL) format.

The following conditions will be discussed in this Module:

SCHIZOPHRENIA
On completing the Module the student should know:

- The basic known neuropathology and sub-types of schizophrenia.
- The pharmacology of treatment in Schizophrenia and the complications of pharmacological treatment (cf. 2.3)

- The importance of early recognition and treatment in prodromal Schizophrenia.
- The role of cannabis (and other substances) in early diagnosis and treatment of Schizophrenia.
- About psychosis secondary to general medical conditions.

6.4.1.3 *Content of Module 3*

MODULE 3 – CHRONIC COMMON PSYCHIATRIC DISORDERS (Part 2)

MOOD DISORDERS

On completing the Module the student should know how to:

- Understand the differences between Bipolar Disorders and Depressive Disorders (including subtypes).
- Manage and treat Mood Disorders.
- Manage the complications of treatment (cf. 2.4)
- Recognise patients at risk of committing suicide.
- Differentiate the phases of grief.
- Differentiate Mood Disorders secondary to General Medical Conditions.
- Explain the meaning of Adjustment Disorders.

6.4.1.4 *Content of Module 4*

MODULE 4 – CHRONIC COMMON PSYCHIATRIC DISORDERS (Part 3)

ANXIETY DISORDERS

On completing the Module the learner should be able to explain:

- Generalised Anxiety Disorder.
- Obsessive Compulsive Disorder.
- Post Traumatic Stress Disorder.
- Panic Disorder.
- Social Anxiety Disorder.
- How to recognise Avoidant, Dependent and Obsessive Personality Disorders.
- The differential diagnosis of Anxiety Disorders.
- Treat the above-mentioned conditions and have a knowledge of complications of treatment (pharmacotherapy).
- Understand the concept of co-morbidity relating to Anxiety Disorders and Depressive Disorders.
- Have a working knowledge of non-pharmacological treatment of Anxiety Disorders.
- Be able to decide if a patient with Anxiety Disorder and Co-morbid Depression will possibly qualify for impairment on psychiatric grounds. The final decision will be made by a psychiatrist.

6.4.1.5 *Content of Module 5*

MODULE 5 - CHILD PSYCHIATRY (Part 1)

On completion of the Module the student should:

- Have an understanding of normal development in humans. This refers to the neuro-developmental and behavioural changes from conception to adulthood (cf 3.4.2).
- Have a basic knowledge of Pervasive Disorders in children (for example Autism).
- Understand Disruptive Disorders in children.
- Have an understanding of approaches in treatment for Elimination Disorders (enuresis and encopresis).
- Have a working knowledge of Intellectual Disability (Mental Retardation).
- Be able to manage victims of abuse (physical, sexual, emotional) at primary health care level.

6.4.1.6 *Content of Module 6*

MODULE 6 – CHILD PSYCHIATRY (Part 2)

On completion of the Module the student should:

- Have a working knowledge of Depressive Disorders and Anxiety Disorders in children.

- Understand issues facing adolescents (including exposure to illicit substances).
- Have a working knowledge of Eating Disorders.
- Be able to counsel parents and families in crisis.

6.4.1.7 *Content of Module 7*

MODULE 7 – FORENSIC PSYCHIATRY

Students who complete this Module should be able to:

- Understand the rights of patients and the Mental Health Care Act.
- Understand the concepts of Trialability and Criminal Responsibility. Section 77 and 78 of Criminal Procedure Act.
- Understand the Law on Sterilization and Legal Abortion.
- Understand ethical issues relating to Psychiatry.
- Be able to advise families regarding legal issues, i.e. if and when patients are no longer able to manage their own affairs.
- Know how intoxication with substances affects Criminal Responsibility.
- Know how to recognise Antisocial and Borderline Personality Disorders.

6.4.1.8 *Content of Module 8*

MODULE 8 – ADDICTION DISORDERS

Students completing this Module should:

- Have a working knowledge of the effects of ethanol (alcohol) in humans.
- Be able to manage patients with acute alcohol withdrawal.
- Understand chronic alcohol dependence.
- Have a working knowledge of the terms use and abuse.
- Have a working knowledge of illicit drugs/substances commonly available in South Africa.
- Be able to manage patients with signs and symptoms of acute withdrawal from a substance until the patient can be managed at secondary/tertiary level.
- Be able to explain how substances affect criminal responsibility.
- Have a working knowledge of drug-substitution therapy.
- Be able to recognise and manage co-morbid psychiatric conditions.

6.4.1.9 *Content of Module 9*

MODULE 9 – GERIATRIC PSYCHIATRY

After completing this Module students should:

- Understand the psychopathology of the aging brain.

- Have a working knowledge of dementia.
- Understand pharmacotherapy in the elderly.
- Be able to counsel families of elderly patients.
- Know how to manage the process of having a patient placed under curatorship (legal implications).

6.4.1.10 *Content of Module 10*

MODULE 10 – INTRODUCTION TO COGNITIVE BEHAVIOUR THERAPY

After completing this Module student should:

- Be able to understand the principles of Cognitive Behaviour Therapy (CBT).
- Be able to apply CBT in counselling patients having Depressive Disorders.
- Be able to apply CBT in patients having Anxiety Disorders.
- Be able to counsel patients who have been acutely traumatized.
- Be able to manage patients with suicidal ideation.
- Have a working knowledge of personality disorders.

Although consensus was not reached concerning 16A – A knowledge of the origins of CBT – most experts thought this knowledge was either essential or useful to be included in the Programme.

6.4.2 Formal lectures

The didactic content of Modules 1 to 10 will be presented using formal lectures (cf. Fig.6.3). The following characteristics of formal lectures are important:

- The content of formal lectures should be geared to the practical needs of medical practitioners working in primary health settings.
- Formal lectures can be used to facilitate OBE.
- By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic.
- Formal lectures can be used to present the core content of the Programme.
- Powerpoint presentations, video-clips, illustrations, hand-outs and Podcasting should be used where appropriate to enhance the lecture and should be available at a website after the lecture.
- Formal lectures containing core knowledge on the topic need to be revised regularly.
- Peer review on the content of core knowledge is important.
- Constructive feedback on the content of the lecture from students should be encouraged.

6.5 PHASE III: THE DESCRIPTION OF THE MODE OF DELIVERY THROUGH WHICH THE PROGRAMME WILL BE PRESENTED

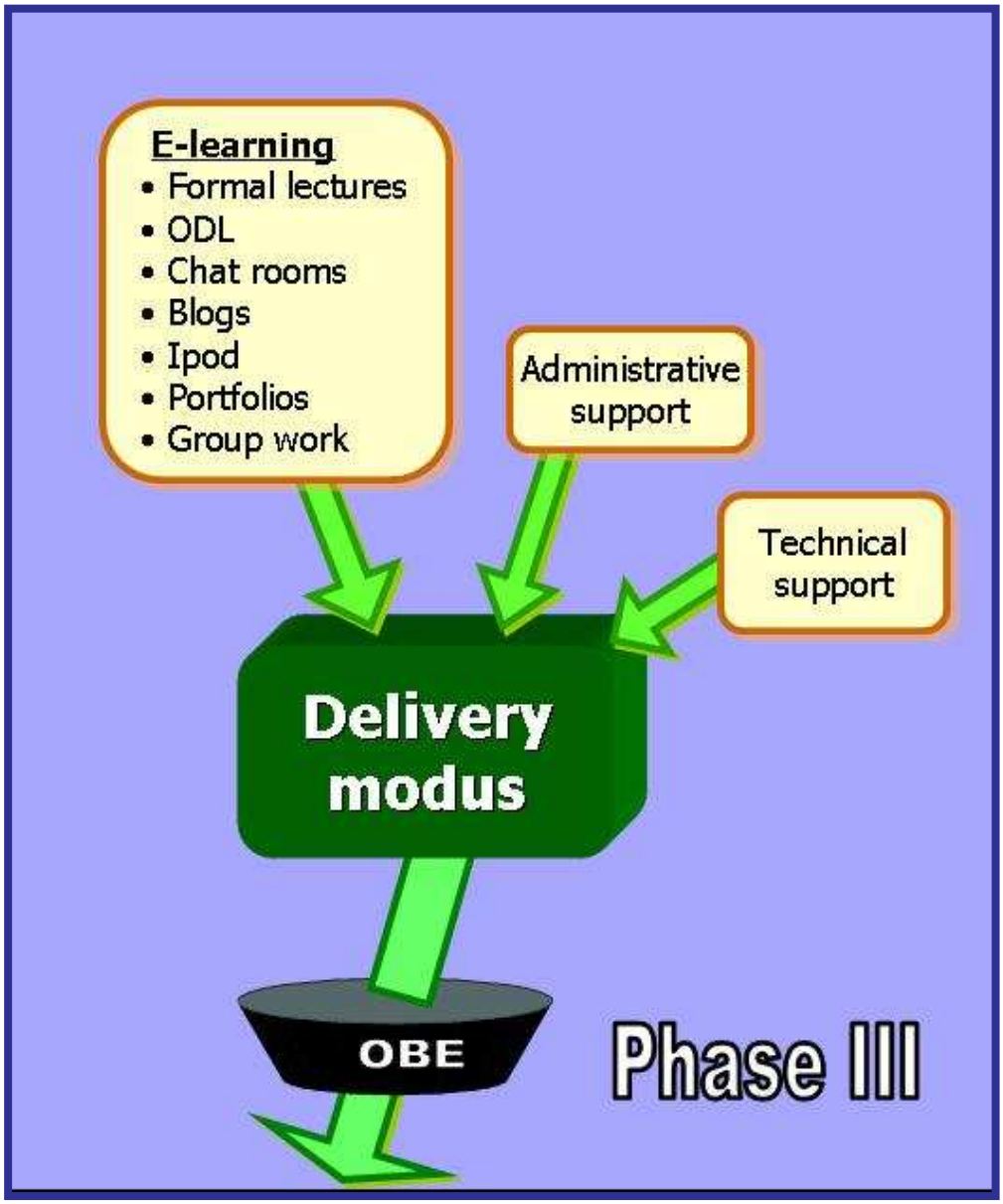


Figure 6.4 Factors influencing the mode of delivery through which the Programme will be presented [This illustration was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.5.1 The mode of delivery whereby the Programme will be presented

The Programme will not only provide the syllabus needed to cover the scope of Mental Health Care but will also be comprehensive enough to accommodate the logistics required to present a modern curriculum harnessing modern technology for online distance education and e-learning (cf. Fig.6.4). This will also help to make the classroom more versatile, although based in an institution (Department of Psychiatry), moving the classroom away to wherever the students are located, but simultaneously allowing for frequent communication at minimal cost.

In chapter 1, electronic learning is defined as: Learning via the Internet, network or standalone computer. The network enables transfer of skills and knowledge. Apart from a few face to face contact sessions (cf. Fig. 6.3), most of the interaction during the Programme will take place using the vehicle of electronic learning.

6.5.2 Online Distance Learning (ODL)

With the exception of Module 1, all the other modules in the curriculum will be presented using ODL (cf. Fig. 6.4 and 3.4.5.1). ODL should be considered as a practical method of facilitating the teaching of Psychiatry in a Primary Health Care setting. The following statements should be considered:

- In the 21st century ODL is essential, allowing for greater interaction between tutor and learner, and meeting the needs of non-traditional learners.
- Administrators of the university presenting the Programme need to be favourably inclined towards ODL.
- ODL calls for a change in academic and educational requirements (compared to traditional curricula).
- The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility and support from medical experts and other members of staff.
- Instructors need more allocated time to develop and deliver online courses and additional technical staff are needed for ODL.
- The need for additional administrative staff for ODL.
- Copyright laws and intellectual property rights should be adhered to.
- Instructors should ensure the quality of ODL remains high.
- Instructors should be taught how to manage possible obstacles they may encounter when teaching online.
- The software used to present the PGDipMH should be of the same type as used by the UFS (in other programmes).
- A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken.
- ODL courses should be revised regularly and updated when the software becomes obsolete.
- Learner training and support (in computer matters) plays an integral part of the Programme.

- Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable.
- A graphic designer should take responsibility for the layout of material on web pages.

As stated in 6.3.2 use will be made of chat rooms as part of ODL. Students would be encouraged to use Ipods and Personal Digital Assistants (PDA) as part of Mobile learning and blogs.

6.5.3 0utcomes-based Education (OBE) in Phases II and III of the study

In keeping with demands, needs and standards formulated on the basis of recommendations made in various declarations such as the Edinburgh Declaration 1988, Yaounde Declaration 1994 as well as the Cape Town Declaration (cf. HPCSA 1999: 1-3), the most appropriate pedagogic approach should be Outcomes-based Education. As seen in Figure 6.1 OBE permeates the other three categories in the study. It closes the gap between the classroom and real life in all its complexity (Kramer 2002:3).

In keeping with the OBET approach, focus will be placed on the attainment of learning outcomes as demonstrated in assessment (RSA DoE 2001:420). Thus, there has to be a clear alignment between the learning outcomes, teaching strategies and assessment (according to statements 20 A - O):

- Evaluation procedures should be consistent and interrelated.

- There should be regular review of the Programme to eliminate ineffective parts and materials.
- A change in orientation from "what I (as a lecturer) must cover" to "what a student should be able to do" as a consequence of instruction.
- Self-evaluation by students should be encouraged, to ensure they know what is expected of them.
- Facilitation of efficient student learning by providing direction and by identifying instructional priorities.
- Demonstration (of knowledge gained) must be of high quality, e.g. chat room contributions, and must show evidence of significant learning.
- A portfolio should form part of the demonstrations of knowledge gained by the student.
- Outcomes (of learning) should be significant, clear and concise.
- Demonstrations of learning must occur in some "own context" (performance setting).

At the start of each tutorial, a clear set of learning outcomes will be mentioned, enabling the students to know which objectives should be attained by the end of the session. Students will be encouraged not only to relate specific conditions to real live patients in their practices or hospital settings, but also share these cases with fellow students during the chat room sessions. Case-studies will also be described and documented and then included as part of the learners' personal portfolio. This is in line with the so called extended abstract responses regarded by Collis and Biggs as the fifth level of the SOLO taxonomy

indicative of an advanced level of understanding by the learners (cf. 3.2.3).

As stated earlier, OBE also helps to quantify certain crucial level outcomes which learners should have gained, namely specific knowledge and skills in Mental Health Care while also being able to adhere to certain values.

6.6 PHASE IV - THE USE OF BLENDED LEARNING TO CONSOLIDATE DIFFERENT PARTS OF THE PROGRAMME IN MENTAL HEALTH

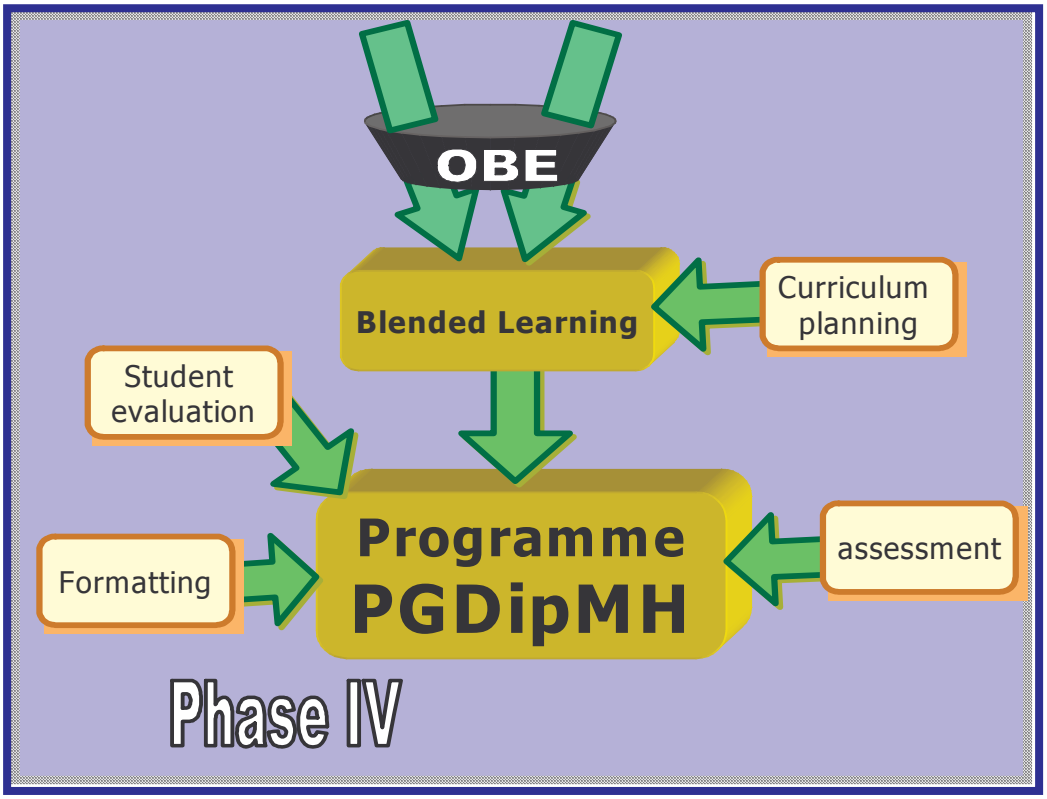


Figure 6.5 Factors influencing Blended Learning and the Programme construction [This illustration was developed by

the researcher, Nichol (2007) as part of the Ph.D. research project.]

Welch (2003:1) maintains that a blended learning model is one that incorporates a variety of delivery styles and accommodates different organizational needs to achieve the most effective knowledge transfer.

The PGDipMH Programme consolidates face to face learning and E-learning (cf. Fig. 6.5). The Programme makes provision for a combination of didactic procedures and exercises which meet the criteria for Wiggins' Model of Understanding (Kramer 2002:15). He describes four tests to determine whether learning has taken place:

- Knowledge = Reveal a mastery of knowledge – facts, concepts, ideas given by accurate description. This knowledge is contained in the content of the curriculum.
- Insight = Reveals insight into the meaning, causes, consequences, consequences and relationships by answering essential questions. This insight will be assessed during tutorials, chat room contributions and oral examinations.
- Application = Undertake tasks linked to or using what has been learned. Students will be expected to link pathology to specific cases in their practices and present (consenting) patients as case- studies and during chat room sessions.
- Innovation = Go beyond what the educator or textbook says by predicting, concluding, deciding, justifying or forming opinions. Innovative thinking will be reflected in the students'

comprehensive approach to case-studies and contents of their portfolios.

After doctors (students) have enrolled for the Programme, they will be expected to attend certain classes (face to face sessions) at the Department of Psychiatry in Bloemfontein as part of the first module (cf. 6.7.5 and Fig. 6.5). The remainder of the curriculum will be presented using Online Distance Education ODL (e-learning).

6.6.1 Curriculum planning, Development and Design

Once the subject contents of the module are in place and the methods of knowledge transfer are organised curriculum planners need to revisit the development and design of the emerging curriculum considering the following factors:

- The curriculum development process should be sensitive to the academic setting of the project, the capabilities, priorities and interests of the students for whom the Programme is designed.
- The development of the Programme should require a detailed knowledge and appreciation of the discipline and an understanding of the resources and options available to the faculty and educators involved. The Programme should have a rationale (or mission statement) to explain why the Programme exists.
- The overall Programme aims must be clearly stated, in order to explain what the Programme will achieve.

- Outcomes statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the Programme.
- Content statements must be provided to indicate what areas of knowledge will comprise the student learning.
- Teaching guidelines must be provided in order to indicate how long the learning activities will be organised.

6.6.2 Format and time frame of the Programme

An essential part of programme construction is to ensure that a format is described where-in blended learning can take place. Using statements (5A - R) the following issues were addressed:

- The time frame for the Programme would be two years.
- The first academic year will contain four (compulsory) modules.
- In the second academic year the students would have to select three modules from a list of six modules to be presented in the second academic year.
- Students would be required to pass the first academic year before proceeding to the second year.
- Students who wish to exit the course after one year will have to pass an oral examination in order to receive a Short Learning Course Certificate was essential to the Programme.
- Students will be assessed using tutorials and worksheets.
- There should be a restriction on the number of students who are allowed to enrol for each academic year.

- Only medical practitioners registered with the South African Health Professions Council will be accepted for enrolment in the Programme.

6.6.3 Student assessment

In developing an educational Programme in Mental Health, recognition must be taken of mechanisms for student assessment in order to ensure that:

- The emphasis is shifted away from the input or content aspect of the Programme towards the objective assessment of the performance of learners in terms of clearly stated outcomes.
- The ultimate outcome (end point) for each and every person learning in a particular programme is equivalent and clearly stated.
- The assessment is objective and verifiable.
- The responsibilities learners are expected to assume to monitor their own learning are defined.
- The assessment criteria for each of the abilities/skills that have been developed are defined.
- An assessment taskforce is established, which will include an assessment expert.
- There is the establishment of a systematic assessment programme, which will aim to ensure uniformity of assessment across all subjects/modules.
- There is an integrated method of assessment covering all aspects of the learning programme.

- Standardised multi-modal methods of learner assessment are used.
- Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors.
- The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected.
- Moderation of learner assessment takes place to ensure that the required level, standard, appropriateness and fairness are observed.
- All forms of assessment are conducted by appropriately trained moderators with specific expertise in the learning area.
- After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online. Learners will have seven working days to return their 'homework' on line. If the tutorial is successfully completed (>70% of answers correct), the student will be asked to form part of the chat room session. If the tutorial is not successfully completed students will have three working days to make corrections. (If >70% of the homework is now correct students will be allowed to form part of the chat room session on the topic). The rationale for the 70% boundary was to ensure students had a working knowledge of the topic, and did not participate in the chat room session unprepared.

6.7 PHASE V: APPROVAL AND IMPLEMENTATION OF THE PROGRAMME

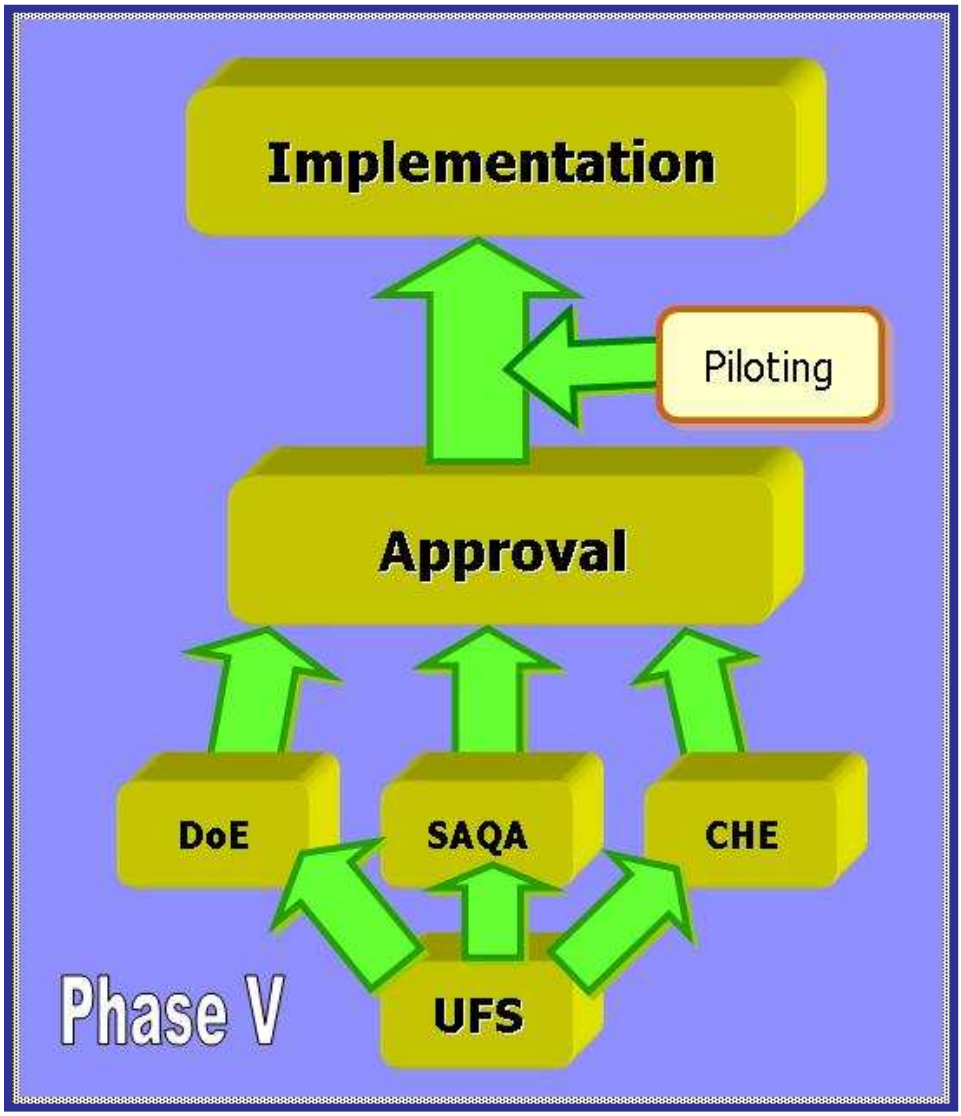


Figure 6.6 Approval and implementation of the Programme [This illustration was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

A specific strategy using an implementation plan (cf. Fig.6.6), with seven **procedural** phases all form subdivisions of Phase V, the APPROVAL AND IMPLEMENTATION PHASE OF THE PROGRAMME. The

term 'procedural phase' was selected to avoid confusion with the major six phases of the programme (I – VI). The procedural phases based on the PRIME MODEL (Van Zyl 2004:370) will be discussed:

- Procedural Phase 1: Approval phase.
- Procedural Phase 2: Information and marketing phase.
- Procedural Phase 3: Situational analysis and adaptation of the PGDipMH Programme.
- Procedural Phase 4: Piloting the Programme.
- Procedural Phase 5: Implementation of the PGDipMH Programme.
- Procedural Phase 6: Research on the PGDipMH Programme.
- Procedural Phase 7: Monitoring and evaluation of the PGDipMH Programme.

6.7.1 Procedural Phase 1: Approval phase

The two major role players affecting programme approval are:

- OBET approach
- UFS requirements

In chapter 3 of the thesis careful cognisance was taken of the Outcomes-based Education and Training (OBET) approach (cf. 3.2.4). The PGDipMH Programme was designed in such a manner that the parameters and criteria for qualifications design (HEQF) are met and that it would easily comply with the NQF requirements for a programme to be accepted as a qualification. The PGDipMH Model will comply with

the format needed in order to receive DoE approval and also CHE and HEQC accreditation.

The UFS guidelines for the approval, accreditation, recording and termination of formal and non-formal academic programmes are listed as Appendix H.

6.7.2 Procedural Phase 2: Information and marketing

Once the Programme is ready for marketing, after being registered with SAQA (cf. step 11 – Appendix I), several strategies will be used to disseminate information to the target audience (medical doctors):

- Word of mouth (even though the framework has still to be finalised certain doctors who have heard about the project, enquire when it will be available).
- Doctors referring patients to the Free State Psychiatric Complex (FSPC) will be informed of the Programme.
- The College of Medicine (Psychiatry) will also inform doctors wishing to enrol for the Diploma.
- The course will be advertised in appropriate medical journals such as the South African Medical Journal.
- The information about the PGDipMH will be posted on the website of the Department of Psychiatry UFS and on the website of the South African Society of Psychiatrists (SASOP).
- Medical representatives of the pharmaceutical industry, who promote psychotropic medications to general practitioners and

medical officers will be requested to inform their clients of the proposed PGDipMH.

6.7.2.1 *Additional factors to be considered before Implementing and Evaluating the Programme*

Based on statements 22A – Y of the Delphi study (cf. 5.4.4.1), prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to implementing and evaluating the curriculum:

- There must be a demonstrable need for the Programme.
- The academic area must be stable and well defined in terms of the knowledge comprising the Programme.
- There must be clear potential for success of the Programme.
- The department/institution presenting the Programme must have the necessary resources available.
- Any social and political factors that may negatively impact the provision of the Programme should be considered.
- The aims/exit level outcomes of the curriculum should be stated.
- There should be a clear rationale and justification for the provision of the Programme.
- Assessment criteria and procedures must be clearly stated.
- The context and community in which the Programme resides should be articulated.
- The entry and admission criteria for the Programme must be adequately described.

- The form of instruction should be appropriate to the learners' needs.
- The Programme should make allowances for individual differences in students or their learning methods (as far as possible).
- Provision must be made for adequate availability of student materials, resources and facilities.
- Criteria must be available for evaluation of all aspects of the Programme for purposes of quality assurance.
- Quality assurances processes should assess the Post-graduate Programme in Mental Health regularly.
- There must be evidence of significant groups (subject specialists) involved throughout the development of the proposed Programme.

6.7.3 Procedural Phase 3: Situation analysis and Adaptation Phase

Before the Programme can be implemented it needs to be refined. Before making the necessary changes, a situational analysis of two main areas is important:

6.7.3.1 *The Situational Analysis of the Institution presenting ODL*

The planning process as described in 3.4.5.2 should be revisited and applied by the teaching staff of the Department of Psychiatry, UFS. The

recommendations of the Delphi Panel concerning Online Distance Learning (ODL) also echo these sentiments in the following areas:

- Administrators of the Institution need to be favourably inclined to the Programme.
- ODL calls for a change in academic and educational requirements (compared to traditional curricula).
- The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility and support from medical experts and other members of staff.
- Instructors will need more time to develop and deliver online courses. They should ensure the quality of ODL remains high and be taught how to manage obstacles that may occur when teaching online.
- Additional technical staff will be required.
- Copyright laws and intellectual property rights will be adhered to.
- The software used to present the PGDipMH Programme should be the same as used by the UFS in other programmes.
- Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable.
- Pharmaceutical companies marketing psychotrophic medications will be approached for sponsorships. A company will be asked to sponsor a module (according to the costs involved in producing and presenting the module), but will not be able to dictate the contents of the module. The sponsor(s) of the module will be acknowledged after the subject content of the module.

- A graphic designer should take responsibility for the layout of material on web pages.

6.7.3.2 *A Situation analysis of the Students*

A needs analysis regarding the learners' access to computers and their computer literacy will be undertaken. During Module 1, students will also spend time at the Computer Training Centre of the Department of Health Sciences. The chat room process will be explained and demonstrated. The students will also partake in a chat room exercise. This will also enable the tutors to get to know the writing style of each particular student. This is important as during the chat room sessions, the students will work from their home bases and can easily have a counterfeit person participating in the session for them. This is also one of the reasons for limiting the amount of students enrolled for each academic year to thirty.

Students will take part in a discussion group concerning the advantages of Mobile learning. Students will also be encouraged to make their own blogs and make use of each others blogs on the Internet.

6.7.4 Procedural Phase 4: Piloting the Programme

As recommended by the Panel of Delphi Experts, the model will be piloted (cf. Fig. 6.6). With the assistance of consenting medical officers and registrars employed at the Department of Psychiatry, UFS, one module will be used as the pilot study. The 'students' will receive the

tutorials on-line and will be expected to return their homework within the prescribed time.

A chat room session will also take place, after which participants will be requested to complete an evaluation questionnaire of the process. When this exercise has been completed the necessary changes will be made. The process will be repeated and readjusted if necessary.

6.7.5 Procedural Phase 5: Implementation of the PGDipMH Programme

At the appointed date the students will be enrolled for the first academic year. The Programme will be presented according to the prescribed dates. A maximum of thirty students will be enrolled each new calendar year for the two year Programme.

6.8 PHASE VI: FINAL ACCREDITATION AND ACCEPTANCE OF THE PROGRAMME

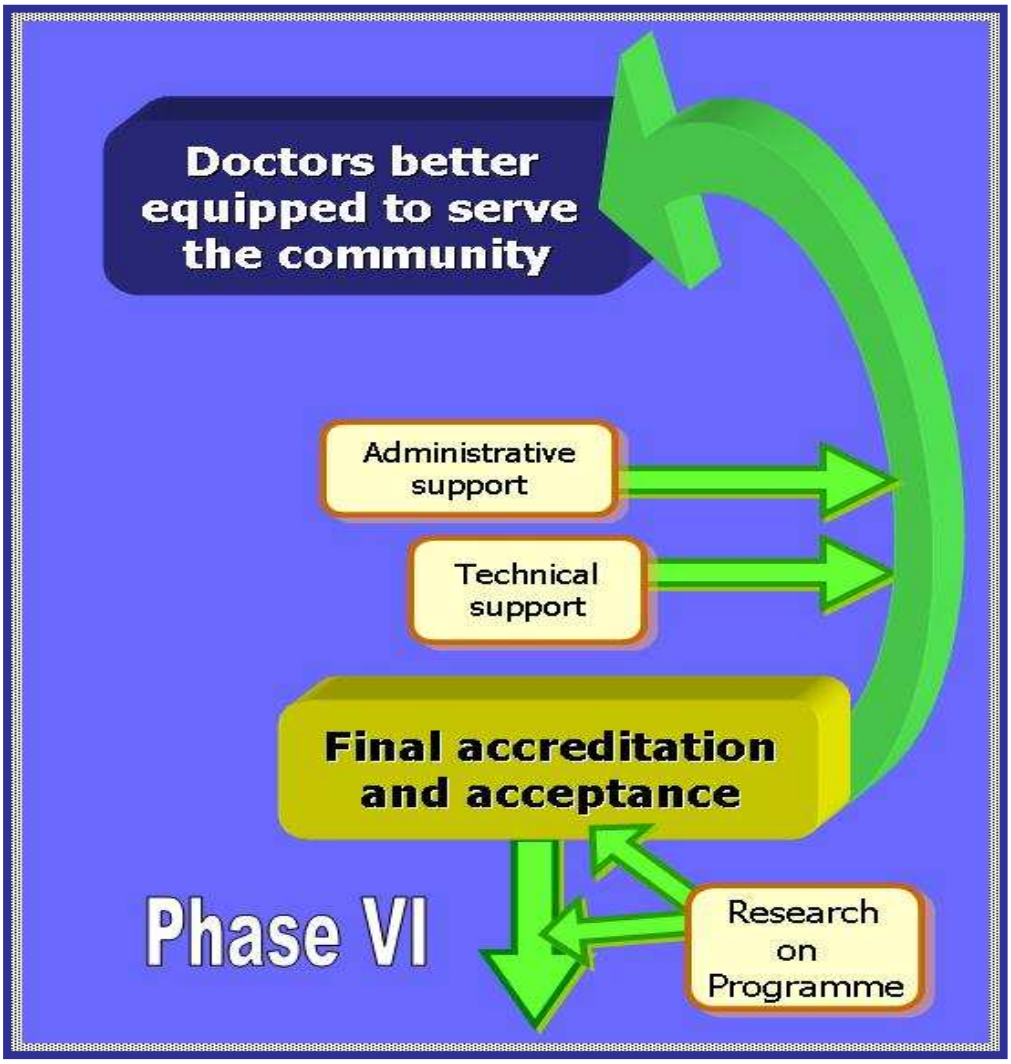


Figure 6.7 Factors influencing the final accreditation and acceptance of the Framework [This illustration was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.8.1 Procedural Phase 6: Research on the PGDipMH Programme

In time, the effectiveness of the Programme can be scientifically researched (cf. Fig.6.7). Using statistical analysis two groups of students who obtained the qualification from the College of Medicine (Psychiatry) will be compared, namely those who have received formal tuition (completed the PGDipMH), and those who studied independently. Candidates will be evaluated 'blindly' (where the examiners will not know into which group the candidate belongs). Students will also be asked to complete questionnaires regarding their views of the course. The results of the findings will be published in an accredited medical journal.

6.8.2 Procedural Phase 7: Monitoring and evaluation of the PGDipMH

Assessment criteria and procedures for the Programme which were compiled prior to implementation of the Programme will be utilised to evaluate all aspects of the Programme for the purposes of quality assurance on a regular basis. These evaluation procedures must be consistent and interrelated. Regular review of the course will ensure ineffective sections and materials are eliminated. As scientific knowledge of Psychiatry increases, where appropriate, these new facts will be reflected in the subject content matter of the modules (cf. 2.3.1).

Moderation of learner assessment, by appropriately trained moderators with specific expertise in the learning area, will also take place to ensure that the required level, standard, appropriateness and fairness is observed.

One year after the first group of students have completed the two year course full accreditation will be sought from the HEQC.

The Programme as a complete entity – containing all six phases – is demonstrated in Figure 6.8

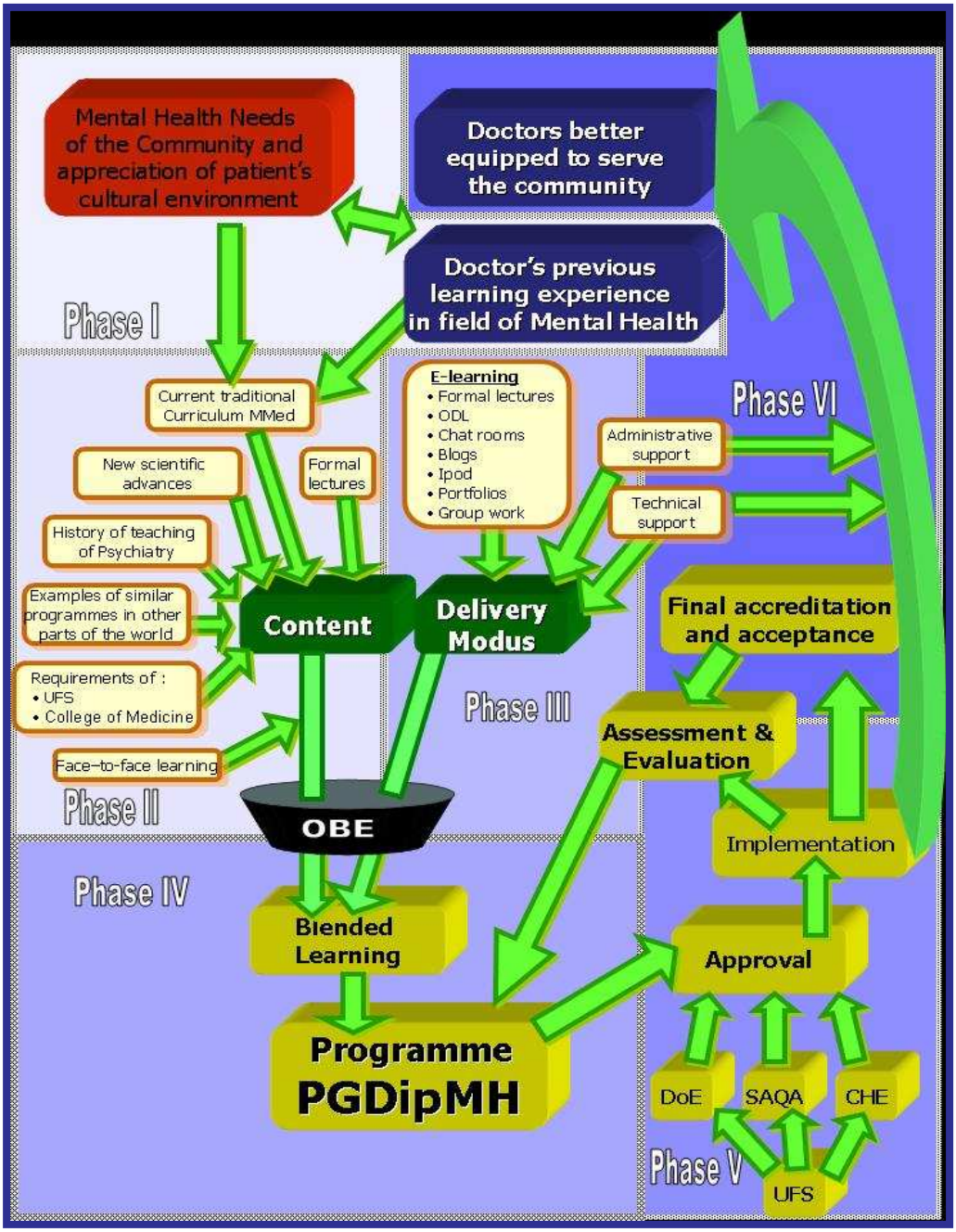


Figure 6.8 The Framework of the Programme for the Post-graduate Diploma in Mental Health. [This figure was developed by the researcher, Nichol (2007) as part of the Ph.D. research project.]

6.9 CONCLUSION

There is an appreciation for the interfaces between the different role-players, namely the central role of Outcomes-based Education, the dynamics relating to psychiatric patients and their care, the characteristics of the Programme and the adult learner involved not only in full-time employment but also in service delivery to patients.

The process of taking a concept and transforming in into a fully accredited diploma programme has been described in this chapter (cf. Fig. 6.8). The framework for the development of a Programme for the Post-graduate Diploma in Mental Health has been described using six phases (cf. Figure 6.8). In the final chapter of this thesis concluding remarks will be stated, limitations of the Programme discussed and recommendations made.

CHAPTER 7

SUMMARY OF CONCLUSIONS, LIMITATIONS OF THE STUDY AND RECOMMENDATIONS

"Any genuine teaching will result in someone's knowing how to bring about a better condition than existed earlier" - John Dewey (Maxwell 2006:348)

7.1 INTRODUCTION

To the best of the researcher's knowledge the PGDipMH Framework is unique. Although there is much teaching in Psychiatry and much to be found in the realms of Outcomes-based Education (OBE), Medical Education and E-learning this thesis combines all four aspects producing a workable framework. In this chapter the main conclusion, the limitations of the study and recommendations made concerning the study, will be highlighted.

7.2 CONCLUSION

With reference to the study the researcher wishes to accentuate the following:

- *Overall goal, aim and objectives.* The researcher believes the overall goal, aim and objectives of the study were addressed. The research

end-product, namely to establish a framework for the development of a Post-graduate Diploma Programme in Mental Health was achieved using scientific methods to formulate in the PGDipMH Programme.

- *The link between literature, research findings and clinical experience.* The process can be linked to a literature survey, research findings and the researcher's own practical knowledge of treating patients (including psychiatric patients) at a primary health care level in different parts of South Africa and third world countries in Central America. The researcher has also managed psychiatric patients as a specialist for many years. A majority of patients seen were referred by medical doctors working as primary health care physicians.

- *Policies and guidelines.* The recommendations of the Delphi Panel were included in the PGDipMH Programme. The recommendations of the Delphi Panel are in line with the policies and guidelines relating to OBE and to the DoE.

- *Innovative education and training initiatives.* The study brings together an interface of widely differing topics and techniques. The field of Communication Technology is progressing in leaps and bounds often linked to Information Technology. The researcher attended a seminar in Bloemfontein in 2006 where the first ever teaching seminar using Skype worldwide was held; this was heralded as a breakthrough and is a cheaper alternative to teleconferencing. New innovations bring new terminology in their

wake; new words and concepts that were unknown to the average medical pedagogic twenty years ago, simply because the words did not exist. There have also been dramatic changes in the field of Medical Education. Many lecturers try to cling to the old system of teaching despite pressure to change.

- *Improved knowledge of Psychiatry leads to enhanced Primary Health Care (Mental Health).* As medical doctors become more proficient in Mental Health Care, their ability to diagnose and manage psychiatric patients improves. Doctors often play a leading role in multi-disciplinary teams. Additional skills in Mental Health will empower these doctors to share their expertise with colleagues in allied professions more confidently, leading to more effective means of serving the community.

- *There is a definite need for the framework to become a reality.* Chairpersons (past and present) of the College of Medicine – Psychiatry – have welcomed the initiative to provide tuition for medical doctors planning to further their studies in Psychiatry. Since the undertaking of this study, there have been remarkable advances in the logistical structuring of provincial Mental Health services especially at primary and secondary health care levels. Regional hospitals in South Africa have created medical officer posts specifically for psychiatric care, and included other mental health care workers including psychologists, occupational therapists, nurses and social workers to assist doctors as part of the therapeutic team at primary and secondary care levels. To date many of these posts have been filled in the Free State Province. Many doctors working in

these posts would probably benefit immensely by successfully completing the PGDipMH. This advantage may also have a spill over effect affecting therapeutic teams positively too.

7.3 LIMITATIONS OF THE STUDY

The researcher recognises the following limitations in the study:

- *The process of selecting Delphi Experts:* The process of selecting Delphi Experts proved to be difficult even though specific preconceived selection criteria had been determined. Three aspirant candidates invited to participate as Delphi Experts in the study declined the invitation. They were, however, replaced by other colleagues with similar expertise. The only impact this had on the study was a delay in the time schedule, as the replacements were of equal academic stature.

- *Inability of the Experts to address a wide field of expertise:* The Delphi Experts who did accept the invitation, although skilled in their own particular field of interest and expertise, were not always able to form educated opinions regarding all aspects of the Delphi study. This produced some puzzling results, for example concerning the Law on Sterilization in South Africa. This law is not complex and most general practitioners will have no difficulty screening potential candidates 18 years and older with possible mental retardation who may qualify for sterilisation. In a real world situation, the final decisions are made by a team comprising of a psychiatrist,

psychologist and a social worker in government institutions. The Delphi Experts could not reach consensus regarding the inclusion of this law in the curriculum of the PGDipMH, but as a majority of Experts indicated it was either essential or useful for the Programme the teaching on this law was included in the Programme.

- *Wording of statements:* Although much effort went into the wording of the statements, during the Delphi study it became apparent that the wording of certain statements could have been phrased more aptly. Statement 1M for example relates to "On completion of the PGDipMH, the student should have gained the following knowledge: Appropriate utilisation of new technology in Psychiatry". No consensus was reached on this statement. The intention of the statement was that the medical practitioner should be encouraged to have a general background relating to specialised diagnostic investigations such as the difference between certain types of neuro-imaging, or what is meant by Transcranial Magnetic Stimulation. The Experts interpreted this as the general practitioner should be encouraged to have a more hands on approach. A majority of the experts did, however, regard the statement as being "useful" rather than "essential" to the study and this statement was not included in the framework, but was discussed in the text.

7.4 RECOMMENDATIONS

The researcher takes the liberty to make the following recommendations:

- *Implementation:* The Programme needs to be implemented using the steps described in Chapter 6. This will include registration of the qualification with the appropriate authorities.

- *Publications:* Using the data and results of the findings described in this thesis the researcher plans to publish several articles in scientific journals (accredited by the UFS).

- *Research:* Additional research studies will be undertaken to determine novel ways of enhancing the field of Mental Health using E-learning. Programmes involving post-graduate professional allied health care workers as students can be developed using the blended learning mode.

- *Extrapolation to other programmes:* The format of the Framework of the Programme may serve as an example for medical educators who plan to use the blended learning mode to present post-graduate diplomas in their disciplines in a more user-friendly manner.

7.5 CONCLUSIVE REMARK

Progressive changes in communication and technology, although designed to make life easier, will probably continue to accelerate the tempo of daily living making life more complex and stressful. This in turn will lead to greater incidence and more prevalence of stress related physical and mental conditions.

New communication technology and knowledge of Medical Education can, however, be harnessed to promote greater expertise and skill in managing mental illness. The researcher would like to express the opinion that in time, with enhanced knowledge of preventative and curative strategies in Mental Health in place, vast changes in the quality of life for the average person in the community will become inevitable.

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APPENDIX A:
LETTER TO DELPHI PARTICIPANTS REQUESTING PARTICIPATION

Date

Name of Delphi participant

Address

Dear Delphi participant

Request to participate in a Ph.D. study entitled: *A FRAMEWORK FOR THE DEVELOPMENT OF A POST-GRADUATE DIPLOMA PROGRAMME IN MENTAL HEALTH*

I am a principal specialist in Psychiatry at the Free State Psychiatric Complex in Bloemfontein. I am employed by the Free State Provincial Administration as well as by the University of the Free State. I am involved in service delivery and training of registrars in psychiatry, among others, medical students.

At present I am writing a thesis to obtain the Ph.D. degree in Health Professions Education in the Faculty of Health Sciences at the University of the Free State (Student number 1988322341).

My supervisors are:

1) Prof. Dr M. M. Nel
   Head: Health Sciences Education
   Faculty of Health Sciences
   University of the Free State

2) Prof. Dr G.J. van Zyl
Head: School of Medicine
Faculty of Health Sciences
University of the Free State

3) Prof. Dr J.F. Hay
Head: Programme Development
University of the Free State

As indicated previously by the title, the **purpose** of this study is to design a framework by which a Post-graduate Programme can be developed and implemented to assist medical doctors who wish to receive tuition through the University of the Free State to assist and train them for the Diploma in Mental Health. The diploma is currently offered by the College of Medicine in South Africa, but no formal structured tuition is available to learners.

Background information:

Our country has a shortage of Psychiatrists. At present there are about 325 Psychiatrists registered in South Africa to serve the Mental Health needs of approximately 45 million people. Thus there is one psychiatrist for every 138 000 people. Greater needs in Mental Health are being experienced by many other countries in Africa. Sadly, trends relating to formal training in Psychiatry show that medical students will receive even less formal grounding in traditional Psychiatry in certain countries for example Malawi.

With the New Mental Health Care Act soon to be functioning in South Africa, additional demands will be placed on mental health care workers, especially medical practitioners to provide adequate care for patients at a primary health care level. Many doctors, however, feel they have insufficient knowledge in the field of Psychiatry and would like to increase their expertise in this field, but do not wish to specialise in this area.

This needs-based opportunity requires a comprehensive educational and training structure that accommodates vertical development, whilst having horizontal exits and the accumulation of credits (also known as the so-called transportability of competence or academic currency). Any post-graduate initiative in South Africa will need to take these factors into consideration before designing and implementing qualifications which will prove to be effective and collaborative, using global information and expertise in an African setting.

According to *The Reader's Digest Oxford Wordfinder* dictionary (Tulloch 1993: 927), a "framework" is succinctly defined as being an essential supporting structure or a basic system.

Distance learning is defined by Holmberg (1983) as "the sort of study not led by teachers in classrooms, but supported by tutors and organizations at a distance from the student" (quoted by R. Harden. 1988:140).

Electronic learning can be considered to be education via the Internet network, or computer.

Against this background, the **problem** which needs to be addressed is that, although undergraduate and post-graduate registrar training in Psychiatry is available, no formal structured tuition exists for the medical officer/general practitioner who wishes to have more knowledge and expertise in this field namely at diploma level.

The overall **goal** of this study would be to provide a framework whereby members of the medical profession may embark on formal post-graduate training on a part-time base, utilising mostly an open learning mode/mixed mode (including contact sessions, directed learning and e-learning), that would support the requirements of the National Qualifications Framework (NQF), the College of Medicine and the Professional Board.

The **aim** of the study therefore would be to establish a framework for the development and implementation of a Post-graduate Diploma Programme in Mental Health. The research **methods** which will be used in the study are:

a) A thorough literature study.
b) Draft/preliminary criteria in the form of statements will be submitted to a panel of Delphi Experts.

The **Delphi Technique** rests on two assumptions namely, first that group decisions are more valid than those made by an individual, especially if the members of the group are experts in the field of study. Second, face–to–face interaction may be influenced by domineering members or by group bias. Since the decision-making is rarely left to a

single person, the success, credibility and validity of the process is increased. The Delphi process allows a wide range of experts from different backgrounds and geographic locations to participate in the communication process.

Your involvement in the study:

I would be grateful if you would assist me in this project by being an Expert Panellist. I know your time is extremely valuable to you, but the completion of the questionnaire and issues relating to it should take approximately 30 – 45 minutes. The questionnaire and other relevant information will be e-mailed to you and a hard copy will be posted to you as well. If you agree to take part in the Delphi process, which is due to take place between October 2006 and March 2007, please complete the consent form attached and return it to me as soon as possible.

Thank you for your attention and time. I sincerely hope you will be able to assist me. I am looking forward to hearing from you.

Yours faithfully

.....

R.J.Nichol
(Student number: 1988322341)
FACULTY OF HEALTH SCIENCES
UNIVERSITY OF THE FREE STATE.
BLOEMFONTEIN 9301
Telephone number: 051 4079293/0825545443

E-mail address: nicholr@fshealth.gov.za
Postal address: P O Box 13205
Noordstad
9302

REGISTERED PROJECT
(ETOVS NO.: 89/06)

CONSENT FORM: DELPHI PROCESS

Date

I, the undersigned, hereby give my consent to participate in the **Delphi Process** Which is scheduled to take place from August 2006 to March 2007. My particulars are:

Title:
Surname:
Full initials:
Postal address:

E-mail address:
Telephone number:
Cellular number:
Signature:

Please return this form (to the following address) on or before 25/08/2006.

P O Box 13205
Noordstad
9302

E-mail address: nicholr@fshealth.gov.za.

APPENDIX B:

FORMAT FOR DELPHI QUESTIONNAIRE – ROUND 1

Section A: CRUCIAL EXIT LEVEL OUTCOMES

1 Student Knowledge
2 Student Skills
3 Student Values
4 Any further comments on Crucial Exit Level Outcomes

Section B: FORMAT OF THE PROGRAMME

5 Format of the Programme
6 Any further Comments on Format of the Programme

Section C: CONTENTS OF THE PROGRAMME

THE FIRST ACADEMIC YEAR

7 The content of module 1: Introduction to Psychiatry
8 The content of module 2: Common Psychiatric conditions (part 1)
9 The content of module 3: Common Psychiatric conditions (part 2)
10 The content of module 4: Common Psychiatric conditions (part 3)

THE SECOND ACADEMIC YEAR

11 The Content of Module 5: Child Psychiatry (part 1)
12 The Content of Module 6: Child psychiatry (part 2)
13 The Content of Module 7: Addiction Disorders
14 The Content of Module 8: Forensic Psychiatry
15 The Content of module 9: Geriatric Psychiatry
16 The Content of Module 10: Introduction to Psychotherapy
17 The Research Project
18 Any further Comments on Content of the Programme

Section D: EDUCATION METHODOLOGY AND MODES OF DELIVERY

19 Policies and Procedures for Programme Approval
20 Outcomes Based Education
21 Curriculum Planning, Development and Design
22 Implementing and Evaluating the Curriculum
23 Student assessment
24 Formal lectures
25 Small Group Sessions
26 Patient Centred Learning
27 Online Distance Learning
28 Any further comments on Education Methodology and Modes of delivery

Section E: STUDENT EVALUATION

29 Student Assessment in the Post-graduate Diploma in Mental Health.
30 Any further comments on Student Assessment.

QUESTIONNAIRE FOR DELPHI PANEL, ROUND ONE

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2006/09/20

Dear Delphi Panellist

Thank you for your willingness to partake in this study.

We live in a world with rapidly changing technology and new approaches to education. As a majority of the experts on the panel were trained in the 'old school' approach I have taken the liberty of including a list of contemporary (and less contemporary definitions) which may be of value to you.

DEFINITIONS:

Blogs (or web logs):
Personal sites to keep in touch with family or friends (O'Leary & O'Leary 2006:104).

Chatroom (chat groups):
An online discussion group that allows direct 'live' communication (O'Leary & O'Leary 2006: 477).

Distance education:
All arrangements for providing instruction through print or electronic communications media to persons engaged in planned learning in a place or time different from that of the instructor(s) (Moore in Maguire 2005:pg 1 of 3).

E-learning (Electronic learning):
Education via the Internet, network, or standalone computer. Network enabled transfer of skills and knowledge. E-learning applications and processes include Web-based learning, computer based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intra/extranet, audio or video tape, satellite TV and CD-ROM (Google 2004:p1 of 1).

M-learning (Mobile learning):
The use of hand-held computers (incorporated into cell-phones) for 'anytime, anywhere' access to learning resources (Powernell & Bailey 2000:3).

Nosology
The programme of describing and taxonomising mental disorders (Porter 2002:213).

Outcome-based Education (OBE):
An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused (Betts & Smith 1998:52).

Online Distance Learning (ODL):
Online teaching using the Internet and the World Wide Web (www) (Harden 1998: 190).

Podcasting:
Learners are able to download lectures or information onto their iPods or any other MP3 players (and listen to these presentations when it suits the learner) (Baird 2006:1).

YOUR INVOLVEMENT IN ROUND ONE OF THE STUDY:
Please be so kind as to complete sections A to E by marking one option as indicated. Please feel free to write any comments next to the statements (or underneath the sections). The statements may be answered electronically and returned via e-mail or you may wish to mark the hard copy and return it in the envelope provided.

Completion of Round 1 SHOULD TAKE APPROXIMATELY 40 minutes. Please return the completed form within 5 working days.

After the information has been collated, statements where there is more than 80% consensus will not feature again in **Round 2.** I trust Round 2's QUESTIONNAIRE will be much shorter.

I look forward to hearing from you.

Kind regards

R.J.NICHOL

SECTION A CRUCIAL LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH the student should have gained the following knowledge:

		Essential	Useful	Unnecessary	Comments
A	The ability to classify the various common types of psycho-pathology				
B	Current theories on the known etiology of mental conditions				
C	Current theories on the pathophysiology of common mental conditions				
D	Current theories on the psychopharmacology used to manage common mental conditions				
E	An appreciation of the effect of the patients' physical environment on their conditions				
F	An appreciation of the effect of the patients' cultural environment on their conditions				
G	Comprehend the importance of patient confidentiality				
H	Know the interpersonal dynamics involved in a multidisciplinary health team approach				

I	The role of risk factors in Mental Health				
J	An understanding of research methods				
K	Current theories relating to the prevention of psychopathology (in people)				
L	Cost-effective utilisation of special investigations in Psychiatry				
M	Appropriate utilisation of new technology in Psychiatry				
N	An understanding of legal issues in Psychiatry				
O	Knowledge of effective counselling skills				

2. On completion of the PGDipMH, the student should have gained the following skills:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The ability to identify most common forms of psycho-pathology				
B	The ability to conduct a thorough mental state examination				
C	The ability to diagnose common mental conditions				
D	The ability to manage common mental conditions				
E	The ability to refer patients appropriately for further manage-ment				
F	Be able to demonstrate cultural sensitivity to all patients				
G	Be able to function as an integral part of a multidisciplinary health care team				
H	Be able to effectively counsel a patient				

I	Be able to communicate using basic computer skills				

3. On completion of the PGDipMH, the student should have adhered to the following values:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The importance of patient confidentiality				
B	The importance of multi-disciplinary health care interventions				
C	A respect for the rights of mental health care users				
D	Empathy for mental health care users (patients)				
E	Empathy for the families of mental health care users				
F	Appreciation that the patient is more important than the disease				
G	A positive approach to self-directed life-long learning				
H	A willingness to participate in self-evaluation				
I	A willingness to participate in peer evaluation.				
J	A positive attitude with regard to continuing professional develop-ment.				

4. Any additional comments on crucial exit level outcomes (Knowledge, skills and values)

SECTION B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES					
This section deals with the basic lay out and content of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary					
5. The following should be considered for the format of the programme content of the modules:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period				
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200)				
C	The second academic year should contain two modules (Notional hours = 600)				
D	The second academic year should contain a research project				
E	Students should be required to pass the first academic year before proceeding to the second academic year				
F	Students who do not wish to enroll for the second academic year, but who have successfully passed the first year, should receive a certificate				
G	The second academic year should contain **SIX** modules, from which learners are required to choose **TWO** modules				
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year. (Students may begin this project in the first academic year)				

I	Students will be assessed using tutorials and worksheets				
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion)				
K	Students will also be evaluated according to their contribution to the chat room discussion				
L	There should be a restriction on the number of students who are allowed to enroll for each academic year				
M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme				
N	Learners should be encouraged to present appropriate case studies in their wards/practice when leading chat room sessions				
O	The academic standard of subject material used in the programme should be closer to MMed(Psych) level than final year M.B.,Ch.B. level				
P	Where possible, teaching should be directed towards practical situations in wards/practice (rather than philosophical theories)				
Q	Where applicable, teaching should be directed towards rural, primary care settings				
R	Where applicable cultural phenomena should also be discussed				

6. Any additional comments on the format of the Programme

SECTION C. CONTENTS OF THE PROGRAMME
This section deals with the basic layout and content of the programme of the first academic year. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option**

7. The content of the module 1: Introduction to Psychiatry. The content of the module will include:					
		Essential	**Useful**	**Unnecessary**	Comments
A	This module should take the form of face-to-face contact sessions where students are required to be present at the UFS for two working days				
B	Basic neuro-anatomy will be discussed using anatomic models				
C	Basic neurophysiology will also be presented and discussed				
D	The basic common psychiatric evaluation will be demonstrated and discussed in a tertiary setting				
E	Four case studies using patients with common chronic psychiatric conditions will be presented by the academic staff.				
F	Discussion in case studies will also include symptomatology of the conditions under discussion				

G	Discussion in case studies will include neuropathology of the conditions under discussion				
H	Discussion in case-studies will include management of the conditions under discussion				
I	Discussion in case-studies will include prognosis of the conditions under discussion				
J	Students will be given a written clinical case report with specific questions relating to the case. Answers have to be e-mailed to the Department within 7 working days				
K	Students will be evaluated according to their ability to integrate knowledge				
L	The new Mental Health Care Act should also be discussed				

8. Content of module 2: Chronic Psychiatric conditions – (part 1)					
This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The basic known neuron-pathology of schizophrenia				
B	The sub-types of schizophrenia				
C	The history of nosology of schizophrenia				
D	The pharmacology of treatment in schizophrenia				
E	The complications of pharma-cological treatment in schizo-phrenia				

F	The importance of early recognition and treatment in prodromal schizophrenia				
G	The role of cannabis (and other substances) in early diagnosis and treatment of schizophrenia				
H	About psychosis secondary to general medical conditions				
I	How to diagnose and treat schizo-affective disorder				
J	How to differentiate schizophrenia from acute delirium				
K	How to recognise culture bound conditions				
L	How to recognise delusional disorders				
M	How to recognise "Group A" Personality Disorders: Paranoid, Schizoid and Schizotypal Personality Disorders)				

9. Content of module three: Common Psychiatric conditions (part two)

This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part two) – MOOD DISORDERS.**
On completing the module the learner should know how to:

		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the differences between Bipolar Disorders and Depressive Disorders (including subtypes)				
B	Treat the conditions mentioned in 9A				
C	Manage complications of treatment				
D	Recognise patients at risk of committing suicide				
E	Differentiate the phases of grief				

F	Differentiate Mood Disorders secondary to General Medical Conditions				
G	Explain the meaning of Adjustment Disorders				
H	Apply the principles of Cognitive Behaviour Therapy				

10. Content of module 4					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part 3 - ANXIETY DISORDERS.** On completion of the module the learner should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Explain **Generalized Anxiety Disorder**				
B	Explain **Obsessive Compulsive Disorder**				
C	Explain **Post Traumatic Stress Disorder**				
D	Explain **Panic Disorder**				
E	Explain **Social Anxiety Disorder**				
F	Treat the conditions mentioned in 10 a to e and have a knowledge of complications of treatment (pharmacotherapy)				
G	Understand the concept of **co-morbidity** relating to anxiety disorders and depressive disorders				
H	Have a working knowledge of **non-pharmacological treatment** of anxiety disorders				
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds**				
J	Know the **differential diagnosis of anxiety disorders**				

K	How to recognize Avoidant Dependent, and Obsessive Personality Disorders				

11. The Second academic year and Module 5

The programme in year two will contain six modules. Students will have the option of selecting three modules.
Module 5 = Child Psychiatry part 1
Module 6 = Child Psychiatry part 2
(only for learners who have completed module 5).
Module 7 = Addiction Disorders
Module 8 = Forensic Psychiatry
Module 9 = Geriatric Psychiatry
Module 10 = Introduction to Psychotherapy.

Students will also be required to complete a research project.
On completion of **Module 5 (CHILD PSYCHIATRY-part 1)** the learner should:

		Essential	**Useful**	**Unnecessary**	Comments
A	Have an understanding of **normal development in humans** (Neuro- developmental and behavioural changes from conception to adulthood				
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism)				
C	Understand **Disruptive Disorders** in children				
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis)				
E	Have a working knowledge of **Intellectual Disability** (Mental retardation)				
F	Be able to manage **victims of 'abuse'** (physical, sexual, emotional) at primary health care level				

12. Module 6 – Child Psychiatry (part 2)					
On completion of this module, learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Have a working knowledge of **Depressive disorders in children**				
B	Have a working knowledge of **anxiety disorders in children**				
C	Understand issues facing **adolescents** (including exposure to illicit substances)				
D	Have a working knowledge of **eating disorders**				
E	Be able to **counsel parents and families in crisis**				

13. Module 7 – Forensic Psychiatry					
Learners who complete this module should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand **the rights of patients** and the **New Mental Health Care Act**				
B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)**				
C	Understand the **Law on Sterilization**				
D	Understand **ethical issues** relating to Psychiatry				

E	Be able to advise families regarding legal issues i.e. if and when patients are no longer able to manage their own affairs				
F	Know how **intoxication with substances affects criminal responsibility**				
G	Know how to recognize Anti-social and Borderline Personality Disorders				

14. Module 8 - Addiction Disorders					
Learners completing this module should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Have a working knowledge of the effects of **ethanol (alcohol)** in humans.				
B	Be able to manage patients with **acute alcohol withdrawal.**				
C	Understand **chronic alcohol dependence**				
D	Have a working knowledge of the terms **use** and **abuse**				
E	Have a working knowledge of **illicit drugs/substances** commonly available in South Africa				
F	Be able to manage patients with signs and symptoms of **acute withdrawal** from a substance until the patient can be managed at secondary/tertiary level				
G	Be able to explain how substances affect **criminal accountability**				
H	Have a working knowledge of **drug-substitution therapy**				
I	Be able to recognize and manage **co-morbid psychiatric conditions**				

15. Module 9 - Geriatric Psychiatry					
After completing this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **psychopatho-logy of the aging brain**				
B	Have a working knowledge of **dementia**				
C	Understand **pharmacotherapy in the elderly**				
D	Be able **to counsel families** of elderly patients				
E	Know how to manage the process of having a patient placed under curatorship (legal implications)				

16. Module 10 – Introduction To Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)**				
B	Be able to understand the principles of CBT				
C	Be able to **apply CBT** in counseling patients having **depressive disorders**				
D	Be able to **apply CBT** in patients having **anxiety disorders**				
E	Be able to **counsel patients** who have recently been **acutely traumatized.**				
F	Be able to manage patients with **suicidal ideation**				

G	Have a working knowledge of **personality disorders.** Learners should be able to identify these disorders and know when to refer patients.				

17. Module 11 - The Research Project					
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	The research project forms an integral part of the Post-graduate Programme in Mental Health				
B	A tutor will be available to assist the learner				
C	Learners will also be able to make use of a biostatistician				
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS				
E	Results of the Research should be published in an **accredited Medical Journal**				
F	If the research project is not completed the learner will not be awarded the qualification				

18. Any additional comments on the contents of the programme

SECTION D. EDUCATION METHODOLOGY AND MODES OF DELIVERY
This section deals with methodology and modes of delivery of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

19. POLICIES AND PROCEDURES FOR PROGRAMME APPROVALI					
In the **development** of an educational programme in Mental Health:					
		Essential	**Useful**	**Unnecessary**	Comments
A	A Postgraduate Programme in Mental Health should be implemented at the National Qualification framework level 7 (post-graduate diploma level)				
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework level 8 (master's degree level)				
C	The Department of Education and the Department of Health should support the educational programme (Post-graduate Programme in Mental Health)				
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health				

E	The Post-graduate Programme in Mental Health should be offered as a structured, formally registered SAQA approved programme pegged at the appropriate level				
F	The Post-graduate Programme in Mental Health should be offered as an informal short course programme				
G	The Post-graduate Programme in Mental Health should contain modules which may serve as credit bearing short courses.				
H	The Post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes				
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses(e.g. M Med Fam)				

20. Outcomes-based Education					
In developing an education programme for the Post-graduate Programme in Mental Health, the following should be considered:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Evaluation procedures are consistent				
B	Evaluation procedures are interrelated				
C	Regular review of the course to eliminate ineffective sections				
D	Evaluation of the materials to eliminate ineffective materials				

E	Orientation from 'What I (as a lecturer) must cover' is changed to 'What a student should be able to do' as a consequence of instruction				
F	Self-evaluation by the students should be encouraged to ensure they know what is expected of them				
G	Efficient student learning is facilitated by providing direction				
H	Efficient student learning is facilitated by identifying instructional priorities				
I	Demonstrations (of knowledge gained) must be of high quality e.g. chat room contributions				
J	Demonstrations must show evidence of significant learning				
K	A portfolio should form part of demonstrations of knowledge gained by each student				
L	The outcomes must be significant				
M	The outcomes must be clear				
N	The outcomes must be concise				
O	Demonstrations must occur in some 'own context' (performance setting)				

21. Curriculum Planning, Development and Design

In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:

		Essential	**Useful**	**Unnecessary**	comments
A	The curriculum development process should be sensitive to the academic setting of the project				

B	The curriculum developmental process should be sensitive to the capabilities of the students for whom the programme is designed				
C	The curriculum developmental process should be sensitive to the interests of the students for whom the programme is designed				
D	The curriculum should be sensitive to the priorities of the students for whom the programme is designed				
E	The development of the programme should require a detailed knowledge and appreciation of the discipline				
F	The development of the programme should require an understanding of the resources available to the faculty and educators involved				
G	The development of the programme should require an understanding of the options available to the faculty and educators involved				
H	The programme should have a rationale (or mission statement) to explain why the programme exists				
I	The overall programme aims must be clearly stated, in order to explain what the programme will achieve				
J	Outcome statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the programme				
K	Content statements must be provided to indicate what areas of knowledge will comprise the student learning				
L	Teaching guidelines must be provided in order to indicate how long the learning activities will be organized				

M	Assessment methodologies must be provided to indicate how student learning will be assessed and reported				

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
A	There must be a demonstrable need for the Programme				
B	The academic area must be stable in terms of the knowledge comprising the Programme.				
C	The academic area must be well defined in terms of the knowledge comprising the Programme				
D	There must be clear potential for success of the Programme				
E	The department/institution providing the Programme must have the necessary resources available				
F	Any social and political factors that may negatively impact the provision of the Programme should be considered				
G	A needs assessment should be considered in terms of the Programme objectives				
H	The aims/exit level outcomes of the curriculum should be stated				
I	There should be a clear rationale and justification for the provision of the Programme				
M	Assessment criteria and procedures must be clearly stated				
N	The context and community in which the Programme resides should be articulated				

O	The entry and admission criteria for the Programme must be adequately described.				
P	The form of instruction should be appropriate to the learners' needs				
Q	The Programme should allow for individual differences in students				
R	The Programme should allow for individual differences in learning methods				
S	Provision must be made for adequate availability of student materials				
T	Provision must be made for adequate availability of student resources. e.g. computers				
U	Provision must be made for adequate availability of student facilities				
V	There should be provision for pilot testing of the proposed Programme prior to final implementation				
W	Criteria must be available for evaluation of all aspects of the Programme for purposes of quality assurance				
X	Quality Assurance Processes should assess the Post-graduate Programme in Mental Health regularly				
Y	There must be evidence of significant groups (subject specialists) involved throughout the development of the proposed Programme curriculum				

23. Student Assessment					
In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The emphasis should be shifted away from the input or content aspect of programmes toward the objective assessment of the performance of learners in terms of clearly stated outcomes				
B	The ultimate outcome (end point) for each and every person learning in a particular Programme should be equivalent and clearly stated				
C	The assessment must be objective and verifiable				
D	The responsibilities learners are expected to assume to monitor their own learning must be defined				
E	The assessment criteria for each of the abilities/skills that have been developed should be defined				
F	An assessment taskforce is established, which will include an assessment expert				
G	There is the establishment of a systematic assessment pro-gramme, which will aim to ensure uniformity of assessment across all subjects/modules				
H	There is an integrated method of assessment covering all aspects of the learning Programme				
I	Standardised multi-modal methods of learner assessment should be used				

J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors				
K	The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected				
L	Moderation of learner assessment takes place to ensure that the required level, standard, appropriateness and fairness is observed				
M	All forms of assessment are conducted by appropriately trained moderators with specific expertise in the learning area				

24. Formal Lectures					
		Essential	**Useful**	**Unnecessary**	Comments
A	There is a place for formal lectures as a means of content delivery to students				
B	The content of formal lectures should be geared to the practical needs of medical practitioners working in primary health settings				
C	Formal lectures can be used to facilitate Outcomes-based education (OBE)				
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic				
E	Formal lectures can be used to present the core content of the Programme				

F	Powerpoint presentations and video-clips should be used where appropriate to enhance the lecture				
G	Copies of hand-outs should be made available at a website for students to access after the lecture.				
H	Copies of illustrations should be made available at a website for students to access after the lecture				
I	The content of the lecture should be available for students to access using Podcasting				
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture				
K	Formal lectures containing core knowledge on the topic need to be revised regularly				
L	Peer review on content of core knowledge is important				
M	Constructive feedback on the content of he lecture from students should be encouraged				

25. Small Group Sessions					
Whether in the format of face-to-face interaction, or on-line distance "chat rooms", small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Familiarise students with an adult approach to learning				
B	Encourage students to take responsibility for their own learning				
C	Promote deeper understanding of the topic				
D	Encourage problem-solving skills				

E	Encourage participation (Some students may be based in remote areas with little contact with other doctors)				
F	Students should also be evaluated on the content of their contributions to small group interactions				
G	Each small group session should be facilitated by both a tutor and a co-tutor				
H	Syndicate groups (without a tutor and co-tutor) should be used				

26. Patient Centred Learning					
As students will be frequently exposed to patients with mental illness, either in in-patient settings or out-patient wards (or in private practice), the use of ward-based teaching in the Programme:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Should be considered, where learners will be asked to link a certain psychiatric condition (under discussion), with a particular patient(s)				
B	Learners may be asked to detect specific symptomatology in certain patients and report to their tutor or group				
C	Learners may relate the effect of certain medications on a patient (efficacy or side-effects)				
D	Learners may have a platform in which to discuss problem patients with tutors and/or the group and so increase their knowledge of the topic				

E	Learners can be instructed to write up case-studies of certain common psychiatric conditions and include this work in their portfolios (which will be assessed at a later date)				
F	Each learner in the group will have an opportunity to present a patient (in their own practice) with specific complaints. This will serve as a learning exercise				

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	In the 21st century ODL is….				
B	ODL allows for greater interaction between tutor and learner				
C	ODL meets the needs of non-traditional learners				
D	ODL allows learners to work at their own pace				
E	Administrators of the university/ Institution presenting the Pro-gramme need to be favourably inclined towards ODL				
F	ODL calls for a change in academic and educational requirements (compared to presenting traditional curricula)				
G	The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility				
H	The rapid evolution of knowledge requires the staff facilitating the online module to have greater support from medical experts				

I	The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff				
J	Instructors need more allocated time to develop online courses				
K	Instructors need more allocated time to deliver online courses				
L	Additional technical staff are needed for ODL				
M	Additional administrative staff are needed for ODL				
N	Copyright laws and intellectual property rights should be adhered to				
O	Instructors should ensure the quality of ODL remains high				
P	Instructors should be taught how to manage possible obstacles they may encounter when teaching online				
Q	The software used to present the Post-graduate Programme in Mental Health should be of the same type as used by the UFS (in other programmes)				
R	A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken				
S	ODL courses should be revised regularly				
T	ODL courses should be updated when the software becomes obsolete				
U	Learner training and support (in computer matters) plays an integral part of the programme				
V	Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable				

X	A graphic designer should take responsibility for the layout of material on web pages				
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent)				
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms)				
AA	Students should be encouraged to make use of Mobile learning.				
BB	Students should be encouraged to make use of blogs				

28. Any further comments on education methodology and Modes of delivery

SECTION E. STUDENT EVALUATION					
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one**					
29. Student Assessment					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online				
B	Learners will have seven working days to return their "homework" online				

C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic				
D	If the tutorial is not successfully completed students will have three days to make corrections				
E	Students will be assessed according to their contributions to the chat room sessions				
F	The case studies for each module will also be assessed				
G	Students who wish to exit the course after year one will have to pass an oral examination in order to receive a Short Learning Programme certificate				
H	The oral examination will consist of a case presentation (30 minutes) related to the subject material in modules 1-4				
I	The allocation of weightings for year one module marks is as follows: Tutorials (first attempt) 45%				
J	The allocation of weightings for year one module marks includes: case-studies = 45%				
K	The allocation for year one module marks includes Chat room contributions = 10%				
L	The learner must have 50% or more to continue to the second academic year				
M	Those who wish to exit after the first academic year must have at least 50% module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				
N	The weightings for the second academic year will be as follows: Tutorials (first attempt) 25%				

O	The weightings for the second academic year will include Case-studies = 25%				
P	The weightings for the second academic year will include Chat room contributions = 10%				
Q	The weightings for the second academic year will include a research project = 40%				
R	Learners who do not have an average mark of at least 50 % will not be allowed to attend the final oral examination				
S	The final oral examination (30 minutes) should take the form of a case presentation				
T	Students obtaining 50% or more will be awarded a qualification				
U	Examiners of the oral examinations will be psychiatrists and psychologists (UFS staff)				
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists				

30. Any futher comments on student assessment in the programme

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX C:
FEEDBACK AND COMMENTS ROUND 1

Shaded areas indicate statements where consensus reached in Round 1.
Answers to comments made by Delphi Experts are given in bold letters

SECTION A CRUCIAL EXIT LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).
Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH. The student should have gained the following knowledge:

		Essential	Useful	Unnecessary	Comments
A	The ability to classify the various common types of psychopathology				
B	Current theories on the known etiology of mental conditions				In broad outline and including the whole spectrum of theories, not just biological. But depends on how detailed.
C	Current theories on the patho-physiology of common mental conditions				In broad outline. But depends on how detailed.
D	Current theories on the psychopharmacology used to manage common mental conditions				As far as they have scientific validity. But depends on how detailed.

E	An appreciation of the effect of the patients' physical environment on their conditions				
F	An appreciation of the effect of the patients' cultural environment				
G	Comprehend the importance of patient confidentiality				
H	Know the interpersonal dynamics involved in a multidisciplinary health team approach				This would need a significant amount of knowledge of psycho-dynamic theory and organizational dynamics
I	The role of risk factors in Mental Health				
J	An understanding of research methods				I'm not sure this is the core business of a post-graduate diploma
K	Current theories relating to the prevention of psychopathology (in people)				Unsure of meaning. **Primary prevention in Mental Health**
L	Cost-effective utilisation of special investigations in Psychiatry				
M	Appropriate utilisation of new technology in Psychiatry				New technology would be? TCMS? New drugs; Neither would be prescribed by non-specialists
N	An understanding of legal issues in Psychiatry				
O	Knowledge of effective counselling skills.				

2. On completion of the PGDipMH, the student should have gained the following skills:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The ability to identify most common forms of psychopathology				

B	The ability to conduct a thorough mental state examination				
C	The ability to diagnose common mental conditions.				Uncomplicated conditions
D	The ability to manage common mental conditions				Basic management
E	The ability to refer patients appropriately for further management.				And further assessment where necessary
F	Be able to demonstrate cultural sensitivity to all patients				
G	Be able to function as an integral part of a multidisciplinary health care team				
H	Be able to effectively counsel a patient				And know when "counseling" is appropriate
I	Be able to communicate using basic computer skills				

3. On completion of the PGDipMH , the student should ha adhered to the following values:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The importance of patient confidentiality				
B	The importance of multidisciplinary health care interventions				
C	A respect for the rights of mental health care users				
D	Empathy for mental health care users (patients)				
E	Empathy for the families of mental health care users.				
F	Appreciation that the patient is more important than the disease				
G	A positive approach to self-directed life-long learning				
H	A willingness to participate in self- evaluation				

I	A willingness to participate in peer evaluation				
J	A positive attitude with regard to continuing professional development.				

4. Any additional comments on crucial exit level outcomes (knowledge, skills and values).

What about language skills? Surely mental health practitioners should be able to talk to their patients in the patient's language, otherwise they will miss a huge amount of information if they have to rely on an interpreter.

I also think that an appreciation of the cultural determinants of mental illness is a value (not just a cognitive issue) and that there are also specific skills attached to this as well

SECTION B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES

This section deals with the basic lay out and content of the Programme. Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

5. The following should be considered for the format of the Programme content of the modules:

		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period				Full time or part time? **Part time**
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200)				
C	The second academic year should contain two modules (Notional hours = 600)				Best give a choice (see G below) + research project
D	The second academic year should contain a research project				Research projects are important for post-graduate diplomas

E	Students should be required to pass the first academic year before proceeding to the second academic year				
F	Students who do not wish to enroll for the second academic year, but who have successfully passed the first year, should receive a certificate				
G	The second academic year should contain **SIX** modules, from which learners are required to choose **TWO** modules				I don't think it is useful to allow a choice. People who are functioning as mental health care practi-tioners need to be able to deal with all ages
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year.(Students may begin this project in the first academic year)				
I	Students will be assessed using tutorials and worksheets				
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion).				
K	Students will also be evaluated according to their contribution to the chat room discussion				
L	There should be a restriction on the number of students who are allowed to enrol for each academic year				

M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme				Surely the Diploma should be multi-disciplinary (like the MPH) if we are trying to build a multi-disciplinary approach. Why not make it available to psychiatric nurses who have a bachelors degree ?
N	Learners should be encouraged to present appropriate case studies in their wards/practice when leading chat room sessions				
O	The academic standard of subject material used in the programme should be closer to MMed(Psych) level than final year M.B.,Ch.B. level				
P	Where possible, teaching should be directed towards practical situations in wards/practice (rather than philosophical theories)				
Q	Where applicable, teaching should be directed towards rural, primary care settings				Not exclusively. Maybe PHC settings in general. Rural settings is another issue.
R	Where applicable cultural phenomena should also be discussed				

6. Any additional comments on the format of the programme

SECTION C. CONTENTS OF THE PROGRAMME
This section deals with the basic layout and content of the programme of the first academic year. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

7. The content of the Module 1: Introduction to Psychiatry.
The content of the module will include:

		Essential	Useful	Unnecessary	Comments
A	This module should take the form of face-to-face contact sessions where students are required to be present at the UFS for two working days				
B	Basic neuro-anatomy will be discussed using anatomic models				
C	Basic neurophysiology will also be presented and discussed				What about basic psychology. See below (18)
D	The basic common psychiatric evaluation will be demonstrated and discussed in a tertiary setting				It would be appropriately demonstrated in a primary setting. Patients who present to tertiary level are not the same as those whom we are expecting the diplomats to manage. **Teaching will take place in a tertiary setting, yet geared for a primary setting.**

E	Four case studies using patients with common chronic psychiatric conditions will be presented by the academic staff				
F	Discussion in case studies will also include symptomatology of the conditions under discussion				
G	Discussion in case studies will include neuropathology of the conditions under discussion				
H	Discussion in case studies will include management of the conditions under discussion.				
I	Discussion in case studies will include prognosis of the conditions under discussion				With care not to induce 'clinical helplessness' in disorders such as schizophrenia
J	Students will be given a written clinical case report with specific questions relating to the case. Answers have to be e-mailed to the Department within 7 working days.				
K	Students will be evaluated according to their ability to integrate knowledge				Not clear how you evaluate this? **Hopefully by testing their 'clinical insight' rather than just repeating know-ledge gained by rote learning**
L	The new Mental Health Care Act should also be discussed				

8. Content of Module 2: Chronic Psychiatric Conditions –(Part 1)
This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:

		Essential	Useful	Unnecessary	Comments
A	The basic known neuron-pathology of schizophrenia				
B	The sub-types of schizophrenia				
C	The history of nosology of schizophrenia				
D	The pharmacology of treatment in schizophrenia.				
E	The complications of pharma-cological treatment in schizo-phrenia				
F	The importance of early recognition and treatment in prodromal schizophrenia				Early recognition essential but not prodromal. The evidence that treatment in the prodrome is beneficial is equivocal at best
G	The role of cannabis (and other substances) in early diagnosis and treatment of schizophrenia				And precipitation
H	About psychosis secondary to general medical conditions				
I	How to diagnose and treat schizo-affective disorder				This is not a diagnosis that should be made by a non-specialist
J	How to differentiate schizophrenia from acute delirium				
K	How to recognise culture bound conditions				With the caveat that a specialist consultation should be obtained before an apparent psychosis is diagnosed as a 'culture bound syndrome'
L	How to recognise delusional disorders				This is less than common and requires a specialist assessment

M	How to recognise 'Group A' Personality Disorders: Paranoid, Schizoid and Schizotypal Personality Disorders)				

9. Content Of Module Three. Common Psychiatric Conditions (Part Two)					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part two) – MOOD DISORDERS.** On completing the module the learner should know how to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the differences between Bipolar Disorders and Depressive Disorders (including subtypes)				
B	Treat the conditions mentioned in 9A				Patients with suspected bipolar disorder should be assessed at specialist level
C	Manage complications of treatment				Emergency management only. If complications arise a psychiatrist should be consulted
D	Recognise patients at risk of committing suicide				
E	Differentiate the phases of grief				
F	Differentiate Mood Disorders secondary to General Medical Conditions				
G	Explain the meaning of Adjustment Disorders				
H	Apply the principles of Cognitive Behaviour Therapy				

10. Content of Module 4
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part three - ANXIETY DISORDERS.** On completion of the module the learner should be able to:

		Essential	Useful	Unnecessary	Comments
A	Explain **Generalized Anxiety Disorder**				Should be able to describe it, not explain it
B	Explain **Obsessive Compulsive Disorder**				As above
C	Explain **Post Traumatic Stress Disorder**				As above
D	Explain **Panic Disorder**				As above
E	Explain **Social Anxiety Disorder**				As above
F	Treat the conditions mentioned in 10 a to e and have a knowledge of complications of treatment (pharmacotherapy)				Basic treatments only. Psychotherapeutic interventions should be prescribed by psychologists.
G	Understand the concept of **co-morbidity** relating to anxiety disorders and depressive disorders				
H	Have a working knowledge of **non-pharmacological treatment** of anxiety disorders				
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds**				Do you mean disability? **Yes** This is a decision that should be made by a psychiatrist. **The student should have a background and know which patients should be referred**
J	Know the **differential diagnosis of anxiety disorders**				Especially the medical differential diagnosis
K	How to recognize Avoidant Dependent, and Obsessive Personality Disorders				

11. The Second Academic Year And Module 5
The Programme in year two will contain six modules. Students will have the option of selecting three modules.

Module 5 = Child Psychiatry part 1
Module 6 = Child Psychiatry part 2
(only for learners who have completed module 5).
Module 7 = Addiction Disorders
Module 8 = Forensic Psychiatry
Module 9 = Geriatric Psychiatry
Module 10 = Introduction to Psychotherapy

Students will also be required to complete a research project.
On completion of **Module 5 (CHILD PSYCHIATRY-part 1)** the learner should:

		Essential	**Useful**	**Unnecessary**	Comments
A	Have an understanding of **normal development in humans** Neuro- developmental and behavioural changes from conception to adulthood				Must include psycho-logical development somewhere. They largely inform the "behavioural changes"
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism)				
C	Understand **Disruptive Disor-ders** in children				Must know the multi-factorial aetiology of these presentations.
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis)				Enuresis yes. Enco-presis is more complex. While primary health care workers can make a diagnosis an d co-ordinate medical screening, the management usually requires a multi-disciplinary team
E	Have a working knowledge of **Intellectual Disability** (Mental retardation)				

F	Be able to manage **victims of 'abuse'** (physical, sexual, emotional) at primary health care level				Only initial management and counseling. The management of the psychiatric and psychological sequelae of child abuse requires more specific skills

12. Module 6 - Child Psychiatry (part 2)					
On completion of this module, learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Have a working knowledge of **Depressive disorders in children**				And adolescents. Treatment of de-pressed children is not appropriately carried out by generalists.
B	Have a working knowledge of **anxiety disorders in children**				And adolescents
C	Understand issues facing **adolescents** (including exposure to illicit substances)				
D	Have a working knowledge of **eating disorders**				
E	Be able to **counsel parents and families in crisis**				

13. Module 7 – Forensic Psychiatry					
Learners who complete this module should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand **the rights of patients** and the new **Mental Health Care Act**				And the rights and obligations of health workers.

B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)**				This is a specialist field Forensic assessments should be carried out by specialists. **I agree, but often general practitioners are asked by the courts whether a person should be referred for evaluation.**
C	Understand the **Law on Sterilization**				
D	Understand **ethical issues** relating to Psychiatry				
E	Be able to advise families regarding legal issues i.e. if and when patients are no longer able to manage their own affairs				
F	Know how **intoxication with substances affects criminal responsibility**				See 13 B
G	Know how to recognize Anti-social and Borderline Personality Disorders				It is important to have a working knowledge of these disorders but the diagnosis of these disorders is complex and should be made by specialists. There is a risk of unwarranted labelling and stigma if diagnoses are made on he basis of negative counter-transference. Such diagnoses shouldn't alter primary level treatment

14. Module 8 - Addiction Disorders					
Learners completing this module should:					
		Essential	**Useful**	**Unnecessary**	Comments

A	Have a working knowledge of the effects of **ethanol (alcohol)** in humans				
B	Be able to manage patients with **acute alcohol withdrawal**				
C	Understand **chronic alcohol dependence**				
D	Have a working knowledge of the terms **use** and **abuse**				
E	Have a working knowledge of **illicit drugs/substances** commonly available in South Africa				
F	Be able to manage patients with signs and symptoms of **acute withdrawal** from a substance until the patient can be managed at secondary/tertiary level				
G	Be able to explain how substances affect **criminal accountability**				This seems to be a matter for forensic specialists
H	Have a working knowledge of **drug-substitution therapy**				
I	Be able to recognize and manage **co-morbid psychiatric conditions**				These can be difficult to manage and the clinician should know when to refer to specialist level

15. Module 9 - Geriatric Psychiatry					
After completing this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **psychopathology of the aging brain**				I'm not sure enough is really known about this to insist that diploma candidates be able to explain it
B	Have a working knowledge of **dementia**				
C	Understand **pharmacotherapy in the elderly**				

D	Be able **to counsel families** of elderly patients				
E	Know how to manage the process of having a patient placed under curatorship (legal implications)				However, assessment of competence should be done at least in consultation with a specialist

16. Module 10 - Introduction To Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)**				
B	Be able to understand the principles of CBT				Including the limitations of both the treatment modality and the clinician.
C	Be able to **apply CBT** in counseling patients having **depressive disorders**				Basic CBT yes, but CBT is a psychological speciality in its own right.
D	Be able to **apply CBT** in patients having **anxiety disorders**				As above
E	Be able to **counsel patients** who have recently been **acutely traumatized**				Evidence-based methods should be taught.
F	Be able to manage patients with **suicidal ideation**				
G	Have a working knowledge of **personality disorders.** Learners should be able to identify these disorders and know when to refer patients				

17. Module 11 - The Research Project
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project

may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	The research project forms an integral part of the Post-graduate Programme in Mental Health				Not a requirement of Diploma, but definitely for Master's degree.
B	A tutor will be available to assist the learner				
C	Learners will also be able to make use of a biostatistician				If necessary
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS				Depends on project. If not necessary, e-committee tends to slow research down and wastes a lot of time.
E	Results of the Research should be published in an **accredited Medical Journal**				Not a requirement though Accredited by whom? **UFS**
F	If the research project is not completed the learner will not be awarded the qualification				For Master's only

18. Any additional comments on the contents of the programme

I think the PGDipMH should be more service orientated. The inclusion of a research project may be a disincentive to some, and will place an additional burden on lecturers, ethics committees etc.

A research project is not necessary for the diploma. It should be clearly distinguished from the MMed or CMSA degree in this regard.

SECTION D. EDUCATION METHODOLOGY AND MODES OF DELIVERY
This section deals with methodology and modes of delivery of the programme. **Please indicate how important each of the following statements is** **according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

19. POLICIES AND PROCEDURES FOR PROGRAMME APPROVAL

In the **development** of an educational programme in mental health:

		Essential	Useful	Unnecessary	Comments
A	A Postgraduate Programme in Mental Health should be implemented at the National Qualification framework level 7 (post-graduate diploma level).				Essential for coverage, must include nurses
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework level 8 (masters degree level)				Specialisation is at this level
C	The Department of Education and the Department of Health should support the educational Programme (Post-graduate Programme in Mental Health)				
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health				Sometimes a mixed blessing. Only acceptable in the form of unrestricted educational grants with no input into course content

E	The Post-graduate Programme in Mental Health should be offered as a structured, formally Registered SAQA approved Programme pegged at the appropriate level				Cannot do otherwise
F	The Post-graduate Programme in Mental Health should be offered as a non-formal short course programme				For non-degree purposes. Some of the modules should be offered as short course; keep RPL in mind (Recognition of Prior Learning).
G	The Post-graduate Programme in Mental Health should contain modules which may serve as credit bearing short courses				
H	The Post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes				
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses (e.g. M Med Fam)				It is difficult to se how single modules would be of value in isolation.

20. Outcomes-based Education					
In developing an education programme for the Post-graduate Programme in Mental Health, the following should be considered:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Evaluation procedures are consistent				
B	Evaluation procedures are interrelated				
C	Regular review of the course to eliminate ineffective sections				
D	Evaluation of the materials to eliminate ineffective materials				

E	Orientation from "What I (as a lecturer) must cover" is changed to "What a student should be able to do" as a consequence of instruction				
F	Self-evaluation by the students should be encouraged to ensure they know what is expected of them				With the caveat that the complexities of mental health care are not easily reduced to protocols and decision trees. Input from experienced tutors is needed to alert the candidates to aspects of the clinical scenario that they may not have thought of and may not have answered in the 'model answer'.
G	Efficient student learning is facilitated by providing direction				
H	Efficient student learning is facilitated by identifying instructional priorities.				Through the thorough identification of learning needs.
I	Demonstrations (of knowledge gained) must be of high quality e.g. chat room contributions				
J	Demonstrations must show evidence of significant learning				
K	A portfolio should form part of demonstrations of knowledge gained by each student				
L	The outcomes must be significant				Not sure what this means. **Significant = applicable to health care in a primary care setting**
M	The outcomes must be clear				
N	The outcomes must be concise.				
O	Demonstrations must occur in some 'own context' (performance setting).				As far as possible

21. Curriculum Planning, Development and Design					
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The curriculum development process should be sensitive to the academic setting of the project				
B	The curriculum develop-mental process should be sensitive to the capabilities of the students for whom the Programme is designed				
C	The curriculum develop-mental process should be sensitive to the interests of the students for whom the Programme is designed				
D	The curriculum should be sensitive to the priorities of the students for whom the Programme is designed				
E	The development of the Programme should require a detailed knowledge and appreciation of the discipline				
F	The development of the programme should require an understanding of the resources available to the faculty and educators involved				
G	The development of the Programme should require an understanding of the options available to the faculty and educators involved				
H	The Programme should have a rationale (or mission statement) to explain why the programme exists				
I	The overall programme aims must be clearly stated, in order to explain what the programme will achieve				

J	Outcome statements must be developed to indicate the knowledge, skills and attitudes learners are to acquire through the programme				
K	Content statements must be provided to indicate what areas of knowledge will comprise the student learning				
L	Teaching guidelines must be provided in order to indicate how long the learning activities will be organized				

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
A	There must be a demonstrable need for the programme				
B	The academic area must be stable in terms of the knowledge comprising the programme				
C	The academic area must be well defined in terms of the knowledge comprising the programme				
D	There must be clear potential for success of the programme.				
E	The department/institution providing the programme must have the necessary resources available				
F	Any social and political factors that may negatively impact the provision of the programme should be considered				
G	A needs assessment should be considered in terms of the programme objectives				

H	The aims/exit level outcomes of the curriculum should be stated.				
I	There should be a clear rationale and justification for the provision of the programme				
M	Assessment criteria and procedures must be clearly stated				
N	The context and community in which the Programme resides should be articulated				
O	The entry and admission criteria for the Programme must be adequately described				
P	The form of instruction should be appropriate to the learners' needs				
Q	The Programme should allow for individual differences in students				
R	The Programme should allow for individual differences in learning methods				
S	Provision must be made for adequate availability of student materials				
T	Provision must be made for adequate availability of student resources. e.g. computers				Students should be responsible for their own.
U	Provision must be made for adequate availability of student facilities				
V	There should be provision for pilot testing of the proposed Programme prior to final implementation				
W	Criteria must be available for evaluation of all aspects of the Programme for purposes of quality assurance				
X	Quality Assurance Processes should assess the Post-graduate Programme in Mental Health regularly				
Y	There must be evidence of significant groups (subject specialists) involved throughout the development of the proposed Programme curriculum				

23. Student Assessment					
In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The emphasis should be shifted away from the input or content aspect of Programmes toward the objective assessment of the performance of learners in terms of clearly stated outcomes				
B	The ultimate outcome (end point) for each and every person learning in a particular Programme should be equivalent and clearly stated				
C	The assessment must be objective and verifiable				
D	The responsibilities learners are expected to assume to monitor their own learning must be defined.				
E	The assessment criteria for each of the abilities/skills that have been developed should be defined				
F	An assessment taskforce is established, which will include an assessment expert				
G	There is the establishment of a systematic assessment Pro-gramme, which will aim to ensure uniformity of assessment across all subjects/modules				Depends what you mean by uniformity of assessment. Why should they be assessed the same way? An equivalence of standards maybe.
H	There is an integrated method of assessment covering all aspects of the learning Programme				Absolutely essential in a modularized format. Can the student 'put it all together'?

I	Standardised multi-modal methods of learner assessment should be used				
J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors				
K	The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected				
L	Moderation of learner assessment takes place to ensure that the required level, standard, appropriateness and fairness is observed.				
M	All forms of assessment are conducted by appropriately trained moderators with specific expertise in the learning area				Not necessarily. Generalists may be the best assessors, rather than subject specialists who know 'too much'. Moderators don't assess!

24. Formal Lectures					
		Essential	**Useful**	**Unnecessary**	Comments
A	There is a place for formal lectures as a means of content delivery to students				
B	The content of formal lectures should be geared to the practical needs of medical practitioners working in primary health settings				
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE)				
D	By using formal lectures, the lecturer can stimulate the learners'				

	interest to self-directed learning about the topic				
E	Formal lectures can be used to present the core content of the Programme				More of a formal academic discussion than a formal lecture.
F	Powerpoint presentations and video-clips should be used where appropriate to enhance the lecture				
G	Copies of hand-outs should be made available at a website for students to access after the lecture				
H	Copies of illustrations should be made available at a website for students to access after the lecture				
I	The content of the lecture should be available for students to access using Podcasting				
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture				
K	Formal lectures containing core knowledge on the topic need to be revised regularly				
L	Peer review on content of core knowledge is important				
M	Constructive feedback on the content of he lecture from students should be encouraged				

25. Small Group sessions					
Whether in the format of face-to-face interaction, or on-line distance 'chat rooms', small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Familiarise students with an adult approach to learning				
B	Encourage students to take responsibility for their own				

	learning				
C	Promote deeper understanding of the topic				
D	Encourage problem-solving skills				
E	Encourage participation (Some students may be based in remote areas with little contact with other doctors)				
F	Students should also be evaluated on the content of their contributions to small group interactions				Quite difficult to do systematically and objectively.
G	Each small group session should be facilitated by both a tutor and a co-tutor				
H	Syndicate groups (without a tutor and co-tutor) should be used				They don't really help students.

26. Patient Centred Learning					
As students will be frequently exposed to patients with mental illness, either in in-patient settings or out-patient wards (or in private practice), the use of ward-based teaching in the programme:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Should be considered where learners will be asked to link a certain psychiatric condition (under discussion), with a particular patient(s)				
B	Learners may be asked to detect specific symptomatology in certain patients and report to their tutor or group				
C	Learners may relate the effect of certain medications on a patient (efficacy or side-effects)				
D	Learners may have a platform in which to discuss problem patients with tutors and/or the group and so increase their knowledge of the topic				

E	Learners can be instructed to write up case-studies of certain common psychiatric conditions and include this work in their portfolios (which will be assessed at a later date)				
F	Each learner in the group will have an opportunity to present a patient (in their own practice) with specific complaints. This will serve as a learning exercise				Very necessary

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	In the 21st century ODL is….				Not everyone has access
B	ODL allows for greater interaction between tutor and learner				Not always
C	ODL meets the needs of non-traditional learners				
D	ODL allows learners to work at their own pace				Unfortunately it also allows students to do very little. **If students do not complete homework within given time frame, they will not be allowed to take part in chat room session.**
E	Administrators of the university/ Institution presenting the Programme need to be favourably inclined towards ODL				If ODL is used –all staff of the institution (including academic)must be favourably inclined

F	ODL calls for a change in academic and educational requirements (compared to presenting traditional curricula)				
G	The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility				
H	The rapid evolution of knowledge requires the staff facilitating the online module to have greater support from medical experts				
I	The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff				If all the staff members don't work together – ODL can't work.
J	Instructors need more allocated time to develop online courses				
K	Instructors need more allocated time to deliver online courses				
L	Additional technical staff are needed for ODL				Depending on the number of students. In the dept. or in the institution? **Both.**
M	Additional administrative staff are needed for ODL				Depending on the number of students.
N	Copyright laws and intellectual property rights should be adhered to				
O	Instructors should ensure the quality of ODL remains high				
P	Instructors should be taught how to manage possible obstacles they may encounter when teaching online				
Q	The software used to present the Post-graduate Programme in Mental Health should be of the same type as used by the UFS (in other Programmes)				If not, the programme will not go forward
R	A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken				
S	ODL courses should be revised				If you decide on ODL,

	regularly				this is essential
T	ODL courses should be updated when the software becomes obsolete				Should be updated every second year
U	Learner training and support (in computer matters) plays an integral part of the Programme				
V	Budget restraints and other financial matters relating to ODL should always be considered in planning to make the course financially viable				ODL ought to work out cheaper than normal lectures
X	A graphic designer should take responsibility for the layout of material on web pages				Use expertise available at University
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent)				
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms)				
AA	Students should be encouraged to make use of Mobile learning				
BB	Students should be encouraged to make use of blogs				

28. Any further comments on education methodology and modes of delivery.
ODL makes many assumptions about the capacity of the learners to engage both with the technology and with the educational process, let alone the content. My experience with the Stellenbosch MFamMed programme is that it has to be complemented by face-to-face meetings.

SECTION E. STUDENT EVALUATION
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one**

29. Student Assessment
During the two academic years students should be assessed in the following manner:

		Essential	Useful	Unnecessary	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online.				
B	Learners will have seven working days to return their "homework" online.				
C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic				Why exclude those who don't make 70%? They need all the help they can get. **> 70% hopefully ensures students have worked through their tutorials**.
D	If the tutorial is not successfully completed students will have three days to make corrections				Perhaps three working days?
E	Students will be assessed according to their contributions to the chat room sessions				Difficult but possible
F	The case-studies for each module will also be assessed				
G	Students who wish to exit the course after year one will have to pass an oral examination in order to receive a Short Learning Programme certificate				
H	The oral examination will consist of a case presentation (30 minutes) related to the subject material in modules 1-4				
I	The allocation of weightings for year one module marks is as follows: Tutorials (first attempt) 45%				

J	The allocation of weightings for year one module marks includes: case-studies = 45%				An acceptable format for case-studies will have to be specified.
K	The allocation for year 1 module marks includes chat room contributions = 10%				
L	The learner must have 50% or more to continue to the second academic year				50% seems rather low. If half the foundation material is mastered the usefulness of further teaching may be compromised
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				50% seems rather low to allow someone to claim to be qualified in mental health care to any degree
N	The weightings for the second academic year will be as follows: Tutorials (first attempt) 25%				
O	The weightings for the second academic year will include Case Studies = 25%				
P	The weightings for the second academic year will include chat room contributions = 10%				
Q	The weightings for the second academic year will include a research project = 40%				I'm not convinced that the research project forms an essential part of this course.
R	Learners who do not have an average mark of at least 50 % will not be allowed to attend the final oral examination				
S	The final oral examination (30 minutes) should take the form of a case presentation.				If this is a fresh case > 30 minutes is needed
T	Students obtaining 50% or more will be awarded a qualification				
U	Examiners of the oral examinations will be psychiatrists and psychologists (UFS staff)				Surely generalists should moderate the examinations? You are not training mini-specialists (I hope).

					Provided objectivity can be assured – an external moderator/ observer might be needed. Moderation essential.
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists				Not sure of the relevance of this. The College selects its own examiners. This raises other issues.

30. Any futher comments on student assessment in the programme
Students could bring in videoed consultations with patients, to be viewed with an examiner, so that the issues of context are diminished and the student can show their true colours in their own environments.

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX D:

FORMAT FOR DELPHI QUESTIONNAIRE – ROUND 2

2006/12/15

Dear Delphi Participant

Thank you for taking the effort to complete the first round of the study. I have taken note of the inputs made as comments, they are much appreciated.

The purpose of Round 2

This questionnaire is structured regarding the importance of the statements where consensus was not reached (having less than 80% agreement). This questionnaire contains numbered statements, provides opportunities for reconsideration and additional comments and suggestions. The questionnaire retains the format of Round One having 5 main categories each divided into subcategories.

Completing the Round 2 questionnaire

Your answers in Round One were analysed. All the statements where consensus was not reached must be answered again please, using the following scale:

1 = Essential (This criterion must definitely feature in the frame work)
2 = Useful (It does not matter if this criterion features in the framework or not)
3 = Unnecessary (This criterion should certainly not be included in the framework).

The responses of all the participants are collated in the second row of each statement. The figure represents the number of experts who chose that particular option. The asterisk denotes the answer you (personally) marked in Round One.

A1 **On completion of the PG Dip MH the student should have gained the following knowledge:**				Comment
The ability to classify the various common types of Psychopathology	1	2	3	
Round One	5	7 *	0	
Round Two				

Round Two allows you to reconsider your opinion (on each statement) in the light of the other experts' views. During this round you are at liberty to change your opinion and choose a different option. However, if you may stick to your original choice if you feel it is appropriate. Please indicate your choice in this round with an X for all the statements even if your opinion has not changed. Once again there is an opportunity to comment should you wish to do so. All the questions in each section must be answered. All information will be treated confidentially. Responses are given anonymously, (the identity of the respondents is not known to the other experts in the study) and will only be known by the researcher.

It should not take longer than 25 minutes to complete this questionnaire. Please return it at your earliest convenience.

Thank you once again for your participation.

Kind regards

Richard Nichol
Student Number 1988322341

27 Online Distance Learning
28 Any further comments on Education Methodology and Modes of delivery

Section E: STUDENT EVALUATION

29 Student Assessment in the Post-graduate Programme in Mental Health.
30 Any further Comments on Student Assessment.

QUESTIONNAIRE FOR DELPHI PANEL, ROUND THREE

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We live in a world with rapidly changing technology and new approaches to education. As a majority of the experts on the panel were trained in the "old school" approach I have taken the liberty of including a list of contemporary (and less contemporary definitions) which may be of value to you.

DEFINITIONS:

Blogs (or web logs):
Personal sites to keep in touch with family or friends (O'Leary & O'Leary 2006:104).

Chatroom (chat groups):
An online discussion group that allows direct 'live' communication (O'Leary & O'Leary 2006: 477).

Distance education:
All arrangements for providing instruction through print or electronic communications media to persons engaged in planned learning in a place or time different from that of the instructor(s) (Moore in Maguire 2005:pg 1 of 3).

E-learning (Electronic learning):
Education via the Internet, network, or standalone computer. Network enabled transfer of skills and knowledge. E-learning applications and processes include Web-based learning, computer based learning, virtual

classrooms as well as digital collaboration. Content is delivered via the Internet, intra/extranet, audio or video tape, satellite TV and CD-ROM (Google 2004:p1 of 1).

M-learning (Mobile learning):
The use of hand-held computers (incorporated into cell-phones) for 'anytime, anywhere' access to learning resources (Powernell & Bailey 2000:3).

Nosology
The programme of describing and taxonomising mental disorders (Porter 2002:213).

Outcome-based Education (OBE):
An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused (Betts & Smith 1998:52).

Online Distance Learning (ODL):
Online teaching using the Internet and the World Wide Web (www) (Harden 1998: 190).

Podcasting:
Learners are able to download lectures or information onto their iPods or any other MP3 players (and listen to these presentations when it suits the learner) (Baird 2006:1).

SECTION A CRUCIAL LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH the student should have gained the following knowledge:

		Essential	**Useful**	**Unnecessary**	Comments
B	Current theories on the known etiology of mental conditions. Round 1	1 8	2 3	3 1	
	Round 2				
C	Current theories on the patho-physiology of common mental conditions Round 1	7	3	2	
	Round 2				
F	An appreciation of the effect of the patients' cultural environment on their conditions Round 1	9	3	0	
	Round 2				
H	Know the interpersonal dynamics involved in a multidisciplinary health team approach. Round 1	8	4	0	
	Round 2				

K	Current theories relating to the prevention of psychopathology (in people) Round 1	6	6	0	
	Round 2				
L	Cost effective utilisation of special investigations in Psychiatry. Round 1	9	3	0	
	Round 2				
M	Appropriate utilisation of new technology in Psychiatry. Round 1	4	8	0	
	Round 2				
O	Knowledge of effective counselling skills. Round 1	9	3	0	
	Round 2				

2. On completion of the PGDipMH the student should have gained the following skills:

		Essential	**Useful**	**Unnecessary**	Comments
F	Be able to demonstrate cultural sensitivity to all patients Round 1	1 9	2 3	3 0	
	Round 2				
I	Be able to communicate using basic computer skills Round 1	5	7	0	
	Round 2				

3. On completion of the PGDipMH the student should have adhered to the following values:					
		Essential	**Useful**	**Unnecessary**	Comments
		1	2	3	
G	A positive approach to self-directed life-long learning Round 1	9	3	0	
	Round 2				
H	A willingness to participate in self-evaluation. Round 1	8	4	0	
	Round 2				
I	A willingness to participate in peer evaluation. Round 1	8	4	0	
	Round 2				
J	A positive attitude with regard to continuing professional develop-ment. Round 1	8	4	0	
	Round 2				

4. Any additional comments on crucial exit level outcomes (knowledge, skills and values)

SECTION B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES
This section deals with the basic lay out and content of the programme. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary

5. The following should be considered for the **format of the programme content of the modules:**

		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period. Round 1	7	4	1	
	Round 2				
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200) Round 1	6	6	0	
	Round 2				
C	The second academic year should contain three modules (Notional hours = 600) Round 1	6	6	0	
	Round 2				
D	The second academic year should contain a research project Round 1	1	5	6	
	Round 2				

E	Students should be required to pass the first academic year before proceeding to the second academic year Round 1	9	2	1	
	Round 2				
F	Students who do not wish to enrol for the second academic year, but who have successfully passed the first year, should receive a certificate. Round 1	5	6	1	
	Round 2				
G	The second academic year should contain **SIX** modules, from which learners are required to choose **THREE** modules. Round 1	2	7	3	
	Round 2				
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year.(Students may begin this project in the first academic year) Round 1	3	5	4	
	Round 2				
I	Students will be assessed using tutorials and worksheets Round 1	9	3	0	
	Round 2				
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion) Round 1	7	5	0	

	Round 2				
K	Students will also be evaluated according to their contribution to the chat room discussion Round 1	7	5	0	
	Round 2				
L	There should be a restriction on the number of students who are allowed to enrol for each academic year Round 1	6	3	3	
	Round 2				
M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme Round 1	7	2	3	
	Round 2				
N	Learners should be encouraged to present appropriate case studies in their wards/practice when leading chat room sessions Round 1	9	3	0	
	Round 2				
O	The academic standard of subject material used in the Programme should be closer to Mmed(Psych) level than final year M.B.,Ch.B. level Round 1	6	3	3	
	Round 2				
Q	Where applicable, teaching should be directed towards rural, primary care settings Round 1	9	3	0	
	Round 2				

6. Any additional comments on the format of the Programme

SECTION C. CONTENTS OF THE PROGRAMME
This section deals with the basic layout and content of the Programme of the first academic year. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

7. The content of the Module 1: Introduction to Psychiatry. The content of the module will include:					
		Essential	**Useful**	**Unnecessary**	Comments
A	This module should take the form of face-to-face contact sessions where students are required to be present at the UFS for two working days. Round 1	9	3	0	
	Round 2				
B	Basic neuro-anatomy will be discussed using anatomic models Round 1	8	3	1	
	Round 2				
C	Basic neurophysiology will also be presented and discussed. Round 1	8	4	0	
	Round 2				

D	The basic common psychiatric evaluation will be demonstrated and discussed in a tertiary setting Round 1	9	2	1	
	Round 2				
E	Four case-studies using patients with common chronic psychiatric conditions will be presented by the academic staff. Round 1	7	5	0	
	Round 2				
G	Discussion in case studies will include neuropathology of the conditions under discussion. Round 1	7	4	1	
	Round 2				
J	Students will be given a written clinical case report with specific questions relating to the case. Answers have to be e-mailed to the Department within 7 working days. Round 1	7	5	0	
	Round 2				

8.Content of Module 2: Chronic Psychiatric Conditions – (part 1)					
This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:					
		Essential	**Useful**	**Unnecessary**	Comments

A	The basic known neuron-pathology of schizophrenia. Round 1	8	4	0	
	Round 2				
B	The sub-types of schizophrenia. Round 1	8	4	0	
	Round 2				
C	The history of nosology of schizophrenia. Round 1	6	4	2	
	Round 2				
I	How to diagnose and treat schizo-affective disorder. Round 1	8	3	1	
	Round 2				
M	How to recognise "Group A" Personality Disorders: Paranoid, Schizoid and Schizotypal Personality Disorders Round 1	9	2	1	
	Round 2				

Content Of Module Three. Common Psychiatric Conditions (part 2)					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part 2) – MOOD DISORDERS.** On completing the module the learner should know how to:					
		Essential	**Useful**	**Unnecessary**	Comments
B	Treat the conditions mentioned in 9A Round 1	9	2	1	
	Round 2				
E	Differentiate the phases of grief Round 1	9	3	0	

	Round 2				
H	Apply the principles of Cognitive Behaviour Therapy Round 1	7	5	0	
	Round 2				

10. Content Of Module 4					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part three – ANXIETY DISORDERS.** On completion of the module the learner should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
H	Have a working knowledge of **non-pharmacological treatment** of anxiety disorders. Round 1	9	3	0	
	Round 2				
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds.** Round 1	8	2	2	
	Round 2				
K	How to recognize Avoidant, Dependent, and Obsessive Personality Disorders. Round 1	8	4	0	
	Round 2				

11. The Second Academic Year and Module 5

The programme in year two will contain six modules. Students will have the option of selecting three modules.
Module 5 = Child Psychiatry part 1
Module 6 = Child Psychiatry part 2
(only for learners who have completed module 5).

Module 7 = Addiction Disorders
Module 8 = Forensic Psychiatry
Module 9 = Geriatric Psychiatry
Module 10 = Introduction to Psychotherapy.

Students will also be required to complete a research project.
On completion of **Module 5 (CHILD PSYCHIATRY- part 1)** the learner should:

		Essential	**Useful**	**Unnecessary**	Comments
A	Have an understanding of **normal development in humans** (Neuro-developmental and behavioural changes from conception to adulthood. Round 1	8	3	1	
	Round 2				
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism). Round 1	8	4	0	
	Round 2				
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis) Round 1	7	4	1	
	Round 2				

13. Module 7 – Forensic Psychiatry

Learners who complete this module should be able to:

		Essential	**Useful**	**Unnecessary**	Comments

B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)** Round 1	5	6	1	
	Round 2				
C	Understand the **Law on Sterilization** Round 1	7	5	0	
	Round 2				
E	Be able to advise families regarding legal issues i.e. if and when patients are no longer able to manage their own affairs. Round 1	8	4	0	
	Round 2				
F	Know how **intoxication with substances affects criminal responsibility** Round 1	8	3	1	
	Round 2				
G	Know how to recognize Anti-social and Borderline Personality Disorders Round 1	8	3	1	
	Round 2				

14. Module 8 – Addiction Disorders					
Learners completing this module Should:					
		Essential	**Useful**	**Unnecessary**	Comments
G	Be able to explain how substances affect **criminal accountability** Round 1	8	3	1	
	Round 2				

15. Module 9 – Geriatric Psychiatry					
After completing this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **psycho-pathology of the aging brain** Round 1	8	4	0	
	Round 2				
E	Know how to mange the process of having a patient placed under curatorship (legal implications Round 1	7	5	0	
	Round 2				

16. Module 10 – Introduction To Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT).** Round 1	7	3	2	
	Round 2				
B	Be able to understand the principles of CBT. Round 1	8	4	0	
	Round 2				

17. Module 11 – The Research Project					
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	A research project forms part of the Post-graduate Programme in Mental Health Round 1	4	3	5	
	Round 2				
B	A tutor will be available to assist the learner. Round 1	8	1	3	
	Round 2				
C	Learners will also be able to make use of a biostatistician. Round 1	6	3	3	
	Round 2				
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS. Round 1	7	2	3	
	Round 2				
E	Results of the Research should be published in an **accredited Medical Journal.** Round 1	2	5	5	
	Round 2				
F	If the research project is not completed the learner will not be awarded the qualification. Round 1	3	1	8	
	Round 2				

18. Any additional comments on the contents of the programme

SECTION D. EDUCATION METHODOLOGY AND MODES OF DELIVERY					
This section deals with methodology and modes of delivery of the Programme. **Please indicate how important each of the following statements is** **according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**					
19. Policies and Procedures for Programme Approval					
In the **development** of an educational programme in mental health:					
		Essential	**Useful**	**Unnecessary**	Comments
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework level 8 (master's degree level) Round 1	3	2	7	
	Round 2				
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health. Round 1	4	6	2	
	Round 2				

F	The Post-graduate Programme in Mental Health should be offered as an informal short course Programme. Round 1	3	5	4	
	Round 2				
G	The Post-graduate Programme in Mental Health should contain modules which may serve as credit bearing short courses. Round 1	6	5	1	
	Round 2				
H	The post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes. Round 1	6	6	0	
	Round 2				
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses (e.g. M Med Fam). Round 1	3	8	1	
	Round 2				

20. Outcomes-based Education					
In developing an education Programme for the Post-graduate Programme in Mental Health, the following should be considered:					
		Essential	**Useful**	**Unnecessary**	Comments
B	Evaluation procedures are interrelated. Round 1	8	4	0	

	Round 2				
K	A portfolio should form part of demonstrations of knowledge gained by each student Round 1	8	3	1	
	Round 2				
L	The outcomes must be significant Round 1	9	3	0	
	Round 2				
O	Demonstrations must occur in some 'own context' (performance setting) Round 1	8	3	1	
	Round 2				

21. Curriculum Planning, Development and Design					
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The curriculum development process should be sensitive to the academic setting of the project Round 1	8	4	0	
	Round 2				
B	The curriculum developmental process should be sensitive to the capabilities of the students for whom the Programme is designed Round 1	9	2	1	
	Round 2				

C	The curriculum developmental process should be sensitive to the interests of the students for whom the Programme is designed Round 1	9	3	0	
	Round 2				
D	The curriculum should be sensitive to the priorities of the students for whom the Programme is designed Round 1	9	3	0	
	Round 2				

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational Programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
B	The academic area must be stable in terms of the knowledge comprising the programme. Round 1	8	2	2	
	Round 2				
N	The context and community in which the programme resides should be articulated. Round 1	9	2	1	
	Round 2				
Q	The programme should allow for individual differences in students. Round 1	6	6	0	
	Round 2				
R	The programme should allow for individual differences in learning methods. Round 1	7	5	0	

	Round 2				
S	Provision must be made for adequate availability of student materials. Round 1	9	3	0	
	Round 2				
V	There should be provision for pilot testing of the proposed programme prior to final implementation. Round 1	7	5	0	
	Round 2				
W	Criteria must be available for evaluation of all aspects of the programme for purposes of quality assurance Round 1	9	3	0	
	Round 2				

23. Student Assessment					
In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The emphasis should be shifted away from the input or content aspect of programmes toward the objective assessment of the performance of learners in terms of clearly stated outcomes Round 1	9	2	1	
	Round 2				
B	The ultimate outcome (end point) for each and every person learning in a particular programme should be equivalent and clearly				

	stated. Round 1	8	3	1	
	Round 2				
C	The assessment must be objective and verifiable. Round 1	9	3	0	
	Round 2				
F	An assessment taskforce is established, which will include an assessment expert. Round 1	9	3	0	
	Round 2				
G	There is the establishment of a systematic assessment Programme, which will aim to ensure uniformity of assessment across all subjects/modules. Round 1	8	4	0	
	Round 2				
H	There is an integrated method of assessment covering all aspects of the learning Programme. Round 1	9	3	0	
	Round 2				
J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors. Round 1	7	4	1	
	Round 2				
K	The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected. Round 1	9	3	0	
	Round 2				

24. Formal Lectures					
		Essential	Useful	Unnecessary	Comments
A	There is a place for formal lectures as a means of content delivery to students. Round 1	6	6	0	
	Round 2				
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE). Round 1	7	5	0	
	Round 2				
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic. Round 1	6	6	0	
	Round 2				
E	Formal lectures can be used to present the core content of the Programme. Round 1	8	4	0	
	Round 2				
G	Copies of hand-outs should be made available at a website for students to access after the lecture. Round 1	8	4	0	
	Round 2				
H	Copies of illustrations should be made available at a website for students to access after the lecture. Round 1	7	5	0	

	Round 2				
I	The content of the lecture should be available for students to access using Podcasting. Round 1	7	5	0	
	Round 2				
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture. Round 1	7	5	0	
	Round 2				

25. Small Group Sessions					
Whether in the format of face-to-face interaction, or online distance 'chat rooms', small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Familiarise students with an adult approach to learning Round 1	9	3	0	
	Round 2				
D	Encourage problem solving skills Round 1	9	3	0	
	Round 2				
F	Students should also be evaluated on the content of their contributions to small group interactions Round 1	7	5	0	
	Round 2				
G	Each small group session should be facilitated by both a tutor and a co-tutor Round 1	5	4	0	

	Round 2				
H	Syndicate groups (without a tutor and co-tutor) should be used Round 1	5	5	2	
	Round 2				

26. Patient-centred Learning					
As students will be frequently exposed to patients with mental illness, either in in-patient settings or out-patient wards (or in private practice), the use of ward-based teaching in the Programme:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Should be considered, where learners will be asked to link a certain psychiatric condition (under discussion), with a particular patient(s). Round 1	8	4	0	
	Round 2				
B	Learners may be asked to detect specific symptomatology in certain patients and report to their tutor or group. Round 1	7	5	0	
	Round 2				
C	Learners may relate the effect of certain medications on a patient (efficacy or side-effects) Round 1	9	3	0	
	Round 2				
E	Learners can be instructed to write up case-studies of certain common psychiatric conditions and include this work in their portfolios (which will be assessed at a later date).				

	Round 1	9	3	0	
	Round 2				

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	In the 21st century ODL is…. Round 1	8	4	0	
	Round 2				
B	ODL allows for greater interaction between tutor and learner Round 1	6	6	0	
	Round 2				
C	ODL meets the needs of non-traditional learners Round 1	7	4	1	
	Round 2				
D	ODL allows learners to work at their own pace Round 1	6	6	0	
	Round 2				
F	ODL calls for a change in academic and educational requirements (compared to presenting traditional curricula) Round 1	8	3	1	
	Round 2				
G	The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility Round 1	8	4	0	
	Round 2				

I	The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff Round 1	9	3	0	
	Round 2				
J	Instructors need more allocated time to develop online courses Round 1	9	3	0	
	Round 2				
K	Instructors need more allocated time to deliver online courses Round 1	7	4	1	
	Round 2				
L	Additional technical staff are needed for ODL Round 1	8	4	0	
	Round 2				
M	Additional administrative staff are needed for ODL Round 1	6	5	1	
	Round 2				
Q	The software used to present the Post-graduate Programme in Mental Health should be of the same type as used by the UFS (in other programmes) Round 1	7	5	0	
	Round 2				
R	A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken Round 1	8	4	0	
	Round 2				
S	ODL courses should be revised regularly.				

	Round 1	9	3	0	
	Round 2				
U	Learner training and support (in computer matters) plays an integral part of the Programme Round 1	9	3	0	
	Round 2				
X	A graphic designer should take responsibility for the layout of material on web pages Round 1	5	7	0	
	Round 2				
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent) Round 1	5	7	0	
	Round 2				
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms) Round 1	5	7	0	
	Round 2				
AA	Students should be encouraged to make use of Mobile learning Round 1	4	8	0	
	Round 2				
BB	Students should be encouraged to make use of blogs Round 1	4	8	0	
	Round 2				

Any further comments on education methodology and modes of delivery

SECTION E. STUDENT EVALUATION
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one.**

29. Student Assessment					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online Round 1	6	6	0	
	Round 2				
B	Learners will have seven working days to return their "homework" online Round 1	6	6	0	
	Round 2				
C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic Round 1	5	5	2	
	Round 2				
D	If the tutorial is not successfully completed students will have three days to make corrections Round 1	4	8	0	
	Round 2				

E	Students will be assessed according to their contributions to the chat room sessions Round 1	6	5	1	
	Round 2				
G	Students who wish to exit the course after year one will have to pass an oral examination in order to receive a Short Learning Programme certificate Round 1	9	2	1	
	Round 2				
H	The oral examination will consist of a case presentation (30 minutes) related to the subject material in modules 1-4 Round 1	9	2	1	
	Round 2				
I	The allocation of weightings for Year One module marks is as follows: Tutorials (First attempt) 45% Round 1	4	8	0	
	Round 2				
J	The allocation of weightings for year one module marks includes: Case studies = 45% Round 1	4	8	0	
	Round 2				
K	The allocation for year one module marks includes Chat room contributions = 10% Round 1	3	8	1	
	Round 2				
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				

	Round 1	8	3	1	
	Round 2				
N	The weightings for the second academic year will be as follows: Tutorials (first attempt) 25% Round 1	3	8	1	
	Round 2				
O	The weightings for the second academic year will include case-studies = 25% Round 1	3	8	1	
	Round 2				
P	The weightings for the second academic year will include chat room contributions = 10% Round 1	3	9	0	
	Round 2				
Q	The weightings for the second academic year will include a Research project = 40% Round 1	4	3	5	
	Round 2				
U	Examiners of the oral examinations will be psychiatrists and psychologists (UFS staff) Round 1	8	3	1	
	Round 2				
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists. Round 1	6	4	2	
	Round 2				

30. Any futher comments on student assessment in the programme

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX E:

FORMAT FOR DELPHI QUESTIONNAIRE FEED BACK ROUND 2

A FRAMEWORK FOR THE DEVELOPMENT OF A POST-GRADUATE DIPLOMA IN MENTAL HEALTH

2007'03/01

Dear Delphi participant

Thank you for your participation in the Rounds One and Two of the study.

According to Larson and Wissman (2000: 45) consensus is reached when 80% of the participants indicate the same value(to a specific item), on a 3 point Lickert scale as their choice. In Round One of this Delphi process containing 290 statements, consensus was reached in 48% of the statements, while consensus was increased to 69 % of the statements after Round Two- see attached copy of the results. I have shaded all the questions where consensus was reached in Round Two. I have also included comments made in this round. This feedback is sent to you with the sole purpose of providing you with information regarding the second round of the Delphi process. YOU DO NOT NEED TO DO ANYTHING WITH IT.

Thus there are only 76 statements left for your consideration in Round Three. Hopefully this will be the final round. This new questionnaire will reach you soon. It will not contain all the statements where in which consensus has been reached. It will therefore be a much shorter questionnaire.

Kind regards

R.J.NICHOL

Larson, E. & Wissman, J. 2000. Critical academic skills for Kansas Community College graduates: A Delphi study. *Community College review* 28(2) 43- 56.

Section A: CRUCIAL EXIT LEVEL OUTCOMES

1 Student Knowledge
2 Student Skills
3 Student Values
4 Any further comments on Crucial Exit Level Outcomes

Section B: FORMAT OF THE PROGRAMME

5 Format of the Programme
6 Any further Comments on Format of the Programme

Section C: CONTENTS OF THE PROGRAMME

THE FIRST ACADEMIC YEAR

7 The Content of Module 1: INTRODUCTION TO PSYCHIATRY
8 The Content of Module 2: COMMON PSYCHIATRIC CONDITIONS (part 1)
9 The Content of Module 3: COMMON PSYCHIATRIC CONDITIONS (part 2)
10 The Content of module 4: COMMON PSYCHIATRIC CONDITIONS (part 3)

THE SECOND ACADEMIC YEAR

11 The Content of Module 5: Child Psychiatry (part 1)
12 The Content of Module 6: Child psychiatry (part 2)
13 The Content of Module 7: Addiction Disorders
14 The Content of Module 8: Forensic Psychiatry
15 The Content of module 9: Geriatric Psychiatry
16 The Content of Module 10: Introduction to Psychotherapy
17 The Research Project
18 Any further Comments on Content of the Programme

Section D: EDUCATION METHODOLOGY AND MODES OF DELIVERY

19 Policies and Procedures for Programme Approval
20 Outcomes Based Education
21 Curriculum Planning, Development and Design
22 Implementing and Evaluating the Curriculum
23 Student assessment
24 Formal lectures
25 Small Group Sessions
26 Patient Centred Learning
27 Online Distance Learning
28 Any further comments on Education Methodology and Modes of delivery

Section E: STUDENT EVALUATION

29 Student Assessment in the Post-graduate Programme in Mental Health.
30 Any further Comments on Student Assessment.

QUESTIONNAIRE FOR DELPHI PANEL, ROUND two

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DEFINITIONS:

Blogs (or web logs):
Personal sites to keep in touch with family or friends (O'Leary & O'Leary 2006:104).

Chatroom (chat groups):
An online discussion group that allows direct 'live' communication (O'Leary & O'Leary 2006: 477).

Distance education:
All arrangements for providing instruction through print or electronic communications media to persons engaged in planned learning in a place or time different from that of the instructor(s) (Moore in Maguire 2005:pg 1 of 3).

E-learning (Electronic learning):
Education via the Internet, network, or standalone computer. Network enabled transfer of skills and knowledge. E-learning applications and processes include Web-based learning, computer based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intra/extranet, audio or video tape, satellite TV and CD-ROM (Google 2004:p1 of 1).

M-learning (Mobile learning):
The use of hand-held computers (incorporated into cell-phones) for 'anytime, anywhere' access to learning resources (Powernell & Bailey 2000:3).

Nosology
The programme of describing and taxonomising mental disorders (Porter 2002:213).

Outcome-based Education (OBE):
An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused (Betts & Smith 1998:52).

Online Distance Learning (ODL):
Online teaching using the Internet and the World Wide Web (www) (Harden 1998: 190).

Podcasting:
Learners are able to download lectures or information onto their iPods or any other MP3 players (and listen to these presentations when it suits the learner) (Baird 2006:1).

SECTION A CRUCIAL LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH. The student should have gained the following knowledge:

		Essential	Useful	Unnecessary	Comments
B	Current theories on the known etiology of mental conditions				
C	Current theories on the pathophysiology of common mental conditions				
F	An appreciation of the effects of the patient's cultural environment on their conditions				
H	Know the interpersonal dynamics involved in a multidisciplinary health team approach				
K	Current theories relating to the prevention of psychopathology (in people)				
L	Cost-effective utilisation of special investigations in Psychiatry				
M	Appropriate utilisation of new technology in Psychiatry				
O	Knowledge of effective ☐enrolling skills				

2. On completion of the **PGDipMH, the student** should have gained the following **skills:**					
		Essential	**Useful**	**Unnecessary**	Comments
F	Be able to demonstrate cultural sensitivity to all patients				
I	Be able to communicate using basic computer skills				Can't do online training with no computer skills.

3. On completion of the **PGDipMH, the student** should have adhered to the following **values:**					
		Essential	**Useful**	**Unnecessary**	Comments
G	A positive approach to self-directed life-long learning				
H	A willingness to participate in self-evaluation				
I	A willingness to participate in peer evaluation.				
J	A positive attitude with regard to continuing professional development.				

4. Any additional comments on crucial exit level outcomes (knowledge, skills and values)

SECTION B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES					
This section deals with the basic lay out and content of the programme. **Please indicate how important each of the following statements is according to the following scale:** 1 = essential 2 = Useful 3 = Unnecessary					
5. The following should be considered for the **format of the programme content of the modules:**					
		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period				
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200)				
C	The second academic year should contain two modules (Notional hours = 600)				
D	The second academic year should contain a research project				
E	Students should be required to pass the first academic year before proceeding to the second academic year				
F	Students who do not wish to ☐nrol for the second academic year, but who have successfully passed the first year, should receive a certificate				
G	The second academic year should contain **SIX** modules, from which learners are required to choose **THREE** modules				Still feel there should be compulsory broad coverage
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year.(Students may begin this				

	project in the first academic year)				
I	Students will be assessed using tutorials and worksheets				
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion)				
K	Students will also be evaluated according to their contribution to the chat room discussion				
L	There should be a restriction on the number of students who are allowed to enrol for each academic year				
M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme				What about doctors from other countries. **As long as they are registered with the SAHPC and have Internet access.**
N	Learners should be encouraged to present appropriate case studies in their wards/practice when leading chat room sessions				
O	The academic standard of subject material used in the programme should be closer to Mmed(Psych) level than final year M.B.,Ch.B. level				I worry that if the standard set is too high there will be no takers since there is basically no incentive in advantage to candi-dates. Half way between the two.
P	Where possible, teaching should be directed towards practical situations in wards/practice (rather than philosophical theories)				
Q	Where applicable, teaching should be directed towards rural, primary care settings				

R	Where applicable cultural phenomena should also be discussed				

6. Any additional comments on the format of the programme

SECTION C. CONTENTS OF THE PROGRAMME					
This section deals with the basic layout and content of the programme of the first academic year. **Please indicate how important each of the following statements is according to the following scale:** 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**					
7. THE CONTENT OF THE MODULE 1: Introduction to Psychiatry. The content of the module will include:					
		Essential	**Useful**	**Unnecessary**	Comments
A	This module should take the form of face-to-face contact sessions where students are required to be present at the UFS for two working days				
B	Basic neuro-anatomy will be discussed using anatomic models				
C	Basic neurophysiology will also be presented and discussed				
D	The basic common psychiatric evaluation will be demonstrated and discussed in a tertiary setting				It can also be in a PHC setting. **Training geared for PHC setting.**
E	Four case studies using patients with common chronic psychiatric conditions will be presented by the academic staff				

G	Discussion in case studies will include neuropathology of the conditions under discussion				
J	Students will be given a written clinical case report with specific questions relating to the case. Answers have to be e-mailed to the Department within 7 working days				

8. Content of Module 2: Chronic Psychiatric conditions – (part 1)					
This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The basic known neuron-pathology of schizophrenia				
B	The sub-types of schizophrenia				
C	The history of nosology of schizophrenia				
I	How to diagnose and treat schizo-affective disorder				
M	How to recognise "Group A" Personality Disorders: Paranoid, Schizoid and Schizotypal Personality Disorders)				

9. Content Of Module 3: Common Psychiatric conditions – (part 2)
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part 2) – MOOD DISORDERS.** On completing the module the learner should know how to:

		Essential	Useful	Unnecessary	Comments
B	Treat the conditions mentioned in 9A (Bipolar and depressive disorders)				Still think specialist opinion should be sought; has become a 'popular' diagnosis
C	Manage complications of treatment				
D	Recognise patients at risk of committing suicide				
E	Differentiate the phases of grief				
H	Apply the principles of Cognitive Behaviour Therapy				

10. Content of Module 4					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part three – ANXIETY DISORDERS.** On completion of the module the learner should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
H	Have a working knowledge of **non-pharmacological treatment** of anxiety disorders				
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds**				There has been widespread abuse in this area; to protect those who are truly disabled, specialist opinion is required. **I agree. PHC doctors can 'sift', to ensure deserving patients are referred.**
K	How to recognize Avoidant Dependent, and Obsessive Personality Disorders				

11.The Second Academic Year and Module 5

The programme in year two will contain six modules. Students will have the option of selecting three modules.
Module 5 = Child Psychiatry part 1
Module 6 = Child Psychiatry part 2
(only for learners who have completed module 5).
Module 7 = Addiction Disorders
Module 8 = Forensic Psychiatry
Module 9 = Geriatric Psychiatry
Module 10 = Introduction to Psychotherapy.

Students will also be required to complete a research project.
On completion of **Module 5 (CHILD PSYCHIATRY- part 1)** the learner should:

		Essential	**Useful**	**Unnecessary**	Comments
A	Have an understanding of **normal development in humans** (Neuro- developmental and behavioural changes from conception to adulthood				
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism)				
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis)				Must know to refer encopresis for specialist assessment/ management. **I agree.**

13. Module 7 – Forensic Psychiatry

Learners who complete this module should be able to:

		Essential	**Useful**	**Unnecessary**	Comments

A	Understand **the rights of patients** and the **New Mental Health Care Act**				
B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)**				
C	Understand the **Law on Sterilization**				
E	Be able to advise families regarding legal issues i.e. if and when patients are no longer able to manage their own affairs				
F	Know how **intoxication with substances affects criminal responsibility**				Should have a basic knowledge but final recommendations to court should be made by a specialist. **I agree**
G	Know how to recognize Anti-social and Borderline Personality Disorders				Still concerned about inappropriate diagnosis, labelling and stigma.

14. Module 8 - Addiction Disorders					
Learners completing this module Should:					
		Essential	**Useful**	**Unnecessary**	Comments
G	Be able to explain how substances affect **criminal accountability**				Final decision should be made by specialist – only basic knowledge should be required.

15. Module 9 – Geriatric Psychiatry					
After completing this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments

A	Understand the **psycho-pathology of the aging brain**				
E	Know how to manage the process of having a patient placed under curatorship (legal implications)				

16. Module 10 – Introduction to Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)**				
B	Be able to understand the principles of CBT				

17. Module 11 - The Research Project					
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	The research project forms an integral part of the Post-graduate Programme in Mental Health				Research should be a requirement for a degree only, not for a diploma.
B	A tutor will be available to assist the learner				If the module is included. If research is required
C	Learners will also be able to make use of a biostatistician				Essential if research is a requirement
D	Learners will have to have protocols for their research projects passed by the Ethics				

	Committee of the UFS				
E	Results of the Research should be published in an **accredited Medical Journal**				
F	If the research project is not completed the learner will not be awarded the qualification				

18. Any additional comments on the contents of the programme

I do not think a research project is necessary at this stage.

SECTION D.

EDUCATION METHODOLOGY AND MODES OF DELIVERY

This section deals with methodology and modes of delivery of the programme.
Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

19. Policies and Procedures for Programme approval

In the **development** of an educational Programme in Mental Health:

		Essential	**Useful**	**Unnecessary**	Comments
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework level 8 (masters degree level)				
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health.				Only restricted grants

F	The Post-graduate Programme in Mental Health should be offered as an informal short course programme				Provided basic modules precede more advanced ones
G	The Post-graduate Programme in Mental Health should contain modules which may serve as credit bearing short courses				
H	The Post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes				
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses(e.g. M Med Fam)				

20. Outcomes-based Education					
In developing an education programme for the Post-graduate Programme in Mental Health, the following should be considered:					
		Essential	**Useful**	**Unnecessary**	Comments
B	Evaluation procedures are interrelated				
K	A portfolio should form part of demonstrations of knowledge gained by each student				
L	The outcomes must be significant				
O	Demonstrations must occur in some 'own context' (performance setting)				

21. Curriculum Planning, Development and Design
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:

		Essential	**Useful**	**Unnecessary**	Comments
A	The curriculum development process should be sensitive to the academic setting of the project				
B	The curriculum developmental process should be sensitive to the capabilities of the students for whom the programme is designed				Hesitant about this because it could lead to compromise of standards
C	The curriculum developmental process should be sensitive to the interests of the students for whom the programme is designed				
D	The curriculum should be sensitive to the priorities of the students for whom the programme is designed				Still can't move away from basic requirements

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
B	The academic area must be stable in terms of the knowledge comprising the programme				
N	The context and community in which the programme resides should be articulated				
Q	The programme should allow for individual differences in students				
R	The programme should allow for individual differences in learning methods				
S	Provision must be made for adequate availability of student materials				

V	There should be provision for pilot testing of the proposed programme prior to final implementation				
W	Criteria must be evaluation of all aspects of the programme for purposes of quality assurance available for				

23. Student Assessment

In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:

		Essential	**Useful**	**Unnecessary**	Comments
A	The emphasis should be shifted away from the input or content aspect of programmes toward the objective assessment of the performance of learners in terms of clearly stated outcomes				
B	The ultimate outcome (end point) for each and every person learning in a particular programme should be equivalent and clearly stated				
C	The assessment must be objective and verifiable				
F	An assessment taskforce is established, which will include an assessment expert				
G	There is the establishment of a systematic assessment programme, which will aim to ensure uniformity of assessment across all subjects/modules				
H	There is an integrated method of assessment covering all aspects of the learning programme				
J	Assessors have received formal training in assessment metho-dology in terms of SAQA				

	requirements for assessors				
K	The flow of assessment information, lines of communication and promotion and exclusion process of students are reflected				

24. Formal Lectures					
		Essential	**Useful**	**Unnecessary**	Comments
A	There is a place for formal lectures as a means of content delivery to students				
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE).				
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic				
E	Formal lectures can be used to present the core content of the programme				
G	Copies of hand-outs should be made available at a website for students to access after the lecture				
H	Copies of illustrations should be made available at a website for students to access after the lecture				Conditional on confidentiality and copyright issues
I	The content of the lecture should be available for students to access using Podcasting				
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture				See 24 H

25. Small Group Sessions
Whether in the format of face-to-face interaction, or on-line distance 'chat rooms', small groups can be important to:

		Essential	Useful	Unnecessary	Comments
A	Familiarise students with an adult approach to learning				
D	Encourage problem-solving skills				
F	Students should also be evaluated on the content of their contributions to small group interactions				
G	Each small group session should be facilitated by both a tutor and a co-tutor				If you have enough staff
H	Syndicate groups (without a tutor and co-tutor) should be used				

26. Patient-Centred Learning

As students will be frequently exposed to patients with mental illness, either in in-patient settings or out-patient wards (or in private practice), the use of ward-based teaching in the programme:

		Essential	Useful	Unnecessary	Comments
A	Should be considered where learners will be asked to link a certain psychiatric condition (under discussion), with a particular patient(s)				
B	Learners may be asked to detect specific symptomatology in certain patients and report to their tutor or group				
C	Learners may relate the effect of certain medications on a patient (efficacy or side-effects)				
E	Learners can be instructed to write up case-studies of certain common psychiatric conditions				

	and include this work in their portfolios (which will be assessed at a later date).				

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	In the 21st century ODL is….				
B	ODL allows for greater interaction between tutor and learner				
C	ODL meets the needs of non-traditional learners				Only those who have who have internet access.
D	ODL allows learners to work at their own pace				
F	ODL calls for a change in academic and educational require-ments (compared to presenting traditional curricula)				Can't change basic requirements.
G	The rapid evolution of knowledge requires the faculty facilitating the course to have greater flexibility				
I	The rapid evolution of knowledge requires the staff facilitating the module online to have greater support from other members of staff				
J	Instructors need more allocated time to develop online courses				
K	Instructors need more allocated Time to deliver online courses				
L	Additional technical staff are needed for ODL				
M	Additional administrative staff are needed for ODL				
N	Copyright laws and intellectual property rights should be adhered to				

Q	The software used to present the Post-graduate Programme in Mental Health should be of the same type as used by the UFS (in other programmes)				
R	A needs analysis regarding the learners' access to computers and their computer literacy should be undertaken				
S	ODL courses should be revised regularly				
U	Learner training and support (in computer matters) plays an integral part of the programme				
X	A graphic designer should take responsibility for the layout of material on web pages				If possible
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent)				
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms)				
AA	Students should be encouraged to make use of Mobile learning				
BB	Students should be encouraged to make use of blogs				

28. Any further comments on education methodology and delivery					
H	Syndicate groups (without a tutor and co-tutor) should be used				They don't really help students.

SECTION E. STUDENT EVALUATION
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one**

29. STUDENT ASSESSMENT					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online				
B	Learners will have seven working days to return their 'homework' online				Allow for difficult rural on call schedules
C	If the tutorial is successfully completed (More than 70% of answers correct) the student will be asked to form part of the chat room session on the topic				
D	If the tutorial is not successfully completed students will have three days to make corrections				
E	Students will be assessed according to their contributions to the chat room sessions				
G	Students who wish to exit the course after year one will have to pass an oral examination in order to receive a Short Learning Programme certificate				
H	The oral examination will consist of a case presentation (30 minutes) related to the subject material in modules 1-4				
I	The allocation of weightings for year one module marks is as				

	follows: Tutorials (First attempt) 45%				
J	The allocation of weightings for year one module marks includes: Case studies = 45%				
K	The allocation for year One module marks includes Chat room contributions = 10%				
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				Would still like to see higher exit requirement
N	The weightings for the second academic year will be as follows: Tutorials (first attempt) 25%				
O	The weightings for the second academic year will include Case Studies = 25%				
P	The weightings for the second academic year will include Chat room contributions = 10%				
Q	The weightings for the second academic year will include a Research project = 40%				
U	Examiners of the oral examinations will be psychiatrists and psychologists (UFS staff).				Feel Prim.Care Doctors or DMH holders should be included to modify standards.
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists.				College selects its own examiners. **Point taken; I hope both parties will be represented.**

30. ANY FUTHER COMMENTS ON STUDENT ASSESSMENT IN THE PROGRAMME

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX F:

FORMAT FOR DELPHI QUESTIONNAIRE – ROUND 3

2007/03/05

Dear Prof…..
Thank you for taking the effort to complete the second round of the study. I have taken note of the inputs made as comments, they are much appreciated.

The purpose of Round Three
This questionnaire is structured regarding the importance of the statements where consensus was not reached. Consensus is defined according to the literature of Larson and Wissman (2000: 45) where 80% of the participants vote on a specific item within the same value of the three-point scale. This questionnaire contains numbered statements, provides opportunities for reconsideration and additional comments and suggestions. The questionnaire retains the format of Round Two having 5 main categories each divided into subcategories.

Completing the Round Three questionnaire
Your answers in Round Two were analysed. All the statements where consensus was not reached must be answered again please, using the following scale:

1 = Essential (This criterion must definitely feature in the frame work)
2 = Useful (It does not matter if this criterion features in the framework or not)
3 = Unnecessary (This criterion should certainly not be included in the framework).

The responses of all the participants are collated next to each statement. The figure represents the number of experts who chose that particular option. The asterisk denotes the answer you (personally) marked in Round Two.

For example:

A1 **On completion of the PG Dip MH the student should have gained the following knowledge:**				Comment
Current theories on the known etiology of mental conditions	1	2	3	
Round Two	8	3	1	* = denotes your personal response on this statement
Round Three				

Round Three allows you to reconsider your opinion (on each statement) in the light of the other experts' views. During this round you are at liberty to change your opinion and choose a different option. However, you may wish to stick to your original choice if you feel it is appropriate. Please indicate your choice in this round with an X for all the statements even if your opinion has not changed. Once again there is an opportunity to comment should you wish to do so.

All the questions in each section must be answered. All information will be treated confidentially. Responses are given anonymously, (the identity of the respondents is not known to the other experts in the study) and will only be known by the researcher.

It should not take longer than 15 minutes to complete this questionnaire. Please return it at your earliest convenience.

Thank you once again for your participation.

Kind regards

Richard Nichol
Student Number 1988322341

Section A: CRUCIAL EXIT LEVEL OUTCOMES

Section B: FORMAT OF THE PROGRAMME

Section C: CONTENTS OF THE PROGRAMME

THE FIRST ACADEMIC YEAR

THE SECOND ACADEMIC YEAR

Section D: EDUCATION METHODOLOGY AND MODES OF DELIVERY

25 Small Group Sessions
26 Patient Centred Learning
27 Online Distance Learning
28 Any further comments on Education Methodology and Modes of delivery

Section E: STUDENT EVALUATION

29 Student Assessment in the Post-graduate Programme in Mental Health.
30 Any further Comments on Student Assessment.

QUESTIONNAIRE FOR DELPHI PANEL, ROUND THREE

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We live in a world with rapidly changing technology and new approaches to education. As a majority of the experts on the panel were trained in the "old school" approach I have taken the liberty of including a list of contemporary (and less contemporary definitions) which may be of value to you.

DEFINITIONS:

Blogs (or web logs):
Personal sites to keep in touch with family or friends (O'Leary & O'Leary 2006:104).

Chatroom (chat groups):
An online discussion group that allows direct 'live' communication (O'Leary & O'Leary 2006: 477).

Distance education:
All arrangements for providing instruction through print or electronic communications media to persons engaged in planned learning in a place or time different from that of the instructor(s) (Moore in Maguire 2005:pg 1 of 3).

E-learning (Electronic learning):
Education via the Internet, network, or standalone computer. Network enabled transfer of skills and knowledge. E-learning applications and

processes include Web-based learning, computer based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intra/extranet, audio or video tape, satellite TV and CD-ROM (Google 2004:p1 of 1).

M-learning (Mobile learning):
The use of hand-held computers (incorporated into cell-phones) for 'anytime, anywhere' access to learning resources (Powernell & Bailey 2000:3).

Nosology
The programme of describing and taxonomising mental disorders (Porter 2002:213).

Outcome-based Education (OBE):
An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused (Betts & Smith 1998:52).

Online Distance Learning (ODL):
Online teaching using the Internet and the World Wide Web (www) (Harden 1998: 190).

Podcasting:
Learners are able to download lectures or information onto their iPods or any other MP3 players (and listen to these presentations when it suits the learner) (Baird 2006:1).

SECTION A. CRUCIAL LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH. The student should have gained the following knowledge:

		Essential	Useful	Unnecessary	Comments
K	Current theories relating to the prevention of psychopathology (in people) Round 2	8	4	0	
	Round 3				
M	Appropriate utilisation of new technology in Psychiatry. Round 2	5	7	0	
	Round 3				

2. On completion of the PGDipMH, the student should have gained the following skills:

		Essential	Useful	Unnecessar	Comments
I	Be able to communicate using basic computer skills Round 2	6	6 *	0	

	Round 3				

3. On completion of the PGDipMH , the student should have adhered to the following values:					
		Essential	**Useful**	**Unnecessar**	Comments
		1	2	3	
I	A willingness to participate in peer evaluation. Round 2	8	4 *	0	
	Round 3				

4. Any additional comments on crucial exit level outcomes (Knowledge, Skills and Values)

SECTION B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES					
This section deals with the basic lay out and content of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary					
5.The following should be considered for the **format of the programme content of the modules:**					
		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period. Round 2	8 *	3	1	

	Round 3				
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200) Round 2	6	6 *	0	
	Round 3				
C	The second academic year should contain three modules (Notional hours = 600) Round 2	6	6 *	0	
	Round 3				
D	The second academic year should contain a research project Round 2	3	3	6 *	
	Round 3				
E	Students should be required to pass the first academic year before proceeding to the second academic year. Round 2	9	3 *	0	
	Round 3				
F	Students who do not wish to enrol for the second academic year, but who have successfully passed the first year, should receive a certificate. Round 2	4 *	6	2	
	Round 3				
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year. (Students may begin this project in the first academic year)				

	Round 2	4*	5	3	
	Round 3				
I	Students will be assessed using tutorials and worksheets Round 2	9	3*	0	
	Round 3				
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion). Round 2	8	4*	0	
	Round 3				
K	Students will also be evaluated according to their contribution to the chat room discussion. Round 2	8	4*	0	
	Round 3				
L	There should be a restriction on the number of students who are allowed to enrol for each academic year. Round 2	7*	2	3	
	Round 3				
M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme. Round 2	8	2	2*	
	Round 3				

O	The academic standard of subject material used in the programme should be closer to Mmed(Psych) level than final year MB ChB level. Round 2	8	4 *	0	
	Round 3				
Q	Where applicable, teaching should be directed towards rural, primary care settings. Round 2	9 *	3	0	
	Round 3				

6. Additional comments on the format of the programme

SECTION C. CONTENTS OF THE PROGRAMME

This section deals with the basic layout and content of the programme of the first academic year.
Please indicate how important each of the following statements is according to the following scale:
1 = Essential 2 = Useful 3 = Unnecessary
Please mark the appropriate block with an X. Only mark one option.

8. CONTENT OF MODULE 2: CHRONIC PSYCHIATRIC CONDITIONS –(Part 1)

This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)**
SCHIZOPHRENIA and related conditions.
On completing the module, the student should know:

		Essential	Useful	Unnecessary	Comments
B	The sub-types of schizophrenia. Round 2	9	3 *	0	
	Round 3				
C	The history of nosology of schizophrenia. Round 2	7	3	2 *	
	Round 3				

9. Content of module 3. Common Psychiatric conditions (part 2)
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part 2) – MOOD DISORDERS.** On completing the module the learner should know how to:

		Essential	Useful	Unnecessary	Comments
H	Apply the principles of Cognitive Behaviour Therapy. Round 2	7 *	5	0	
	Round 3				

10. Content of Module 4
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part 3 – ANXIETY DISORDERS.** On completion of the module the learner should be able to:

		Essential	Useful	Unnecessary	Comments
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds.** Round 2	7 *	3	2	
	Round 3				
K	How to recognize Avoidant Dependent, and Obsessive-compulsive Personality Disorders. Round 2	8 *	4	0	
	Round 3				

11. The Second Academic Year and Module 5

The programme in year two will contain six modules. Students will have the option of selecting three modules.
Module 5 = Child Psychiatry part 1
Module 6 = Child Psychiatry part 2
(only for learners who have completed module 5).
Module 7 = Addiction Disorders
Module 8 = Forensic Psychiatry
Module 9 = Geriatric Psychiatry
Module 10 = Introduction to Psychotherapy.

Students will also be required to complete a research project.
On completion of **Module 5 (CHILD PSYCHIATRY-part 1)** the learner should:

		Essential	Useful	Unnecessary	Comments
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism) Round 2	9	3 *	0	
	Round 3				
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis) Round 1	9	3 *	0	
	Round 2				

13. Module 7 – Forensic Psychiatry					
Learners who complete this module should be able to:					
		Essential	Useful	Unnecessary	Comments
B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)** Round 2	8 *	4	0	
	Round 3				
C	Understand the **Law on Sterilization** Round 2	8	4 *	0	
	Round 3				

F	Know how **intoxication with substances affects criminal responsibility.** Round 2	9 *	3	0	
	Round 3				

16. Module 10 – Introduction To Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)** Round 2	8	2 *	2	
	Round 3				
B	Be able to understand the principles of CBT. Round 2	9 *	3	0	
	Round 3				

17. Module 11 – The Research Project					
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	A research project forms an integral part of the Post-graduate				

	Programme in Mental Health Round 2	4	2	6	
	Round 3				
C	Learners will also be able to make use of a biostatistician Round 2	7	2	3	
	Round 3				
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS. Round 2	9 *	0	3	
	Round 3				
E	Results of the research should be published in an **accredited Medical Journal** Round 2	0	7 *	5	
	Round 3				
F	If the research project is not completed the learner will not be awarded the qualification. Round 2	2	1	9 *	
	Round 3				

18. Any additional comments on the contents of the programme

SECTION D. EDUCATION METHODOLOGY AND MODES OF DELIVERY
This section deals with methodology and modes of delivery of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

19. Policies and Procedures for Programme Approval					
In the **development** of an educational programme in Mental Health:					
		Essential	**Useful**	**Unnecessary**	Comments
B	A Post-graduate Programme in Mental Health should be implemented at the National Qualification Framework level 8 (masters degree level) Round 2	1 *	2	9	
	Round 3				
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health. Round 2	2	8 *	2	
	Round 3				
F	The Post-graduate Programme in Mental Health should be offered as an informal short course programme. Round 2	2 *	9	1	
	Round 3				

G	The post-graduate Programme in mental Health should contain modules which may serve as credit bearing short cases. Round 2	9 *	2	1	
	Round 3				
H	The Post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes. Round 2	8 *	4	0	
	Round 3				
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses (e.g. M Med Fam). Round 2	3 *	9	0	
	Round 3				

21. Curriculum Planning, Development and Design					
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The curriculum development process should be sensitive to the academic setting of the project. Round 2	9	3 *	0	
	Round 3				

C	The curriculum developmental process should be sensitive to the interests of the students for whom the programme is designed. Round 2	9 *	3	0	
	Round 3				

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational programme in mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
Q	The programme should allow for individual differences in students. Round 2	7 *	5	0	
	Round 3				
R	The programme should allow for individual differences in learning methods. Round 2	6 *	6	0	
	Round 3				
V	There should be provision for pilot testing of the proposed programme prior to final implementation. Round 2	9	3 *	0	
	Round 3				

23. Student Assessment					
In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:					
		Essential	**Useful**	**Unnecessary**	Comments
F	An assessment taskforce is established, which will include an assessment expert. Round 2	9	3 *	0	
	Round 3				
J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors. Round 2	9	2 *	1	
	Round 3				

24. Formal Lectures					
		Essential	**Useful**	**Unnecessary**	Comments
A	There is a place for formal lectures as a means of content delivery to students. Round 2	6	6 *	0	
	Round 3				
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE).				

	Round 2	9	3 *	0	
	Round 3				
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic. Round 2	8	4 *	0	
	Round 3				
I	The content of the lecture should be available for students to access using Podcasting. Round 2	7	5 *	0	
	Round 3				
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture. Round 2	9 *	3	0	
	Round 3				

25. Small Group Sessions					
Whether in the format of face-to-face interaction, or on-line distance 'chat rooms', small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Comments
F	Students should also be evaluated on the content of their contributions to small group interactions Round 2	7	5 *	0	
	Round 3				

G	Each small group session should be facilitated by both a tutor and a co-tutor Round 2	7	4	1 *	
	Round 3				
H	Syndicate groups (without a tutor and co-tutor) should be used Round 2	4	6 *	2	
	Round 3				

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
B	ODL allows for greater interaction between tutor and learner Round 2	7	5 *	0	
	Round 3				
C	ODL meets the needs of non-traditional learners Round 1	9 *	3	0	
	Round 2				
D	ODL allows learners to work at their own pace Round 2	6	6 *	0	
	Round 3				
J	Instructors need more allocated time to develop online courses				

	Round 2	9	3 *	0	
	Round 3				
K	Instructors need more allocated time to deliver online courses. Round 2	8	3	1 *	
	Round 3				
M	Additional administrative staff are needed for ODL. Round 2	8	2 *	2	
	Round 3				
X	A graphic designer should take responsibility for the layout of material on web pages. Round 2	5	7 *	0	
	Round 3				
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent). Round 2	6	6 *	0	
	Round 3				
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms). Round 2	4	8 *	0	
	Round 3				
AA	Students should be encouraged to make use of Mobile learning. Round 2	3	9 *	0	
	Round 3				
BB	Students should be encouraged to make use of blogs				

	Round 2	3	9 *	0	
	Round 3				

28. Any further comments on education methodology and modes of delivery.

SECTION E. STUDENT EVALUATION
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one**

29. Student Assessment					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online. Round 2	6	6 *	0	
	Round 3				
B	Learners will have seven working days to return their 'homework' online. Round 2	6	6 *	0	
	Round 3				

C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic. Round 2	5	6	1 *	
	Round 3				
D	If the tutorial is not successfully completed students will have three days to make corrections. Round 2	3	9 *	0	
	Round 3				
E	Students will be assessed according to their contributions to the chat room sessions. Round 1	3	9 *	0	
	Round 2				
K	The allocation for year one module marks includes chat room contributions = 10% Round 2	3	9 *	0	
	Round 3				
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health. Round 2	9	3 *	0	
	Round 3				
Q	The weightings for the second academic year will include a Research project = 40% Round 2	3	2	7 *	

	Round 3				
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists. Round 2	7	4 *	1	
	Round 3				

30. Any further comments on student assessment in the programme

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX G:

FORMAT FOR DELPHI QUESTIONNAIRE RESULTS – ROUND 3

Section A: CRUCIAL EXIT LEVEL OUTCOMES

1 Student Knowledge
2 Student Skills
3. Student Values
4 Any further comments on Crucial Exit Level Outcomes

Section B: FORMAT OF THE PROGRAMME

5 Format of the programme
6 Any further Comments on Format of the Programme

Section C: CONTENTS OF THE PROGRAMME

THE FIRST ACADEMIC YEAR

7 The content of Module 1: INTRODUCTION TO PSYCHIATRY
8 The Content of Module 2: COMMON PSYCHIATRIC CONDITIONS (part 1)
9 The Content of Module 3: COMMON PSYCHIATRIC CONDITIONS (part 2)
10 The Content of module 4: COMMON PSYCHIATRIC CONDITIONS (part 3)

THE SECOND ACADEMIC YEAR

11 The Content of Module 5: Child Psychiatry (part 1)
12 The Content of Module 6: Child psychiatry (part 2)
13 The Content of Module 7: Addiction Disorders
14 The Content of Module 8: Forensic Psychiatry
15 The Content of module 9: Geriatric Psychiatry
16 The Content of Module 10: Introduction to Psychotherapy
17 The Research Project
18 Any further Comments on Content of the Programme

Section D: EDUCATION METHODOLOGY AND MODES OF DELIVERY

19 Policies and Procedures for Programme Approval
20 Outcomes Based Education
21 Curriculum Planning, Development and Design
22 Implementing and Evaluating the Curriculum
23 Student assessment
24 Formal lectures
25 Small Group Sessions
26 Patient Centred Learning
27 Online Distance Learning
28 Any further comments on Education Methodology and Modes of delivery

Section E: STUDENT EVALUATION

29 Student Assessment in the Post-graduate Programme in Mental Health.
30 Any further Comments on Student Assessment.

QUESTIONNAIRE FOR DELPHI PANEL, ROUND 3

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We live in a world with rapidly changing technology and new approaches to education. As a majority of the experts on the panel were trained in the "old school" approach I have taken the liberty of including a list of contemporary (and less contemporary definitions) which may be of value to you.

DEFINITIONS:

Blogs (or web logs):
Personal sites to keep in touch with family or friends (O'Leary & O'Leary 2006:104).

Chatroom (chat groups):
An online discussion group that allows direct 'live' communication (O'Leary & O'Leary 2006: 477).

Distance education:
All arrangements for providing instruction through print or electronic communications media to persons engaged in planned learning in a

place or time different from that of the instructor(s) (Moore in Maguire 2005:pg 1 of 3).

E-learning (Electronic learning):
Education via the Internet, network, or standalone computer. Network enabled transfer of skills and knowledge. E-learning applications and processes include Web-based learning, computer based learning, virtual classrooms as well as digital collaboration. Content is delivered via the Internet, intra/extranet, audio or video tape, satellite TV and CD-ROM (Google 2004:p1 of 1).

M-learning (Mobile learning):
The use of hand-held computers (incorporated into cell-phones) for 'anytime, anywhere' access to learning resources (Powernell & Bailey 2000:3).

Nosology
The programme of describing and taxonomising mental disorders (Porter 2002:213).

Outcome-based Education (OBE):
An outcomes-based system relies on a clear set of learning outcomes on which the curriculum, learning facilitation and assessment are focused (Betts & Smith 1998:52).

Online Distance Learning (ODL):
Online teaching using the Internet and the World Wide Web (www) (Harden 1998: 190).

Podcasting:
Learners are able to download lectures or information onto their iPods or any other MP3 players (and listen to these presentations when it suits the learner) (Baird 2006:1).

SECTION A. CRUCIAL LEVEL OUTCOMES

This section deals with the knowledge, skills and values which can be anticipated in students completing the Post-graduate Diploma in Mental Health (PGDipMH).

Please indicate how important each of the following statements is according to the following scale:

1 = Essential 2 = Useful 3 = Unnecessary

Please mark the appropriate block with an X. Only mark one option.

1. On completion of the PGDipMH the student should have gained the following knowledge:

		Essential	Useful	Unnecessary	Comments
K	Current theories relating to the prevention of psychopathology (in people)				**CONSENSUS ROUND 3 (12 0 0)**
M	Appropriate utilisation of new technology in psychiatry				**STABILITY (4 8 0)**

2. On completion of the **PGDipMH, the student** should have gained the following **skills:**

		Essential	Useful	Unnecessary	Comments
I	Be able to communicate using basic computer skills				**STABILITY (8 4 0)**

3. On completion of the **PGDipMH , the student** should have adhered the following **values:**					
		Essential	**Useful**	**Unnecessary**	Comments
I	A willingness to participate in peer evaluation.				**CONSENSUS ROUND 3 (12 0 0)**

4. Any additional comments on crucial exit level outcomes (knowledge, skills and values)

B. FORMAT OF THE PROGRAMME CONTENT OF THE MODULES
This section deals with the basic lay out and content of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = essential 2 = Useful 3 = Unnecessary

5.The following should be considered for the format of the programme content of the modules:					
		Essential	**Useful**	**Unnecessary**	Comments
A	The programme should be taught over a two year period				**STABILITY (9 2 1)**
B	The first academic year should contain **FOUR** compulsory modules (Notional hours = 1200)				**STABILITY (7 5 0)**
C	The second academic year should contain **THREE** modules. (Notional hours = 600)				**STABILITY (6 6 0)**

D	The second academic year should contain a research project				**STABILITY (1 4 7)**
E	Students should be required to pass the first academic year before proceeding to the second academic year				**CONSENSUS ROUND 3 (12 0 0)**
F	Students who do not wish to enrol for the second academic year, but who have successfully passed the first year, should receive a certificate				**STABILITY (2 3 7)**
H	Students will be required to complete a community-based research project, in collaboration with an allocated study leader in the second academic year. (Students may begin this project in the first academic year)				**STABILITY (4 6 2)**
I	Students will be assessed using tutorials and worksheets				**CONSENSUS ROUND 3 (12 0 0)**
J	Each tutorial will also contain a chat room session (60-90 minutes) (Students will be given turns to lead the discussion on the topic under discussion and all the learners will be required to contribute to the discussion)				**CONSENSUS ROUND 3 (10 1 1)**
K	Students will also be evaluated according to their contribution to the chat room discussion				**CONSENSUS ROUND 3 (10 2 0)**
L	There should be a restriction on the number of students who are allowed to enrol for each academic year				**CONSENSUS ROUND 3 (10 0 2)**
M	Only medical practitioners registered with the South African Health Professionals Council will be accepted for enrolment in the programme				**CONSENSUS ROUND 3 (10 0 2)**
O	The academic standard of subject material used in the programme should be closer to Mmed(Psych) level than final year MB ChB level				**CONSENSUS ROUND 3 (10 2 0)**

Q	Where applicable, teaching should be directed towards rural, primary care settings				**CONSENSUS ROUND 3 (11 1 0)**

6. Any additional comments on the format of the programme

SECTION C. CONTENTS OF THE PROGRAMME
This section deals with the basic layout and content of the programme of the first academic year. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

8. Content Of Module 2: Chronic Psychiatric Conditions – (part 1)
This module features **CHRONIC PSYCHIATRIC CONDITIONS (part 1)** **SCHIZOPHRENIA and related conditions.** On completing the module, the student should know:

		Essential	**Useful**	**Unnecessary**	Comments
B	The sub-types of schizophrenia				**CONSENSUS ROUND 3 (10 2 0)**
C	The history of nosology of schizophrenia				**STABILITY (8 3 1)**

9. Content of module three. Common Psychiatric conditions (part 2)
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS (part two) – MOOD DISORDERS.** On completing the module the learner should know how to:

		Essential	Useful	Unnecessary	Comments
H	Apply the principles of Cognitive Behaviour Therapy				**STABILITY (9 3 0)**

10. Content of Module 4					
This module contains **CHRONIC COMMON PSYCHIATRIC CONDITIONS – part 3 - ANXIETY DISORDERS.** On completion of the module the learner should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
I	Be able to decide if a patient with anxiety disorder and co-morbid depression qualifies for **impairment on psychiatric grounds.**				**CONSENSUS ROUND 3 (11 1 0)**
K	How to recognize Avoidant Dependent, and Obsessive Personality Disorders.				**CONSENSUS ROUND 3 (12 0 0)**

11.The Second Academic Year and Module 5
The programme in year two will contain six modules. Students will have the option of selecting three modules. Module 5 = Child Psychiatry part 1 Module 6 = Child Psychiatry part 2 (only for learners who have completed module 5). Module 7 = Addiction Disorders Module 8 = Forensic Psychiatry Module 9 = Geriatric Psychiatry Module 10 = Introduction to Psychotherapy. Students will also be required to complete a research project. On completion of **Module 5 (CHILD PSYCHIATRY-part 1)** the learner should:

		Essential	Useful	Unnecessary	Comments
B	Have a basic knowledge of **Pervasive Disorders in children** (e.g. autism)				**CONSENSUS ROUND 3 (11 1 0)**
D	Be able to treat **Elimination Disorders** in children (e.g. enuresis + encopresis)				**CONSENSUS ROUND 3 (11 1 0)**

13. Module 7 - Forensic Psychiatry					
Learners who complete this module should be able to:					
		Essential	**Useful**	**Unnecessary**	Comments
B	Understand the concepts of **Trialability** and **Criminal responsibility (Section 77 + 78 of Criminal Procedure Act)**				**CONSENSUS ROUND 3 (10 2 0)**
C	Understand the **Law on Sterilization**				**STABILITY**
F	Know how **intoxication with substances affects criminal responsibility**				**CONSENSUS ROUND 3 (12 0 0)**

16. Module 10 - Introduction to Cognitive Behavioural Therapy					
On completion of this module learners should:					
		Essential	**Useful**	**Unnecessary**	Comments
A	Understand the **origins of Cognitive Behavioural Therapy (CBT)**				**STABILITY (9 2 1)**

B	Be able to understand the principles of CBT				**CONSENSUS ROUND 3 (11 1 0)**

17. Module 11 THE RESEARCH PROJECT					
Learners will also have to complete a **Research Project** containing original work before completing the second academic year. The project may be completed during the first academic year but must form part of the learner's portfolio.					
		Essential	**Useful**	**Unnecessary**	Comments
A	The research project forms an integral part of the Post-graduate Programme in Mental Health				**STABILITY (4 2 7)**
C	Learners will also be able to make use of a biostatistician				**CONSENSUS ROUND 3 (10 2 0)**
D	Learners will have to have protocols for their research projects passed by the Ethics Committee of the UFS				**CONSENSUS ROUND 3 (11 0 1)**
E	Results of the Research should be published in an **accredited Medical Journal**				**STABILITY (0 9 3)**
F	If the research project is not completed the learner will not be awarded the qualification.				**STABILITY (1 2 9)**

SECTION D. EDUCATION METHODOLOGY AND MODES OF DELIVERY
This section deals with methodology and modes of delivery of the programme. Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the appropriate block with an X. Only mark one option.**

19. POLICIES AND PROCEDURES FOR PROGRAMME APPROVAL					
In the **development** of an educational programme in mental health:					
		Essential	**Useful**	**Unnecessary**	Comments
B	A post-graduate programme in Mental Health should be implemented at the National Qualification Framework level 8 (masters degree level)				**CONSENSUS ROUND 3 (0 2 10)**
D	The pharmaceutical industry should be approached for financial assistance (sponsorship), in order to support the Post-graduate Programme in Mental Health				**CONSENSUS ROUND 3 (1 10 1)**
F	The Post-graduate Programme in Mental Health should be offered as an informal short course programme				**CONSENSUS ROUND 3 (0 12 0)**
G	The Post-graduate Programme in Mental Health should contain modules which may serve as credit bearing short courses				**CONSENSUS ROUND 3 (11 1 0)**
H	The post-graduate Programme in Mental Health should contain modules which may be used for Continuing Medical Education (CME) purposes				**STABILITY (9 3 0)**
I	The Post-graduate Programme in Mental Health should contain modules which may serve as short courses which may be used for articulation to other courses(e.g. M Fam Med).				**CONSENSUS ROUND 3 (2 10 0)**

21. Curriculum Planning, Development and Design
In developing an educational Post-graduate Programme in Mental Health, recognition must be taken of **curriculum planning, development and design,** therefore:

		Essential	**Useful**	**Unnecessary**	Comments
A	The curriculum development process should be sensitive to the academic setting of the project				**CONSENSUS ROUND 3 (12 0 0)**
C	The curriculum developmental process should be sensitive to the interests of the students for whom the programme is designed				**CONSENSUS ROUND 3 (10 2 0)**

22. Implementing and Evaluating the Curriculum					
Prior to implementing an educational programme in Mental Health, recognition must be taken of factors relating to **implementing and evaluating** the curriculum, therefore:					
		Essential	Useful	Unnecessary	Comments
Q	The programme should allow for individual differences in students.				**STABILITY (8 4 0)**
R	The programme should allow for individual differences in learning methods.				**STABILITY (7 5 0)**
V	There should be provision for pilot testing of the proposed programme prior to final implementation				**CONSENSUS ROUND 3 (11 1 0)**

23. Student Assessment					
In developing an education Programme in Mental Health, recognition must be taken of mechanisms for student **assessment** in order to ensure that:					
		Essential	**Useful**	**Unnecessary**	Comments

F	An assessment taskforce is established, which will include an assessment expert				**CONSENSUS ROUND 3 (11 1 0)**
J	Assessors have received formal training in assessment methodology in terms of SAQA requirements for assessors				**CONSENSUS ROUND 3 (11 1 0)**

24. FORMAL LECTURES					
		Essential	**Useful**	**Unnecessary**	Comments
A	There is a place for formal lectures as a means of content delivery to students				**STABILITY (6 6 0)**
C	Formal lectures can be used to facilitate Outcomes-based Education (OBE				**CONSENSUS ROUND 3 (12 0 0)**
D	By using formal lectures, the lecturer can stimulate the learners' interest to self-directed learning about the topic				**CONSENSUS ROUND 3 (11 1 0)**
I	The content of the lecture should be available for students to access using Podcasting				**STABILITY (9 3 0)**
J	Copies of Powerpoint slides should be made available at a website for students to access after the lecture				**CONSENSUS ROUND 3 (11 1 0)**

25. Small Group Sessions					
Whether in the format of face-to-face interaction, or on-line distance "chat rooms", small groups can be important to:					
		Essential	**Useful**	**Unnecessary**	Comments
F	Students should also be evaluated on the content of their				**STABILITY (9 3 0)**

	contributions to small group interactions				
G	Each small group session should be facilitated by both a tutor and a co-tutor				**STABILITY (8 4 0)**
H	Syndicate groups (without a tutor and co-tutor) should be used				**CONSENSUS ROUND 3 (1 10 1)**

27. Online Distance Learning					
Online Distance Learning (ODL) should be considered as a practical method of facilitating the teaching of Psychiatry in a primary health care setting, therefore:					
		Essential	**Useful**	**Unnecessary**	Comments
B	ODL allows for greater interaction between tutor and learner.				**CONSENSUS ROUND 3 (10 2 0)**
C	ODL meets the needs of non-traditional learners				**CONSENSUS ROUND 3 (11 1 0)**
D	ODL allows learners to work at their own pace				**STABILITY (7 5 0)**
J	Instructors need more allocated time to develop online courses				**CONSENSUS ROUND 3 (11 1 0)**
K	Instructors need more allocated time to deliver online courses				**CONSENSUS ROUND 3 (11 1 0)**
M	Additional administrative staff are needed for ODL				**STABILITY (9 2 1)**
X	A graphic designer should take responsibility for the layout of material on web pages				**CONSENSUS ROUND 3 (2 10 0)**
Y	Use should be made of 'video clips' to demonstrate certain signs and symptoms in patients (with their consent)				**STABILITY (7 5 0)**
Z	Use should be made of simulated patients (actors demonstrating certain signs and symptoms)				**STABILITY (3 9 0)**

AA	Students should be encouraged to make use of Mobile learning.				**CONSENSUS ROUND 3 (2 10 0)**
BB	Students should be encouraged to make use of blogs				**CONSENSUS ROUND 3 (2 10 0)**

28. ANY FURTHER COMMENTS ON EDUCATION METHODOLOGY AND MODES OF DELIVERY

SECTION E. STUDENT EVALUATION
Please indicate how important each of the following statements is according to the following scale: 1 = Essential 2 = Useful 3 = Unnecessary **Please mark the option with an X. Only mark one**

29. Student Assessment					
During the two academic years students should be assessed in the following manner:					
		Essential	**Useful**	**Unnecessary**	Comments
A	After receiving each formal lecture each learner will also receive a tutorial relating to the subject matter online				**STABILITY (5 7 0)**
B	Learners will have seven working days to return their "homework" online				**STABILITY (6 6 0)**
C	If the tutorial is successfully completed (more than 70% of answers correct) the student will be asked to form part of the chat room session on the topic				**STABILITY (2 9 1)**
D	If the tutorial is not successfully completed students will have three days to make corrections				**STABILITY (3 9 0)**

E	Students will be assessed according to their contributions to the chat room sessions				**CONSENSUS ROUND 3 (0 12 0)**
K	The allocation for year One module marks includes Chat room contributions = 10%				**CONSENSUS ROUND 3 (2 10 0)**
M	Those who wish to exit after the first academic year must have at least 50 % module mark on average and at least 50% in the oral examination to obtain the Certificate in Mental Health				**CONSENSUS ROUND 3 (11 1 0)**
Q	The weightings for the second academic year will include a research project = 40%				**STABILITY (3 1 8)**
V	Examiners at the oral examinations will also be requested to examine on behalf of the South African College of Psychiatrists.				**STABILITY (8 3 1)**

30. ANY FUTHER COMMENTS ON STUDENT ASSESSMENT IN THE PROGRAMME

Thank you so much for your time.

Kind regards

Richard Nichol

APPENDIX H:
UNIVERSITY OF THE FREE STATE GUIDELINES FOR THE APPROVAL, ACCREDITATION, REGISTRATION, RECORDING AND TERMINATION OF FORMAL AND NON-FORMAL ACADEMIC PROGRAMMES WITH REFERENCE TO THE PGDIPMH PROGRAMME

According to these guidelines published in 2004 two types of programme regulations apply to the PGDipMH:

i) Short Learning Programme – The SAQA document *Criteria and Guidelines for Short Courses and Skills Programmes (June 2004)* defines short learning programmes as 'all short programmes, whether credits are awarded or not and is inclusive of skills programmes, credit bearing courses and non-credit bearing courses'. When further explored only the 'credit bearing short course' is applicable.

A credit bearing short course is defined as 'a type of short learning programme for which credits in relation to its contribution to a particular programme, unit standard and/or part qualification is awarded'. A credit bearing course contains fewer than 120 credits. The UFS defines a short learning programme 'as any skills programme, credit bearing short course (towards a UFS qualification) or non credit bearing short course (non credit bearing towards a UFS qualification) of less than 120 credits for which a certificate of

successful completion is awarded ,i.e. where formal assessment is involved'.

Students enrolled for the PGDipMH who have an average of 50% or more for their year mark but who do not wish to proceed to the second academic year will be able to request an oral examination. If this examination is passed successfully (>50% mark), a Short Learning Certificate will be awarded to the student.

ii) Formal Academic Programme- implies all structured offerings at the University which, on successful completion, will lead to the award of a formal qualification such as a diploma (or degree) i.e. PGDipMH.

THE PROCESS TO BE FOLLOWED FOR APPROVAL, ACCREDITATION, REGISTRATION AND RECORDING OF PROGRAMMES.

This process is described using the ten steps and three phases that a programme must pass through are described, including the

1) Institutional phase
2) The regional phase and
3) The national phase

These steps will be discussed briefly:

1) The Institutional phase

Step 1: A new concept is formed – tuition for the Diploma in Mental Health (awarded by the College of Medicine). The viability and relevance is discussed by members of staff

Step 2: Support by the Department (Department of Psychiatry). A submission is formulated in consultation with the UFS Planning Unit regarding programme planning and review.

Step 3: This submission of a programme is then considered by the Faculty Programmes Structure (e.g. faculty Programmes Committee and/or Faculty Committee).

Step 4: If approved at the Faculty Programmes Structure, it is submitted to the Administration System Advisory Group for attention to all administrative issues such as qualification and module codes

Step 5: The submission is now routed to the UFS Programmes Committee with a letter of recommendation from the Faculty Programmes Structure.

Step 6: If approved by the UFS Programmes Committee, the submission is routed to the relevant Faculty Board, with a letter of recommendation from the chairperson of the UFS Programmes Committee. In the case of a new programme/ qualification, the developer is now requested to add the relevant regulations of the programme/ qualification to serve at Faculty Board.

Step 7: If approved by the relevant Faculty Board, the submission of new programmes are routed to the Executive Management/ Senate.

Step 8: If a programme is approved by the Executive Management/ Senate, the UFS Planning Unit (Programme Planning and Review) submits it to the DoE, CHE and SAQA.

The registrar: Student Academic Services is informed of the approval by the relevant minutes and is recorded. After recording, the Dean is informed accordingly and this credit bearing short learning programme may now be offered at the UFS.

2) The Regional phase

This phase involves regional clearance of new programmes to be offered. In the Free State clearance will be via the Free State Higher Education Consortium (FSHEC). This phase ensures that no unnecessary duplication of programmes takes place in the central region of South Africa.

3) The National phase

Programmes and qualifications are submitted first to the Department of Education on the DoE form 1. The UFS Planning Unit prepares these submissions in collaboration with relevant developers/programme directors and submits these to the DoE before the indicated closing date.

Step 9: The DoE responds to the Head: UFS Planning Unit about approved programmes/qualifications, which in turn informs the Programmes Planning and Review Division which then informs the relevant developers/programme directors/deans of the outcome, and requests those involved with approved programmes to submit the CHE Form 2 Learning Programme Catalogue before the indicated submission date. The Programme Planning and Review Division prepares these submissions and submits them to the Head: UFS Planning Unit for submission to the CHE (branch HEQC).

Step 10: The HEQC responds to the Head: UFS Planning Unit on the provisional accreditation of the programmes/qualifications, who then ensures that the provisionally accredited programmes are captured on the UFS database of accredited programmes. This is also fed back to the UFS Planning Unit (Programme Planning and Review) which feeds it back to the relevant developer/programme director/dean.

If a qualification is temporarily accredited by the HEQC it now needs to be registered by SAQA. The UFS Planning Unit now requests qualification developers/programme directors to prepare the SAQA Qualification Catalogue Form 3 and submits it to the Head: UFS Planning Unit, for submission to SAQA.

Step 11: If a qualification is successfully registered with SAQA, the Head: UFS Planning Unit ensures that it is captured on the UFS database of registered qualifications, and feeds the information to

the Programme Planning and Review Division, which then feeds it back to the relevant developer/programme director/dean. The Faculty Manager/Secretary is then responsible, in collaboration with the developer, to arrange that the qualification is captured in terms of regulations in the yearbook for official offering.

Step 12: A programme/qualification is finally accredited by the HEQC one year after the first students have completed the qualification. The status of full accreditation can now be read into the UFS database.