

A PRACTICE FRAMEWORK TO ENHANCE THE IMPLEMENTATION OF THE POLICY ON INTEGRATION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE IN KWAZULU-NATAL PROVINCE

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Declaration

This is to certify that this work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student

Date

Approved for final submission

Prof MN Sibiya
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Date

Dedication

I dedicate this thesis to my late father and mother, my daughters Gugulethu and Canny, and my family and friends.

Acknowledgements

I am grateful to God for giving me the opportunity to complete this study, and I give Him my thanks and praise.

I would also like to give my thanks to the following persons for their invaluable support and unending encouragement:

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Abstract

Background

Policy on Integration of Mental Health Care into primary health care (PHC) was developed in 1997 at the time when the White Paper for the Transformation of the Health System in South Africa was published (Republic of South Africa 1997). The White Paper made provision for a new health care system based on the principles of the PHC approach to care. This was followed by the promulgation of the Mental Health Care Act No. 17 of 2002 which is based on the principle that mental health care should be integrated into PHC; however there have been challenges with regard to implementation of this policy.

Aim of the study

The aim of the study was to analyse the implementation of Policy on Integration of Mental Health Care into PHC with the ultimate aim of developing a practice framework for PHC nurses to enhance such implementation in KwaZulu-Natal (KZN).

Methodology

A qualitative approach using grounded theory design was used to develop a practice framework to enhance the implementation of Policy on Integration of Mental Health Care into PHC in KZN. A non-probability sampling approach using purposeful sampling and theoretical sampling was used. PHC managers, operational managers and professional nurses were selected for collection of data. The sample consisted of 42 participants. Data was collected by means of one-on-one interviews and focus group interviews. Strauss and Corbin's approach of data analysis was used for analysing data. Three coding procedures were used for analysing data, namely, open coding, axial coding and selective coding. The paradigm model as described by Strauss and Corbin was used as a guide to develop a practice framework to enhance implementation of Policy on Integration of Mental Health Care into

PHC in KZN.

Results

The findings of this study are that integration of mental health care into PHC is understood as provision of comprehensive care that is needed by all mental health care users at the clinic, and is being offered using either a supermarket approach or a one-stop-shop approach at PHC clinics. Strategies that can be used at PHC clinics in KZN to ensure that integration of mental health care into PHC is implemented include screening of all patients that come to the PHC clinic for mental illness, fast tracking of mental health care users once they have been assessed and found to be mentally ill, and chronic management of all patients including mental health care users.

The practice framework developed identifies comprehensive mental health care being offered to mental health care users using either a supermarket approach or one-stop-shop approach depending on the availability of staff with a qualification in Psychiatric Nursing Science. It emerged that there should be an enabling environment for integration of mental health care to take place namely adequate space for consultation of mental health care users, adequate medication, protocol and procedure for referral and management of mental health care users, a qualification in Psychiatric Nursing Science and Primary health care for all nurses working in PHC clinic as well as availability of Psychiatrist and advanced psychiatric nurses at each PHC clinic.

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Acronyms

Acronym	Full word/sentence
CEO	Chief Executive Officer
CHC	Community Health Centre
DUT	Durban University of Technology
FGD	Focus Group Discussion
HIV	Human Immune Deficiency Virus
IMCI	Integrated Management of Childhood Illnesses
IPHC	Integrated Primary Health Care
KZN	KwaZulu-Natal
P	Participant
PHC	Primary health care
TB	Tuberculosis
WHO	World Health Organization

CHAPTER 1 : OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

According to the Alma Ata Declaration, health is a fundamental human right and is defined by the World Health Organization (WHO) as state of complete physical, mental and social well-being and not merely absence of disease (WHO 1978: 2). Prior to 1994, the health care system in South Africa was fragmented and not only segregated by race or ethnic group, but also with the best resourced facilities located in urban areas while rural areas remained under resourced (African National Congress 1994: 1). Prior to 1994, the health care system in South Africa was fragmented and not only segregated by race or ethnic group, but also with the best resourced facilities located in urban areas while rural areas remained under resourced (African National Congress 1994: 1). In keeping with the Constitution of South Africa (Republic of South Africa 1997), the White Paper for the Transformation of the Health System in South Africa was published in 1997, which made provision for a new health system based on primary health care (PHC) principles (Republic of South Africa 1997). The PHC system emphasises prevention and promotion instead of being curative and hospital based. According to the Alma Ata Declaration, primary health care is based on acceptable methods and technology of basic health care which is made accessible to individuals, families and communities through their participation, and is cost effective. Primary health care forms part of a country's health care system and is the first level of contact for individuals, families and the community (WHO 1978: 1). In a PHC approach, health care should take place at district level where patients have access to an integrated health care system near to where they live. South Africa has made significant strides to eliminate divisions of the past and to align the health care system of the country with international trends such as the Alma Ata Declaration and the WHO in terms of management of

health care, including mental health care.

Prior to 1994 mental health care was characterised by violations of human rights and mental illness was regarded as supernatural and treatment therefore ranged from religious to physical care (Burns 2008: 45). In 1973, the Mental Health Care Act No. 18 of 1973 was promulgated and this Act reinforced isolation of the mentally ill patients from general health care. Psychiatric services were stand-alone services and not integrated into PHC (Burns 2008: 46). Post 1994, changes in the health care system as well as mental health care took place, and South Africa put more emphasis on comprehensive care as well as integration of mental health care services so as to align the country's health services with international trends (Mkhize and Kometsi 2008: 104).

In line with international trends, the Mental Health Care Act No. 17 of 2002 was promulgated based on the principle that mental health care should be integrated into PHC and should take place near to where people live. Although the policy on integration of mental health care was promulgated in 1997 at the same time as the White Paper for the Transformation of the Health System in South Africa, it took 9 years for the National Department of Health to release guidelines on the management of mentally ill patients at PHC level in South Africa. In 2007, the KwaZulu-Natal (KZN) Department of Health (KZN Department of Health 2007:1) released treatment protocols and an essential drug list for the management of mental disorders which was based on the guidelines issued by the Department of National Health. In 2013, the National Mental Health Policy Framework and Strategic Plan 2013 to 2020 was developed for South Africa (Department of Health 2013). Although South Africa has made significant achievements at the level of policy development and legislation in trying to bring the country in line with international trends, there have been challenges with regard to implementation of these policies, including that of integration of mental health

care into PHC.

Mental health conditions contribute to 13% of the global burden of disease and 16.5% of South African adults suffer from common mental health disorders (Williams *et al.* 2008: 4). In response to the increasing burden of mental disease, the policy on integration of mental care into PHC identifies important principles which stipulate that mental health care should be integrated into general health care. People with mental disorders should be treated in PHC clinics (Department of Health 2013).

1.2 PROBLEM STATEMENT

Since the publication of the White Paper for the Transformation of the Health System in South Africa in 1997, there has been emphasis on the promotion of health as well as the re-engineering of PHC including the integration of mental health care into PHC. PHC re-engineering in South Africa is a national strategy launched in 2010 by the National Minister of Health, and is aimed at improving primary health care. This strategy promotes health care which is more practical, integrated and based on the needs of the population (Department of Health 2010: 1). In a PHC clinic, nurses are responsible for the management, administration and counselling of patients. Nurses are at the forefront of the management of patients, including management of the mental health care users (Department of Health 2010: 2).

After the development of policy on integration of mental health care into PHC, the South African National Department of Health released guidelines on the management of mental health care users at PHC level (Department of Health 2006a: 17). These guidelines concluded that integrating mental health services into PHC would increase prevention, screening, self-care, treatment, and rehabilitation of mental health care users, and reduce the number of mental health users who are referred for secondary and tertiary treatment.

The researcher, a qualified psychiatric nurse, observed that in KZN there are still many challenges pertaining to the integration of mental health care into PHC. At PHC clinics there are mental health care users who have been discharged from hospitals who require continuity of care and clients who have mental illness but have not yet been diagnosed. Ineffective implementation of the Policy on Integration of Mental Health Care into PHC results in mental health care users being seen at PHC clinics but PHC nurses not being able to manage their condition or identify clients with mental health problems.

Since the publication of these policies, there has been insufficient information to guide PHC nurses on the implementation of the policy. This statement is supported by Bhana *et al.* (2010: 602) who point out that there are insufficient directives on how integration should be conducted. Petersen *et al.* (2011: 4) warn that despite the release of guidelines, there are gaps in the management of mental health care users at PHC clinics, especially in rural areas. Bhana *et al.* (2010: 4) identified that there is insufficient support for PHC nurses and warned that poor identification of mental disorders at PHC clinics may increase the rate of health care service utilisation (Petersen *et al.* 2011: 4). Awenza *et al.* (2012: 184) warn that one of the major challenges affecting the quality of the mental health care services in PHC clinics is that PHC nurses do not have time to provide quality mental health care. This is supported by Draper *et al.* (2009: 342) who state that nurses in PHC clinics are poor in detecting and managing mental health conditions. Dube and Uys (2015: 1) found that in five clinics in the uThungulu District in KZN, 83.3% of treatments for mental health care users were not reviewed every 6 months as they should be. There were no local protocols on the administration of emergency drugs. None of these clinics gave mental health education on medication and their side effects. They concluded that PHC services remain ineffective in managing mental health care users despite all the guidelines that have been developed. Therefore, it is important to develop a practice framework to enhance the implementation of the Policy on Integration of Mental Health

Care into PHC in KZN.

1.3 AIM OF THE STUDY

The aim of the study was to develop a practice framework for PHC nurses in order to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

1. Explore the understanding of the phenomenon, namely, integration of mental health care into PHC.
2. Analyse the process of the phenomenon, namely, integration of mental health care into PHC.
3. Identify and describe the causal conditions, intervening conditions or challenges, if any, that might hinder the implementation of the Policy on Integration of Mental Health Care into PHC.
4. Identify and describe consequences or outcomes of ineffective implementation of the Policy on Integration of Mental Health Care into PHC.
5. Determine and document the degree of implementation of the Policy on Integration of Mental Health Care into PHC in KZN.
6. Develop a practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

1.5 RESEARCH QUESTIONS

The study was guided by the following questions:

1. What is the understanding of the concept of integration of mental health care into PHC?
2. What are the main components of an integrated mental health care

programme in a PHC clinic?

3. What are the causal conditions of ineffective implementation of the Policy on Integration of Mental Health Care into PHC?
4. What are the intervening conditions or challenges, if any, that might be hindering the implementation of the Policy on Integration of Mental Health Care into PHC?
5. What are the consequences or outcomes, if any, of ineffective implementation of the Policy on Integration of Mental Health Care into PHC?

1.6 SIGNIFICANCE OF THE STUDY

The year 2017, marks 20 years since the publication of the White Paper for the Transformation of the Health System in South Africa which emphasised a PHC approach to health care. The PHC approach to care should take place at district level where patients have access to health care needs, in an integrated health care system near to where people live. From the literature review it was evident that there is poor integration of mental health care into PHC. The practice framework that was developed will allow integration of mental health care to be more efficient and the mental health care users will be the beneficiaries of this improved practice.

Various studies have indicated that PHC services remain ineffective in managing mental health care users despite the various guidelines that have been developed (Dube and Uys 2015: 2; Kigozi *et. al.* 2009: 37; Burns 2008: 1). PHC nurses are at the forefront of the provision of PHC at clinics. So far no study has been conducted to develop a practice framework that will enhance the implementation of the policy on integration of mental health care into PHC by PHC nurses. This study addressed the following questions: What is PHC nurses' understanding of the policy on integration of mental health care into PHC? What are the causal conditions for the poor implementation of

the policy? What are the intervening conditions, and what are the consequences of ineffective implementation of the policy? The information received from the study has been used to develop a practice framework to enhance the implementation of the policy on the integration of mental health care into PHC. The practice framework developed might be used as a guideline for nursing practice, nursing education and training of PHC nurses as well as future research.

1.7 DEFINITIONS OF CONCEPTS

For the purpose of this study it is necessary to define the concepts that were used throughout the thesis to ensure that the readers and the researcher share the same meaning attached to specific concepts.

1.7.1 De-institutionalisation

According to Uys and Middleton (2010: 11) de-institutionalisation is the scaling down of state institutions that used to keep mental health care users for longer periods and discharging of mental health care users to the community. This involves transfer of mental health care users from psychiatric institutions into the community. For the purposes of this study, de-institutionalisation refers to discharging mental health care users who have recovered from acute episodes of mental illness and are receiving treatment from PHC nurses

1.7.2 Service integration

Service integration is defined as bringing together of services and activities that share common goals (Sibiya and Gwele 2009: 31; Thema and Singh 2013: 1).

1.7.3 Mental health care

Mental health care is a human clinical science based on a variety of theoretical frameworks with emphasis on the psychosocial and biophysical sciences. It constitutes knowledge regarding promotion of mental health and primary, secondary and tertiary prevention of mental illness (Townsend 2009: 19). For the purpose of this study, mental health care will mean care given to mental health care users by nurses working in PHC clinics.

1.7.4 Mental illness

Townsend (2009: 19) defines mental illness as a clinically significant behavioural or psychological syndrome or pattern that occurs in a person that is associated with personal distress. It is characterised by maladaptive responses to stressors from internal or external environments evidenced by thoughts, feelings and behaviours that are not congruent with local and cultural norms and which interfere with an individual's social, occupational and or physical functioning. For the purposes of this study, mental illness will mean a condition that warrants psychiatric treatment from PHC nurses.

1.7.5 Primary health care

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology which is accessible to individuals, families and community through their full participation and at a cost that community and country can afford to maintain at every stage of their development. For the purposes of this study PHC will refer to the mental health care given to mentally health care users at the nearest clinic (Dennill, King and Swanepoel 2005: 2).

1.7.6 Mental health

Townsend (2009: 19) defines mental health as a successful adaption to stressors from internal or external environments evidenced by thoughts, feelings and behaviours that are age appropriate and congruent with local and cultural norms. For the purposes of this study, mental health will mean a person who is successful in working, loving, resolving conflict and adapting well to the environment.

1.8 OUTLINE OF THE THESIS

This thesis is presented in seven chapters, as outlined in Table 1.1.

Table 1.1: Structure of the thesis

Chapter	Title	Content description
1	Overview of the study.	Orientation to the study, research background, overview of the research problem, aims and objectives, research questions, significance of the study.
2	Literature review.	An in-depth review of the literature related to the topic under investigation.
3	Research methodology.	Research methodology that underpins the study.
4	Presentation of results.	Presentation and interpretation of the research findings.
5	Discussion of results.	Discussions of research findings.
6	Development of the practice framework.	Presentation of the practice framework to enhance the implementation of the policy on integration of mental health care into PHC.
7	Summary of the findings, limitations of the study, conclusion and recommendations.	Presentation of the summary of findings, limitations of the study, conclusion and recommendations.

1.9 SUMMARY OF THE CHAPTER

Chapter 1 presents the background information of integration of mental health care into PHC. The information included a review of the South African health care system, mental health care prior to 1994 including the promulgation of

Mental Health Care Act No. 18 of 1973 and its challenges. Following the advent of democracy in South Africa in 1994, the National Department of Health adopted a White Paper for the Transformation of the Health System in South Africa. Together with amendments of the Mental Health Care Act No. 17 of 2002, guidelines for the management of mental health care users at PHC level in South Africa were developed in 2006 (Department of Health 2006a:1). This was followed by the release of treatment protocols and an essential drug list for the management of mental disorders by the KZN Department of Health in 2007. In response to these developments in mental health care, a policy framework for the integration of mental health care into PHC was adopted which made integration of mental health care possible. The review of literature will be presented in Chapter 2.

CHAPTER 2 : LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews relevant literature to provide background to the study. Literature review is important in the research process because it provides the researcher with background information and research ideas, and it orientates the researcher to what is already known about the topic. Strauss and Corbin (1990: 50) state that the literature review is conducted so that the researcher can come to the research with a background idea. In contrast, Chenitz and Swanson (1986: 1249) argue that a lengthy review of existing literature can reflect overdependence on existing knowledge, but further state that a review of existing literature can show gaps in existing knowledge. PubMed and the Cumulative Index to Nursing and Allied Health literature (CINAHL) databases were searched for papers using the following terms: mental health, PHC, integration of mental health care, and grounded theory. Google Scholar was also used to retrieve mental health care policies including policy on integration of mental health care and related articles. This chapter starts by reviewing the global view on integration of mental health care into PHC. The subsequent headings include integration of mental health care into PHC in Africa and integration of mental health care into PHC in South Africa.

2.2 GLOBAL VIEW ON INTEGRATION OF MENTAL HEALTH CARE INTO PHC

Worldwide, mental health care is regarded as the treatment of people that cannot function according to society's norms without treatment (Townsend 2009: 19). According to Svab and Svab (2013: 22), community health care centres and clinics worldwide are experiencing mental health care challenges. In Slovenia, a European country with a total population of around 2 million

people, access to mental health care is limited and mental health care services are mostly hospital based. Health care services in PHC are provided by PHC centres which are owned by the local authority. In trying to improve mental health care in Slovenia a programme was developed for improving access to, and quality of, psychiatric services according to modern trends. A team consisting of a psychiatrist, a social worker, an occupational therapist and three graduate nurses was formed to follow up frequently re-admitted patients in the community. This effort resulted in a reduction in hospital admissions by almost 50% (Svab and Svab 2013: 23).

In contrast to mental health care in Slovenia, Currid *et al.* (2011:1) reported that mental health care in London after 1999 is now part of PHC services, especially for conditions such as depression and anxiety. Mental health disorders are the second most common reason after respiratory conditions for consultation in PHC and are implicated in 25% of all primary care appointments. Mental health is a public health issue that needs to be given the same status and recognition as physical health and this has the potential to have positive effect on social, political, educational, economic and social factors both in the long and short term. Currid *et al.* (2011: 21) state that the majority of people with mental disorders in London view PHC as the cornerstone of their health care system.

According to Sharma and Copeland (2009: 11), PHC services in London provide inadequate services and health care staff members have poor skills in detecting and treating people with mental disorders. The authors further state that there is a lack of training and time available for general practitioners and PHC workers to adequately take care of mental health of their patients (Sharma and Copeland 2009: 11). This is supported by Al-Khathami *et al.* (2013: 204) in Saudi Arabia who reported that 60% of patients presenting at PHC clinics have mental health problems. If this illness is undetected, it can later lead to difficulties in management. The Ministry of Health in Saudi Arabia

established a PHC programme to meet the demand of mental health problems. Multidisciplinary teams were formed to assess patients at the clinics at their first visit after which management and follow-up plans were formulated. Although there was a high rate of mental illness among the patients who attended PHC clinics, it was reported that there was a high rate of improvement among the treated cases (Al-Khathami *et al.* 2013: 204).

2.3 INTEGRATION OF MENTAL HEALTH CARE INTO PHC IN AFRICA

In Africa, although policies have been developed, there are still challenges with regard to implementation of these policies. Bhana *et al.* (2010: 602) describe implementation of the policy on integration of mental health care as problematic in Ghana and Uganda. In Ghana, a mental health policy document was adopted in 1994 and was revised in 2000 but the policy was not implemented. Uganda endorsed a policy on integration of mental health care into PHC but failed to provide implementation guidelines. This is supported by Kigozi and SSebunnya (2009: 1) who state that integration of mental health care into PHC has not been fully understood in Uganda. Kigozi and SSebunnya (2009: 37) further state that irrespective of the various changes and opportunities with regard to policies in place in Uganda, integration of mental health care into PHC still faces many challenges and call for more effort to speed up activities for integration of mental health care into PHC. The authors further state that although mental health policy was revised in Ghana in 2000, emphasising decentralisation of mental health services and development of community care, health workers were not aware of the policy and the Mental Health Care Act of 1990. Kigozi and SSebunnya (2009: 37) state that irrespective of the various changes and opportunities with regard to policies in place in Ghana, integration of mental health care into PHC faces many challenges, namely:

- Policy is not yet fully institutionalised at all levels of care.
- There is little appreciation and understanding of what it entails.

- Most general nurses are not equipped to manage mentally ill patients.
- PHC nurses do not regard it as their role to manage mentally ill patients.
- Negative attitude towards mental illness.
- Interest in nursing mentally ill among general nurses is still very low.
- There is understaffing with few experts to provide technical support and supervision.
- Mental health care is not receiving enough support.

According to Kigozi and Ssebunnya. (2009: 37), mental health services in PHC involve diagnosing and treating people with mental disorders within the general framework of available health services. This involves putting in place strategies to prevent mental disorders, ensuring that primary health workers are able to apply psychosocial and behavioural skills, as well as ensuring an effective referral system.

Kigozi and Ssebunnya (2009: 38) list the advantages of integrating mental health care into PHC in Uganda as including:

- Reduced stigma for people for people with mental disorders and their families.
- Improved access to care and protection of human rights.
- Reduced chronicity and improved social integration.
- Improvement in the human resource capacity for mental health.

2.4 INTEGRATION OF MENTAL HEALTH CARE INTO PHC IN SOUTH AFRICA

Integration of health services has been widely advocated as a key strategy to improve access to care, efficiency and cost-effectiveness of service provision and patient satisfaction (Haskins, Phakathi, Grant, Mntambo, Wilford and Horwood 2016: 1; Kerber, de Graft-Johnson, Bhutta, Okong, Starrs and Lawn 2007: 1358; Stange 2009: 100). Post 1994, South Africa put more emphasis

on integration of mental health services so as to align the country's health services with international trends such as the Alma Ata Declaration and the WHO reports. The Alma Ata Declaration promoted comprehensive approach to health care which includes physical, social and economic well-being (Mkhize and Kometsi 2008: 104). In line with international trends, the Mental Health Care Act No. 17 of 2002 was promulgated in South Africa which was based on a number of principles, namely:

- Patients are referred to as mental health care users.
- Health services that are offered include care, treatment and rehabilitation.
- Human rights of the mentally ill patients are not inferior to the welfare of the country.
- Mental health care should be integrated with PHC.
- Mentally ill patients should be treated near to their homes and within their communities (Burns 2008: 47).

Uys and Middleton (2010: 11) further state that changes to the South African health care system included de-institutionalisation and the integration of previously institutionalised patients with severe or chronic mental illness into their communities. They argue that patients were transferred into the community without preparing the community for the influx of patients. A further downfall of this policy implementation is that psychiatric nurses continue to be concentrated in hospitals while patients are in the community.

After 1994, after the promulgation of the Mental Health Act No.17 of 2002, a number of policies were formulated as discussed below.

2.4.1 White Paper for the Transformation of the Health System in South Africa (1997)

Goals and objectives of transformation of the health system in South Africa as referred to in the White Paper included:

- Unify fragmented health services at all levels into a comprehensive and efficiency integrated national health system.
- Extend the availability and ensure the appropriateness of health services, namely, establish a district health system in which all communities are covered by a basic health unit which offers an essential package of care.
- Ensure a functioning referral system at primary, secondary and tertiary levels, and improve access to comprehensive health services.
- Ensure universal availability of high quality, low cost essential drugs.
- Ensure that every South African develops his or her potential fully with the support of community based nutrition promotion activities to develop health promotion activities.
- Develop the human resources available to the health sector namely promote optimal use of skills and experiences of all health personnel.
- Develop education and training programmes aimed at recruiting and developing staff that are competent to respond appropriately to the health needs of the people they serve.
- Ensure that the composition of human resources in the health sector reflects the demographic pattern of the general population.
- Promote a new culture of democratic management in the health sector.
- Foster community participation across the health sector.
- Involve communities in various aspects of the planning and provision of health services.
- Establish mechanisms to improve public accountability and encourage communities to take greater responsibility for their own health promotion and care.

- Improve health sector planning and the monitoring of health status and services, namely develop a national health information system that will facilitate the measurement and monitoring of the health status of the South African population.
- Enable the evaluation of the delivery of health services and support effective management at all levels of the health services.
- Ensure that those responsible for the health status of South Africa's population are kept up to date with the information, and build capacity at the provincial, district, local and community levels to develop plans based on priority issues and ensure appropriate and cost-effective interventions (Republic of South Africa 1997:5)

2.4.2 Strategic Plan for the Delivery of Mental Health Care Services in KZN (2007)

In an attempt to implement the Mental Health Act No. 17 of 2002, KZN was the first province to develop a plan, called the Strategic and Implementation Plan for the Delivery of Mental Health Care Services in KZN in 2007 (KZN Department of Health: 2007:1). This plan stipulated the framework for integrated mental health services at primary, secondary and tertiary levels of care (Burns 2008: 48). The plan endorsed primary health services to treat mentally ill patients being offered at community level at PHC, at community health centres (CHCs) and district hospitals. According to this plan:

- General practitioners are expected to offer care, treatment and rehabilitation to mental health care users.
- Services provided will include PHC, CHCs, outpatients' services, screening, and services, follow-up care and provision of short term inpatient care for a period of 72 hours.
- Secondary level of care will be available at regional hospitals. Designated psychiatric hospitals will be responsible for tertiary care (Burns 2008: 46).

2.4.3 Psychosocial Rehabilitation Policy (2006)

This policy was developed to facilitate and assist mental health care users to integrate well into the community. This policy focuses on psychiatric services in a holistic manner. The objectives of the policy include:

- Reduce symptomology through appropriate pharmacology, psychological treatments and psychosocial interventions.
- Reduce iatrogenic illnesses by reducing and eliminating where possible the adverse physical and behavioural consequences of the above.
- Improve social competences by enhancing individual's' social and psychological coping and occupational functioning.
- Reduce discrimination and stigma.
- Enhance support to families with a member who has a mental disorder.
- Create and maintain a long-term system of social support, covering at least basic needs related to housing, employment, social networking and leisure, and empowering carers and users through psycho-education programmes, active involvement in the programme and encouraging advocacy (Department of Health 2006b: 17).

2.4.4 Policy on Integration of Mental Health Care into PHC (1997)

Policy on integration of mental health care into PHC was developed in March 1997. It took another 15 years for the National Department of Health to develop the National Mental Health Policy Framework and Strategic Plan 2013 to 2020 through consultation which culminated in a mental health summit in 2012 where declaration of the policy was adopted. The mental health policy identifies key principles that are important to transform mental health services in South Africa which include:

- Mental health care should be integrated into general health care.
- People with mental disorders should be treated in PHC clinics.
- Mental health care services should be planned at all levels of care including primary, secondary and tertiary levels.

- The human rights of people with mental illness should be promoted and protected.
- Mental health care users should have access to care near to the places where they live and work.
- Mental health care services should be accessible to all people regardless of geographical location, economic status, race, gender or social condition (Department of Health 2013: 19).

This is to be achieved by ensuring that mental health care is accessible, equitable, comprehensive and integrated at all levels of health (Department of Health 1997: 12). The PHC approach to mental health care seeks to improve mental health and social well-being of individuals, families and communities.

According to Dennill, King and Swanepoel (2005: 3), PHC elements of care include:

- Promotion of food supply and proper nutrition.
- An adequate supply of safe water and basic sanitation.
- Maternal and child health care.
- Immunisation against major infectious diseases.
- Prevention and control of endemic diseases and appropriate treatment of common diseases.
- Promotion of essential drugs.

Although South Africa has made significant achievements at the level of policy development and legislation in trying to bring the country in line with international trends, there have been challenges with regard to implementation of policies including the integration of mental health care into PHC in KZN.

Many studies have raised concerns regarding the implementation of policy on integration of mental health care into PHC with the main concern being the lack of resources (Bhana *et al.* 2010; Lund *et al.* 2012; Petersen *et al.* 2009). Bhana *et al.* (2010: 599) list uneven implementation of the policy, inadequate access to essential drugs, and lack of mental health specialists as some of the reasons for the challenges in providing mental health at the PHC clinics. Bhana *et al.* (2010: 599) raise concerns that decentralisation and integration of mental health into PHC is recognised in the White Paper for the Transformation of the Health System in South Africa and in the Policy Guidelines for Mental Health Services which have been in place since 1997, but these policies were not given official status and insufficient directives on how integration should be done. Integration was further compromised by lack of financial resources.

Petersen *et al.* (2009: 1) state that while decentralisation and integrated PHC is a core of mental health policies in many low and middle-income countries, implementation of the integration of mental health care remains a challenge. According to Lund *et al.* (2012: 402), the key challenges of integration of mental health services in PHC include training and supervision of staff in the detection and management of common mental disorders, as well as development of community based psychosocial programmes for people with severe mental illness. In support, Burns (2008:46) states that problems with the implementation of the Act include lack of resources, lack of infrastructure, inadequate skills, poor support and training. Awenza *et al.* (2012: 184) warn that one of the major challenges affecting the quality of the mental health care services in PHC clinics is that PHC nurses do not have time to provide quality mental care. This is supported by Draper *et al.* (2009: 342) who state that nurses in PHC clinics are poor in detecting and managing mental health conditions. Dube and Uys (2015: 1) found that in five clinics in the uThungulu District in KZN, 83.3% of treatments for mental health care users were not reviewed every 6 months as they should be. There were no local protocols on

the administration of emergency drugs. None of these clinics gave mental health education on medication and side effects to the mental health care users. They concluded that PHC services remain ineffective in managing the mental health care users despite all guidelines that have been developed.

Mkhize and Kometsi (2008: 10) identified factors that affect the integration of mental health care into PHC to include inadequate community participation and involvement, limited resources, lack of infrastructure, lack of political will, excessive workload, and inadequate support for PHC workers. Mkhize and Kometsi (2008: 109) further suggest that there is a need to develop information systems to monitor and review the transition of mental health care users from hospital to community based clinics, and a reliable data base on the prevalence of mental disorders. They further state that there should be research into intervention models that take into account the culture of the mental health care user, their explanation of their illness as well as their pathways for seeking help. General Nurses should be trained to be able to identify and refer mental disorders and must be supervised by specialists. Mechanisms need to be developed to narrow the gap between policy making and implementation. Mental health care users need to be empowered and must have forums to discuss their problems.

It is evident from the literature review that there are many challenges with regard to implementation of the policy on integration of mental health care into PHC. Therefore, this study aimed to analyse implementation of the policy on integration of mental health care into PHC with the ultimate aim of developing a practice framework which will assist PHC nurses in improving quality of mental health care which is provided at PHC clinics in KZN.

2.5 SUMMARY OF THE CHAPTER

Chapter 2 reviewed the state of integration of mental health care into PHC internationally, regionally and nationally in South Africa. Review of the literature reveals problems with integration of mental health care into PHC and it is evident that integration of mental health care into PHC has not been implemented effectively worldwide including South Africa, hence the need for this study. The research methodology for this study will be presented in Chapter 3.

CHAPTER 3 : RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter, the research methodology is described in terms of design, methods, population and procedures used for data collection as well as procedures used during the data analysis. The aim of the study was to develop a practice framework for PHC nurses to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN. The broad elements of the study are presented in Table 3.1.

Table 3.1: Broad elements of the study utilising grounded theory process

Methodology.	Qualitative method using grounded theory approach.
Sampling methods.	Purposive sampling. Theoretical sampling.
Data collection methods.	Focus group interviews. One-on-one in-depth interviews. Follow-up interviews. Constant comparison. Writing memo. Field notes.
Data generation.	Open coding: identification of concepts. Axial coding: identification of categories. Selective coding: identification of core categories. Saturation of data. Formulation of a framework using paradigm model.

3.2 DESIGN

According to Polit and Beck (2012: 58), research design is the overall plan for obtaining answers to the research questions. Brink, Van Der Walt and Van Rensburg (2012:121) further state that the researchers who want to obtain an inside perspective of the situation need to sit back and let the participants express their voices. Qualitative research focuses on the meaning,

experience, and understanding of the phenomenon, and it allows the researcher to interact with individuals or groups to understand their experiences (Brink *et al.* 2012: 122). A qualitative approach using grounded theory design was used to develop a practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN. Strauss and Corbin (1990: 17) define qualitative research methodology as any kind of research that produces findings not arrived at by means of quantification. Qualitative research was used in this study as it is the most appropriate method to gain in-depth understanding of the phenomenon of integration of mental health care into PHC in KZN.

Grounded theory design is a highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that improves the understanding of social and psychological phenomenon (Strauss and Corbin 1998: 15). Data collection, analysis, and the development of a theory or a framework, happen simultaneously. Grounded theory allows the researcher to look at slices of life as they can portray moments of time and offer a set of flexible strategies, not rigid prescriptions (Strauss and Corbin 1998: 15). Grounded theory was appropriate for the study as it is well known for its contribution in areas where little research has been conducted and when new viewpoints are needed to describe a familiar phenomenon that is not clearly understood (Chenitz and Swanson 1986: 7). The rationale for this approach was that the research was aimed at developing a practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN.

3.3 GROUNDED THEORY

Grounded theory has its roots in sociology in the 1960s and was first described by Glaser and Strauss (1967; 460) as a qualitative research method for the study of complex social behaviour from a sociological point of

view. Grounded theory is an inductive investigative process in which a researcher attempts to formulate a theory (Glaser and Strauss 1967: 46). According to Strauss and Corbin (1990: 12), grounded theory is something that is discovered, developed and verified through data collection and analysis. When using grounded theory, data collection and analysis occur simultaneously. The researcher begins with an area of study and allows a theory or framework to emerge from the data which is collected and analysed. Glaser and Strauss (1967: 47) have different views on a number of aspects namely on the research question, on data analysis and verification, on validation of the emerging framework, and on hypotheses. According to Strauss and Corbin (1998: 38), the research question should be formulated at the beginning of the study so as to help the researcher stay focused. They further state that the research question narrows the field of study to a researchable size. Glaser and Strauss (1967: 22), on the other hand, feels that having a research question from the initial phase of the study is limiting, in that the developing theory may not develop from the data but will be shaped by the question. He further states that the researcher should start with an area of interest. He believes that the research problem and question are only discovered when coding begins (Glaser and Strauss 1967: 23). In the current study the researcher followed Strauss and Corbin's idea of having a research question at the beginning of the study because the researcher believes that it is important to have a research question in order to stay focused in the process of the study.

Glaser (1998:67) has different views on the use of literature review. According to Strauss and Corbin (1998: 39), all kinds of literature can be used before the research study. Literature can assist to develop a research question and can facilitate theoretical sensitivity during data collection and analysis. Glaser disagrees with having previous knowledge when entering the field of research, and states that literature should not be reviewed so as not to contaminate the new, emerging theory. Glaser and Strauss (1967: 47) believe

in pure methodology that is free from previous knowledge. The researcher acknowledges the views of Glaser and Strauss, but has chosen to use Strauss and Corbin's approach. The rationale for using Strauss and Corbin's approach is that it is more appropriate for this study because the researcher reviewed literature related to integration of mental health care into PHC so as to get background information and knowledge to assist in the development of a practice framework to enhance the implementation of Policy on Integration of Mental Health Care in KZN of South Africa.

Glaser (1978:55) describes data analysis as an essential aspect of transforming raw data into theoretical constructs of a social process. The process is characterised by substantive and theoretical coding. Theoretical coding conceptualises how codes may relate to each other as hypotheses to be integrated into a theory, whereas substantive coding conceptualises the empirical substance of the area of research. Glaser (1978: 55) believes that concepts necessary for the development of the framework or theory should be allowed to emerge on their own through the grounded theory process. Strauss and Corbin (1990:61) use the process of open coding, axial coding and selective coding using a paradigm model to allow the researcher to fit emerging concepts. As a result of these differences, the researcher selected data analysis using Strauss and Corbin's approach because it provides a clear and structured way of analysing data. Strauss and Corbin's data analysis method is more appropriate for this study because the researcher will be able to develop a practice framework based on the emerging concepts and categories according to a paradigm model.

3.4 STUDY SETTING

Strauss and Corbin (1990: 39) state that the selection of the setting should be directed by theoretically relevant concepts and therefore the researcher must select settings that will provide relevant data. The study took place in selected

health districts in KZN. There are 11 health districts in KZN namely uGu, uMgungundlovu, uThukela, uMzinyathi, Amajuba, Zululand, uMkhanyakude, King Cetswayo, iLembe, Harry Gwala and eThekweni (Metropolitan). Out of these eleven districts, four districts were purposefully selected.

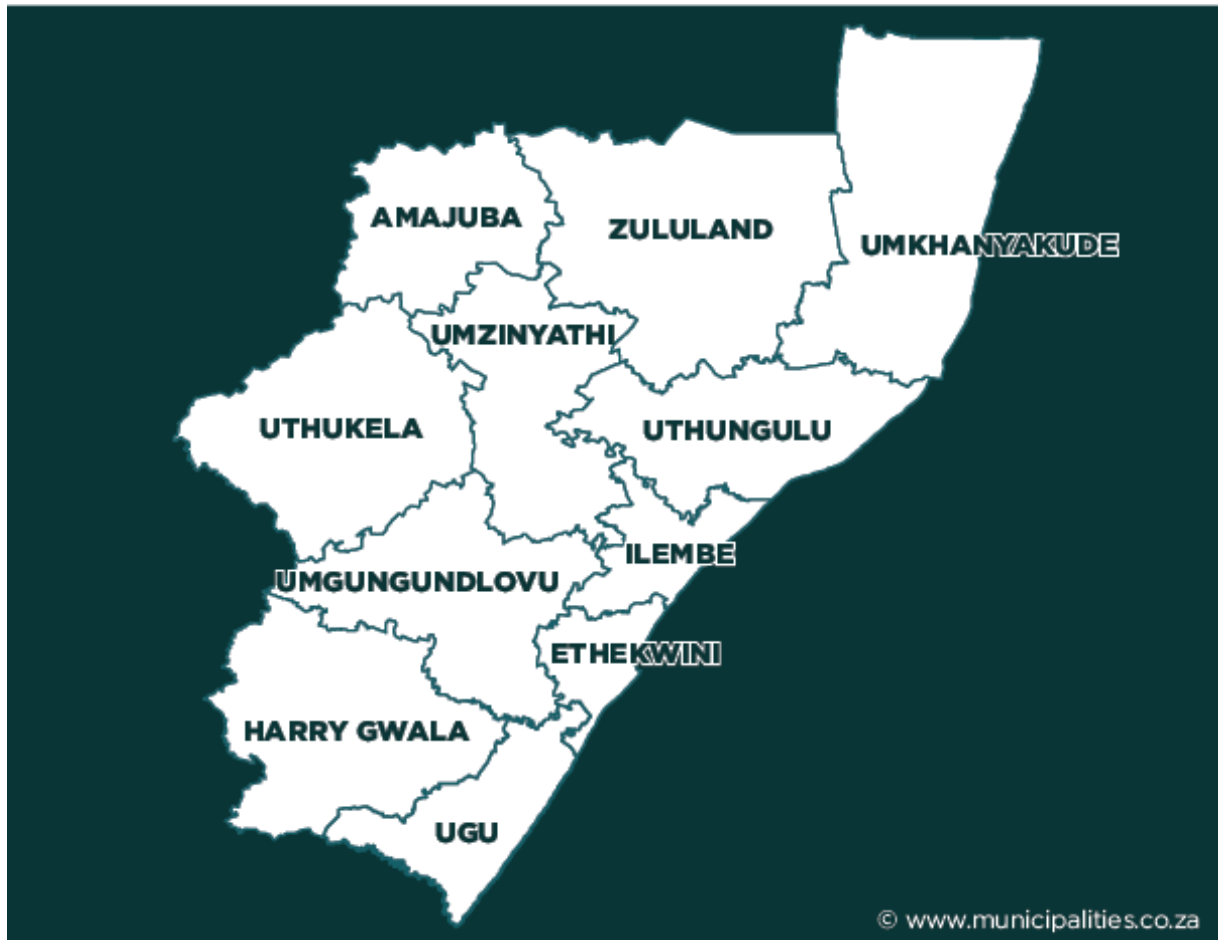


Figure 3.1: Map representing 11 Health Districts in KZN

3.5 SAMPLING PROCESS

Sampling is a process of selecting a portion of the population to represent the entire population (Polit and Beck 2012: 339). According to Botman *et al.* (2010: 13), sampling should be based on reasons directly related to the research study and these authors argue that sampling should not be based

only on the researchers' understanding of sampling method or preferences. Polit and Beck (2012: 275) describe two methods of sampling, namely, probability sampling which involves random selection of participants, and non-probability sampling which involves non-random methods. The non-probability sampling approach that was used in this research was purposeful sampling and theoretical sampling because PHC managers, operational managers and professional nurses are best suited to answer the research question. Purposeful sampling is based on the assumption that the researcher's aim is to discover, understand and gain insight whereas theoretical sampling is a process whereby the researcher collects, codes and analyses data, and then from the data analysis results the researcher decides what data to collect next and where to find it in order to develop a theory (Glaser and Strauss 1967: 48). The process of purposeful sampling used in this study involved the researcher selecting nurse managers, operational managers as well as professional nurses who are involved in the management of mental health care users at PHC clinics. Theoretical sampling means participants were selected on the basis of their ability to contribute to the development of a practice framework (Creswell 2009: 6). The process of theoretical sampling involved the researcher going back and forth to look for particular participants to fill the gaps and clarify issues that were not clear to the researcher. Grounded theory requires an interactive process of data collection, coding, analysing and planning (Strauss and Corbin 1998: 101).

A three-stage sampling approach was applied:

1. *1st stage* was selecting health districts in KZN which were purposefully selected according to their geographical location since these boundaries of the health districts coincide with the district and metropolitan municipal boundaries. The districts selected included central (eThekweni), midlands (uMgungundlovu), north (iLembe) and south (uGu), eThekweni and uMgungundlovu health districts are situated in urban areas and iLembe and uGu health districts are situated in rural

areas. It is often assumed that health facilities which are located in urban areas are better resourced than facilities located in rural areas. All four districts had implemented the policy on the integration of mental health care into PHC at their clinics.

2. *2nd stage* sampling was to select clinics located within districts of eThekweni, uGu, uMgungundlovu and iLembe. The researcher purposefully selected one central and accessible clinic per district, that provides comprehensive care and which had implemented the policy on integration of mental health care. The clinics that were purposefully selected were KwaDabeka clinic in eThekweni, Gamalakhe Clinic at uGu district, Mbalenhle Clinic at uMgungundlovu district and Ndwedwe Clinic at iLembe district.

All four purposefully selected clinics provide a 24 hour comprehensive package which include preventive, promotive including curative and treatment of minor ailments, maternal and neonatal care as well as management of chronic illness including mental health care.

3. *3rd stage* sampling was selecting participants who were going to take part in the study. Purposeful sampling and theoretical sampling were used to select participants. Only PHC managers, operational managers as well as professional nurses who are providing mental health care at selected clinics participated in this study, as these cadres of health care workers are directly involved in the implementation of the policy on integration of mental health care into PHC at the selected clinics. According to Glaser and Strauss (1967: 49), the researcher should choose participants who will further the development of emerging categories, generate as many properties of categories as possible, and help relate categories to each other.

3.5.1 Inclusion criteria

- PHC programme managers of each selected clinics;
- Operational managers of the PHC clinics; and
- Professional nurses with 2 years' exposure to PHC setting.

3.5.2 Exclusion criteria

- Staff nurses at selected clinics;
- Enrolled nursing assistants; and
- Community service practitioners.

3.6 BACKGROUND INFORMATION ON SELECTED DISTRICTS

3.6.1 EThekwini District

EThekwini is a health district which incorporates the largest city in KZN and is largely urban as it is within a metropolitan area. The district has a population of 3.5 million. It ranks 2nd after Johannesburg in terms of population and size. The eThekwini health district has eight CHCs and comprises the following racial groups

- Black African (51%).
- Coloured (8.6%).
- Indians (24%).
- Whites (15.3%).
- Other (1.1 %)

Only 35% of the sub-districts are predominantly urban and the remainder are rural and semi-rural. It has a humid subtropical climate and has annual rainfall of 1000 millimetres. It has ethnically diverse cultures with mixed traditions with Zulus being the largest group. According to the 2011 census, the main languages spoken are isiZulu (82.18%), English (9.63%), isiXhosa (3.31%)

and isiNdebele (2.5%) (KZN Department of Health 2013a).

3.6.2 uMgungundlovu District

The seat of uMgungundlovu district is located in Pietermaritzburg. According to 2011 census, the majority of the 1 017 763 inhabitants speak isiZulu, followed by English, isiXhosa, Afrikaans and Sesotho. It covers 9.513 square kilometres. uMgungundlovu is surrounded by eThekweni to the south, Harry Gwala to the south-west, iLembe to the east, and uGu to the south, uMzinyathi to the north and uThukela to the north-west. It has seven local municipalities namely:

- Umsunduzi which covers 59.63%.
- Umshwathi which covers 11.64%.
- Umngeni which covers 7.96%.
- Richmond which covers 6.81%.
- Mkhambathini which covers 6.37%.
- Mpofana which covers 3.97%.
- Impendle which covers 3.62%.

According to District Health Plan 2014 to 2015, the district carries 10% of the provincial population, second to the eThekweni metropolitan with a population of 1 052 730. The uMgungundlovu district has 17 mobile PHC teams, 54 fixed PHC clinic and 3 CHCs. The district has been selected as a pilot district to prepare for the implementation of the National Health Insurance (NHI) (KZN Department of Health 2013d).

3.6.3 uGu District

The seat of uGu district is Port Shepstone. According to the 2011 census the majority of its population speak isiZulu, followed by English, isiXhosa and isiNdebele. It is surrounded by uMgungundlovu, eThekweni, the Indian Ocean on its Eastern border and Harry Gwala district to the west and covers 5 047 square kilometres. uGu is the 5th largest of 11 districts in the province. It has

a population of 733 228. Black Africans constitute 90.6% of the total population, followed by Whites (4.9%), Indians (3.4%) and Coloureds (0.8%), with females heading most households. Child headed households are still a challenge with 0.5% of all households being headed by children of 10 to 15 years of age. Eighty percent of the population live in rural areas. According to 2014- 2015 District Health Plan uGu district makes up 7% of the total population of KZN. UGu district comprises six sub-districts: Ezingoleni, Hibiscus coast, Umdoni, Umuziwabantu, Umzumbe and Vulamehlo. Vulamehlo, Umzumbe and Umuziwabantu are rural whereas Ezingoleni, Umdoni and Hibiscus coast are urban and on the coastal belt of uGu and have highly developed tourism and easy access to the N2 freeway. More than two thirds of the population (68%) has access to piped water. The district has two CHCs, 54 fixed clinics including gateway clinics and 15 mobile clinics (KZN Department of Health 2013c).

3.6.4 iLembe District

According to the District Health Plan 2014-2015 iLembe district has a population of 630 464 (KZN Department of Health 2013b). It comprises four sub-districts namely Ndwedwe, Maphumulo, Mandeni and KwaDukuza. KwaDukuza and Mandeni are semi-urban with surrounding rural areas. KwaDukuza comprise 38% of the district population but they only have 29% of the health facilities. The district has two CHCs, 31 fixed clinics and three gateway clinics. One clinic provides 24 hour services except maternal services and 18 clinics provide on call services. There are seven PHC supervisors in the district.

3.7 DATA COLLECTION PROCESS

Grounded theory was used to guide the organisation, analysis and interpretation of results. When using grounded theory, the research process does not start with a hypothesis but the researcher collects and analyses data

to formulate a practice framework. Based on the principle of symbolic interactionism Glaser believes that when using grounded theory:

- There is a need to get out in the field if one wants to know what is going on; the importance of grounded theory is to study reality.
- The evolving nature of experience in the field for the participants and the researcher.
- The active role of persons in shaping the world they live in through the process of symbolic interaction.
- The relationship between participants' meanings and their actions in the environment (Glaser 1967: 16).

After the researcher obtained ethics clearance from the Durban University of Technology and the KZN Department of Health, data was collected from four PHC clinics in four districts as previously discussed. The chief executive officers (CEO) of each clinic as well as nursing managers were informed two weeks in advance of the visit. The research proposal and permission letters from KZN Department and DUT were emailed to CEOs and nurse managers two weeks in advance. On the days of the collection of data in each clinic, the researcher reported to the CEO and the nurse manager as part of the protocol.

The sample consisted of 42 participants of whom four were PHC managers, six were operational managers and 32 were professional nurses. One-on-one interviews were conducted with ten participants namely four PHC managers and six operational managers. Focus group interviews were conducted with five groups of professional nurses. The first four groups consisted of six professional nurses and one group consisted of eight professional nurses.

All clinics were busy early in the morning, so the researcher had to wait until participants were available each day for one-on-one interviews and focus group interviews. Management at each clinic was very supportive and the

researcher was accommodated. In each clinic the researcher was given a co-ordinator who made sure that all participants were ready for the one-on-one interviews or focus groups. The researcher was then allocated a room which was big enough to accommodate focus group interviews and one-on-one interviews for each day. With the assistance of each clinic co-ordinator, the researcher started on the first day with nursing managers who are in charge of the clinic, thereafter operational managers took turns, depending on their busy schedule. Focus group interviews with professional nurses started after the researcher finished with nursing managers and operational managers.

Before each one-on-one interview and focus group interview, the researcher introduced herself and gave a brief explanation of the research, including the purpose, and all participants were given an informed consent form to sign to indicate their voluntary participation. The duration of focus group interviews was one hour with each group. The interview and focus group discussions were voice recorded and field notes were used as a backup. Seating arrangements were convenient for one-on-one interview as well as for focus group interviews. Participants were relaxed and looked happy to be part of the study. The collection of data occurred in two phases:

Phase 1

The first phase of data collection involved one-on-one in-depth interviews with the PHC managers and PHC operational managers who were involved in the formulation of policy on the integration of mental health care into PHC. A guide was used to facilitate the interviews (Appendix 4). Data obtained during the discussion was voice recorded and field notes were used as a backup.

Phase 2

The second phase was directed at analysing how the Policy on Integration of Mental Health Care is implemented in selected clinics. Focus group

discussions were conducted with the professional nurses who had at least two years' experience in a PHC setting. These professional nurses, who were directly involved in implementing policy at the operational level, were interviewed so as to clarify, fill in gaps and verify the information derived from the data collection during Phase 1. A guide was used to facilitate the focus group discussions (Appendix 4). Data obtained during the discussion were voice recorded using field notes as a backup.

Data collection continued until saturation of data was reached. Data collection and analysis occurred concurrently. Data collection and analysis took over three months. This allowed the researcher to constantly compare similarities and variations to determine common categories and subcategories and go back to interview participants to fill in gaps identified during analysis. The interviews and focus group discussions were transcribed within 12 hours after being conducted. The researcher had to simplify questions in order for participants to understand the questions. The simplified questions that guided focus group discussions and one-on-one interviews were:

- What is your understanding of the term integration of mental health care into PHC?
- What led to the implementation of the Policy on Integration of Mental Health Care into PHC?
- What processes do you have in place at your clinic to ensure implementation of the Policy on Integration of Mental Health Care into PHC?
- What makes the process work at your clinic?
- What makes this process not work at your clinic?
- What needs to be in place in order for the process to work?
- What are the intended and unintended consequences that have happened due to implementation or non-implementation of the policy?
- What are the challenges that you have in implementing the policy?

3.8 DATA ANALYSIS

The researcher used Strauss and Corbin's approach to data analysis. According to Strauss and Corbin (1990: 57), analysing data using grounded theory is a process which reduces raw information into concepts that can be coded and designated as subcategories (Chenitz and Swanson 1986: 217). Memos and diagrams were used during data collection and analysis. Memos are written records of analysis and diagrams are visual devices that show the relationship between concepts. Memos are an integral part of doing grounded theory since it is difficult for the researcher to keep track of all categories, properties and hypotheses that result from the analysis of data (Chenitz and Swanson 1986: 217).

Three coding procedures were used namely open coding, axial coding and selective coding.

3.8.1 Open coding

According to Strauss and Corbin (1998: 101), open coding is the analytic process through which concepts are identified with their properties and dimensions. Open coding was accomplished by breaking down data, examining, and comparing, labelling and categorising data. The product of labelling and categorising result in the development of concepts which are the basic building blocks of grounded theory. During open coding, questions were asked and data was examined until the stage that no new categories emerged from the process. The analytic tools which facilitate open coding are questioning and constant comparative analysis. Concepts were examined by asking questions about them such as: why does the phenomenon occur, when does it occur, how does it occur, what are the effects and consequences or outcome and what causes the phenomenon. Data was compared and categorised. Constant comparison allowed the researcher to take the data collected and constantly compare it to the existing categories

and look for characteristic and properties. Data analysed was linked to emerging categories. Categorisation is the process of grouping similar incidents (Strauss and Corbin 1990: 61). Microanalysis was used to generate categories. According to Strauss and Corbin (1998: 57), micro analysis is the detailed line by line analysis which is necessary at the beginning of a study to generate initial categories and to suggest relationships among categories.

3.8.2 Axial coding

Axial coding is the process of relating categories to their subcategories (Strauss and Corbin 1998:123). *Axial coding* was used to connect categories of data found when using open coding (Strauss and Corbin 1990: 96). The researcher made a full list of categories produced at the end of open coding. Further analysis and refinement of the list was accomplished by deleting or combining some of the categories once the connections were made between them. Categories were linked according to their characteristics and similarities. After linking the categories according to categories, subcategories that shared the same meaning were grouped together. Categories which shared similar characteristics were merged into the categories found in Strauss and Corbin's paradigm model and included: the phenomenon, which is the core of the central problem; the causal conditions, which are events that lead to conditions; the intervening conditions or conditions in which the phenomenon is managed; the action/interactional strategies, which are actions and response that occur as a result of the phenomenon; and, the consequences, which are the outcomes (Strauss and Corbin 1998: 130).

3.8.3 Selective coding

Selective coding was used which involves the integration of categories of data that have been gathered to form a model (Strauss and Corbin 1990: 96). Selective coding is the process of integrating and refining categories. It involves the identification of a core category from which the practice

framework will be developed. All major categories were integrated to form a larger practice framework. Strauss and Corbin (1990: 97) suggest the use of a paradigm model to explain the relationship between subcategories.

The paradigm model is an analytic tool devised to help the researcher to integrate structure with process. It allows the researcher to answer questions such as why, who, when and what, thereby allowing the researcher to relate structure with process. The paradigm model is an organising tool that connects subcategories of data to the central idea so as to help the researcher to think systematically about the data, and allows the researcher to ask questions on how categories of data relate to each other (Strauss and Corbin 1990: 127). Elements of the paradigm model include phenomenon, causal conditions, context, action/interaction strategies, intervening conditions and consequences.

The phenomenon under study is the central idea which indicates the problem or issue. In this study the central idea is the implementation of the policy on the integration of mental health care in PHC clinics in KZN. Causal conditions refer to the events that lead to the development of the phenomenon. In this study causal conditions were factors that influenced integration of mental health care into PHC. Context refers to specific properties of a phenomenon and a set of conditions that affect the action/interaction strategies. In this study context included context within which integration of mental health care is practised. Action/interaction strategies refer to the ways in which the phenomenon is managed, handled, carried out and responded to in a certain context and under specific conditions. In this study interactional strategies included how the integration of mental health care was implemented at PHC clinics in KZN. Intervening conditions are the conditions that either facilitate or hinder interaction strategies in a particular context. In this study facilitative conditions included factors that made the integration of mental health care work, whereas hindering conditions included factors that made the integration

of mental health care not work. Consequences are the outcomes both intended and unintended of actions and responses (Strauss and Corbin 1990: 130). In this study consequence included the positive as well as the negative effects of integration of mental health care into PHC. The paradigm model was used as a guide to develop a practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN.

3.9 TRUSTWORTHINESS

To ensure trustworthiness of the study, the researcher ensured that the research met the criteria described by Strauss and Corbin grounded theory, namely, that a good grounded theory should be judged on the criteria related to the process of generating a theory. According to Strauss and Corbin (1990: 253), research should meet criteria laid out in the following subsections.

3.9.1 Data needs to be valid, reliable and credible

To ensure richness of data, triangulation was implemented by using multiple methods of collecting data which included one-on-one interviews and focus group interviews, memos and field notes. Credibility was ensured through prolonged engagement in the study field with the participants during data collection over three months from morning till afternoon during which initial and follow up interviews were conducted to further verify data collected, and to verify whether collected data represented what the participant had said. Credibility was also achieved through multiple reviews of the voice recordings and field notes during data analysis (Babbie and Mouton 2010: 277).

3.9.2 Research process should be adequate

To ensure rigour in the research process, the researcher ensured the following elements were explained (Strauss and Corbin 1990: 253):

- How the sample was selected.
- How the categories emerged.
- The process of purposeful sampling.
- The process of theoretical sampling.
- The process of selection of major themes and sub-categories.

3.9.3 Research findings should be empirically grounded

To ensure empirical grounding in grounded theory research findings, the following elements were explained (Strauss and Corbin 1990: 254):

- How concepts are generated.
- How concepts are systematically related.
- How categories are developed.
- Ensure broader conditions that affect the phenomenon under study are built into its explanation. How practice framework seems significant and to what extent.

3.10 ETHICAL CONSIDERATIONS

Ethical approval for conducting this study was obtained from the Ethics Committee (IREC No: 46/16). Permission to study was requested from the District Manager (Appendix 3) and the KZN Department of Health (Appendix 2a). All participants in the study were given a letter of information (Appendices 4 and 5) and consent form to consent to participating in the study (Appendix 6). Their participation was voluntary and they were told that they had a right to withdraw from the study at any time without any penalty. The researcher requested permission to voice record the interviews. The participants were informed that they would not receive monetary benefits from participating in the study. Extra precautions were taken to safeguard participants with regard to anonymity and confidentiality. Their names were not mentioned and recorded during discussions. They were advised of the confidentiality and anonymity of the discussion and responses.

3.11 SUMMARY OF THE CHAPTER

Chapter 3 discussed the research methodology that was followed in conducting the study. Grounded theory design was explained in detail. The study setting, the theoretical framework that guided the study as well as sampling process including exclusion and inclusion criteria was explained. The four districts that were used for the research study are explained and the figure representing 11 districts in KZN were presented. Three phases of data collection, Strauss and Corbin's approach to data analysis, and criteria used to ensure trustworthiness of the research process and ethical considerations were explained. Chapter 4 will present and discuss the analysis of the data obtained from interviews and focus group discussions with PHC managers, operational managers and professional nurses.

CHAPTER 4 : PRESENTATION OF RESULTS

4.1 INTRODUCTION

Chapter 4 will present the analysis of the data obtained from one-on-one interviews and focus group discussions with PHC managers, operational managers and professional nurses. The presentation of results is organised under the sub-headings which were discussed in the paradigm model which was discussed in Chapter 3. This model includes phenomenon, causal conditions, context, action, interactional strategies and consequences. During data analysis, open coding was used where data from one-on-one interviews and focus group discussions was coded line by line to identify similarities and differences.

4.2 DEMOGRAPHIC DATA

The sample was drawn from PHC managers, operational managers and professional nurses from the selected four PHC clinics namely KwaDabeka CHC in eThekweni district, Gamalakhe CHC in uGu District, Ndwedwe CHC in Ilembe district and Mbalenhle CHC in uMgungundlovu District. The researcher interviewed four PHC managers, six operational managers and had a total of five focus group interviews, four with six participants and the last one with eight participants, with a total of 42 participants. The researcher continued with interviews and focus group discussions until data saturation was reached. Data saturation occurs when sampling provides no new information and the data collected becomes redundant (Grove, Burns and Gray 2013:371). In this study, data saturation was reached when the researcher was interviewing the third PHC manager, the fifth operational manager and the seventh focus group interview. This is when the researcher felt the participants were repeatedly giving the same information. Demographic data

appears in Table 4.1

Table 4.1: The demographic description of the study participants

Participant	Method of data collection	Category
P1	Interview	PHC manager
P2	Interview	PHC manager
P3	Interview	PHC manager
P4	Interview	PHC manager
P5	Interview	Operational manager
P6	Interview	Operational manager
P7	Interview	Operational manager
P8	Interview	Operational manager
P9	Interview	Operational manager
P10	Interview	Operational manager
P1	FGD interview	Professional nurse
P 2	FGD interview	Professional nurse
P3	FGD interview	Professional nurse
P4	FGD interview	Professional nurse
P5	FGD interview	Professional nurse
P6	FGD interview	Professional nurse
P7	FGD interview	Professional nurse
P8	FGD interview	Professional nurse
P9	FGD interview	Professional nurse
P10	FGD interview	Professional nurse
P11	FGD interview	Professional nurse
P12	FGD interview	Professional nurse
P13`	FGD interview	Professional nurse
P14	FGD interview	Professional nurse
P15	FGD interview	Professional nurse
P16	FGD interview	Professional nurse
P17	FGD interview	Professional nurse
P18	FGD interview	Professional nurse
P19	FGD interview	Professional nurse
P20	FGD interview	Professional nurse
P21	FGD interview	Professional nurse
P22	FGD interview	Professional nurse
P23	FGD interview	Professional nurse
P24	FGD interview	Professional nurse
P25	FGD interview	Professional nurse
P26	FGD interview	Professional nurse
P27	FGD interview	Professional nurse
P28	FGD interview	Professional nurse
P29	FGD interview	Professional nurse
P30	FGD interview	Professional nurse
P31	FGD interview	Professional nurse

P32	FGD interview	Professional nurse
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4.3 PRESENTATION OF THE RESULTS

Codes were developed by using the transcripts from the participants as well as field notes. The phenomenon of the study, which is the integration of mental health care into PHC, became the core concept around which other concepts revolved. Through constant comparison of data from participants, similar codes were discovered and labelled. Similar codes with the same meaning were grouped into descriptive categories and sub-categories.

The results are outlined in the manner in which they indicate how the objectives of the study were achieved, as follows:

- Conceptualisation of the phenomenon, integration of mental health care into PHC.
- Factors which contributed to the implementation of the policy on integration of mental health care into PHC (Causal conditions).
- Factors which contributed to non-implementation of the policy on integration of mental health care into PHC (Intervening conditions).
- The context within which integration of mental health care into PHC was practised.
- The actualisation and practice of Policy on Integration of Mental Health Care into PHC.
- Consequences – unintended and intended outcomes of the integration of mental health care into PHC as viewed PHC managers, operational managers and professional nurses.

Table 4.2 shows the categories and sub-categories that were identified.

Table 4.2: Table outlining the categories and subcategories

Research objectives	Categories	Sub-categories
4.3.1 Conceptualisation of the phenomenon, integration of mental health care into PHC.	4.3.1.1 Comprehensive approach.	Supermarket approach One-stop approach
4.3.2 The context within which integration of mental health care into PHC was practised.	4.3.2.1 The Mental Health Care Act No. 17 of 2002. 4.3.2.2 The White Paper for the Transformation of the Health System in South Africa which was published in 1997. 4.3.2.3 Guidelines on the management of the mental health care users at PHC level in South Africa which was published in 2006.	Rights of mental health care user Integration of the mental health into PHC is based on legislation. Transformation of health services Provisions of the White Paper. Guidelines on how to manage mental health care users.
4.3.3 Causal conditions.	4.3.3.1 Stigma attached to mental illness. 4.3.3.2 Neglect of the mental health care users. 4.3.3.3 Isolation of the mental health care users.	Feeling judged, stigmatised. Name calling, ridiculed. Below standard treatment. Treatment far away from home. Treated in separate clinics, far from other clinics.
4.3.4 The Action/interactional strategies.	4.3.4.1 Screening of all patients. 4.3.4.2 Fast tracking of mental health care users. 4.3.4.3 Chronic management of patients at the clinic.	Assessing all patients for mental illness and treat. Refer to a psychiatric nurse if there are signs and give treatment. Rerouting of mental health care users. Not allowing mental health care user Use of PC101 to assess and manage chronic illness. Patient given chronic treatment at the clinic. Treating all chronic patients the same.
4.3.5 Intervening conditions.	4.3.5.1 Facilitative intervening conditions.	Relationship between staff. Involvement of multidisciplinary team. Organisation of the clinic.

	4.3.5.2 Hindering interventions	Availability of resources. Lack of training opportunities in mental health care. Limited access to policies. Resistance to change. Inadequate resources. Poor communication. Lack of skills. Prioritisation of mental health care users.
4.3.6 Consequences	4.3.6.1 Intended consequences 4.3.6.2 Unintended consequences.	Improving access to mental health care. Holistic management of mental health care user. Capacity building of staff. Lack of space. Poor quality of mental health care.
4.3.7 Conditions that need to be in place for integration of mental health care into PHC to take place.	4.3.7.1 Enough medication supply. 4.3.7.2 Protocol for management of mental health care users. 4.3.7.3 Involvement of all stakeholders. 4.3.7.4 All PHC nurses to have qualification in Psychiatric Nursing Science. 4.3.7.5 Each clinic to have a resident Psychiatrist and Advanced Psychiatric Nurse.	Medication to stabilise and maintain patient condition. Step by step guide on how to manage a mental health care user. All stake holders to be involved. Nurse who have knowledge of mental health and Primary health to diagnose and treat at the clinic. Support from mental health specialists to support PHC nurses.

4.4 CONCEPTUALISATION OF INTEGRATION OF MENTAL HEALTH CARE INTO PHC

Participants who were involved in one-on-one interviews as well as focus group discussions viewed integration of mental health care into PHC as the provision of all services including mental health care at the clinic, as it is described in the comprehensive PHC core package. Participants expressed different views on how services are provided; some cited services being provided as a one-stop shop and other participants cited services being

provided in the form of a supermarket approach. The categories and subcategories that emerged from the data analysis are discussed below.

4.4.1 Comprehensive care approach

All participants viewed integration of mental health care as involving the provision of this service alongside all the other health care services that need to be delivered at a PHC level for all patients. The following responses supported the category:

“This is comprehensive service where you give all services to a patient at PHC level to address all the needs of the community”. (Interview P3)

“All services are given to patients everyday Monday to Friday”. (FGD P1)

“You see the patient as whole and refer if it is necessary. The patients get all services. The clinic is opened for 24 hours, Sunday to Sunday, day and night to provide comprehensive services to all patients.” (Interview P1)

“In any consultation room, all patients are screened for mental illness. If a patient comes to our clinics, you first assess any physical, social or psychological illness and if you find that that they have illness, you treat that illness, irrespective of what it is (FGD P1)

“Integration of mental health care means mental health care users must be mixed with other patients. There must be no special time for them.” (Interview P3)

“As the name applies, we are integrating them into PHC. Integrating mental health care into PHC means integrating mental health care as the name applies.” (Interview P1)

“As a nurse I provide all services every day for 24 hours. All services are provided day and night. I provide all services needed by all patients.”
(Interview FGD P10)

4.4.2 One-stop shop approach

Most participants viewed integration of mental health care as a one-stop shop approach to care; clients are managed holistically by one nurse looking at all aspects of care (physical, social and psychological). If the client comes with mental illness, the nurse also checks for other diseases such as tuberculosis or diabetes. Participants viewed integration of mental health care into PHC as one nurse providing all the services that the patient needs. The following responses supported this category:

“Every patient that enters the PHC level must be assessed for mental illness by one nurse so that she can be treated or referred.” (Interview P4)

“When a patient comes you see and treat them and you don’t refer them. If you as a nurse encounter mentally ill patient, you need to attend that patient and not just refer them.” (FGDP11)

“All the mental health care users should be treated the same as other patients when they enter the clinic and there should not be days scheduled specifically for mental health patients. Fair and equal treatment to all patients.”
(Interview P7)

“It includes mental health care users being treated holistically without stigma and discrimination. I look at all aspects of care which include physical, social and psychological aspect.” (FGD P27)

“The nurse does everything for the patient and only refers if it’s beyond her scope of practice.” (Interview P7)

“When the patient enters the clinic or CHC, he or she is presenting with headache or cough, nurse on duty must assess everything including mental health so that if there are symptoms, then the nurse must treat the patient.” (Interview FGP8)

4.4.3 Supermarket approach

A few participants viewed integration of mental health care into PHC as being in the form of a supermarket approach. This means different nurses or health care providers in the same clinic providing all the services that the patient needs. This means that a patient moves from one consulting room to another according to what they need. For instance, if they have received treatment for mental illness but also need family planning, they must then join another queue for that service after they have finished with the mental health service. All services for the patient are given under one roof. The following responses supported the category:

“Mental health care services are provided by one nurse who has been trained. If during assessment I discover that the patient has mental illness, then I refer them to the psychiatric nurse in another consulting room. I know it’s time consuming but the patient gets all services in one place.” (FGD P2)

“The patient gets all the services that she needs in one clinic, only has one trip to the clinic and get all the services in one day but from different nurses.” (Interview FGD P4)

“You give treatment for everything in one place. I think it’s good because the patient gets all the treatment in one clinic. The patient only takes one trip.” (Interview P3)

“All patients are screened for mental illness, if found to be mentally ill, then the mental health care user is referred to a nurse who is a mental health specialist, who will do counselling and treatment and if it beyond her scope, she will refer to a psychiatrists who comes once a week.” (FGD P27)

4.5 CAUSAL CONDITIONS

The phenomenon under the study is the integration of mental health care into PHC. Participants indicated that integration of mental health care into PHC took place as a result of stigma associated with mental illness, neglect of the mental health care user and isolation of the mental health care users from the general patients.

4.5.1 Stigma associated with mental illness

Participants indicated that integration of mental health care into PHC was put in place to address the stigma that was associated with mental illness. The following responses supported the category:

“Mental health care users were feeling judged and stigmatised in the past prior to the integration of mental health care into PHC. They were institutionalised far away from other patients and being kept away in institutions far away from their homes.” (FGD P20)

“Boosting the self-esteem of patients which was low due to name calling and being ridiculed within their communities.” (Interview P1)

“There were stand-alone clinics, mental health care users were looked down, were institutionalised for a long time and were stigmatised.” (FGD P7)

4.5.2 Neglect of the mental health care users

Participants indicated that integration of mental health care was put in place to address the issue of the mental health care users being neglected and receiving below standard care which was separate from other patients. The following responses supported the category:

“Mental health care has been neglected in the past, treated in dirty hospitals, wearing old, torn clothes and eating food that is not healthy because everybody thought they don’t need well balanced diet because they are not physically ill.” (Interview P1)

“Not paying much attention to mental health care as much as, unlike HIV [Human Immune Deficiency Virus] which receives so much attention.” (Interview 7)

“All budgets go to physically ill patients. Policies not implemented because policy makers, don’t think mentally ill patient need attention like physically ill namely patients who have AIDS.” (FGD P28)

“Mental health care users were left at institutions far away from home and given below standard treatment.” (Interview P4)

“Locked and not allowed to go home, institutions where they were hospitalised were far away and also had limited budget to take care of patients. If your relative was mentally ill, you knew that they will be hospitalised and will never see them again.” (Interview P3)

4.5.3 Isolation of the mental health care user

Participants indicated that integration of mental health care into PHC was put in place to address isolation of the mental health care users from the general

patients. Integration was introduced to address mental health care users being treated in separate areas, far away from other health institutions. The following responses supported the category:

“Combining mental health care users with other patients in a PHC clinic were done to avoid isolation by telling them that they need to go to a different clinic.” (FGD P10)

“To improve accessibility of all mental health care users to health care services without being isolated. Integration of mental care came into being to prevent mental health care users from being isolated.” (Interview P6)

“The old Mental Health Care Act re-enforced isolation of the mental health care user.” (FGD P1)

“The policy on integration of mental health care into PHC came into being to prevent isolation of the mental health care user. It allows mental health care users to be treated in the same clinic, next to their homes and with their community.” (Interview P2)

“I think this policy came into being to ensure that mental health care users are not isolated and they are treated next to their homes.” (FGD P22)

4.6 THE CONTEXT WITHIN WHICH INTEGRATION OF MENTAL HEALTH CARE INTO PHC IS PRACTISED

In this study the context means the set of conditions under which the integration of mental health care into PHC is practised. Participants highlighted the following conditions that led to the integration of mental health care into PHC:

- The Mental Health Care Act No. 17 of 2002.
- The White Paper for the Transformation of the Health System in South Africa which was published in 1997.

- Guidelines on the management of the mental health care users at PHC level in South Africa which was published in 2006.

Participants highlighted that these policies guided the implementation of integration of mental health care into PHC. They further mentioned that the aims of these policies were to advocate for mental health care to be integrated into PHC and mental health care users to be treated near to their homes and with their communities like any other patient. The following responses supported the category:

“Integration of mental health care was introduced to respond to the provisions of the White Paper for the Transformation of the Health System in South Africa as well as Mental Health Care Act No. 17 of 2002.” (FGD P25)

“Integration of mental health care came with the White Paper for the Transformation of the Health System that included the policy on integration of mental health care into PHC.” (Interview P5)

“Integration of mental health care is based on the principles of policy framework and strategic plan as well as guidelines on the management of the mentally ill.” (Interview P6)

“I think integration of mental health care policy also was re-enforced after the Mental Health Act No. 17 of 2002 which also protected the rights of mental health care user. This Act really brought more changes, and we saw the Department of Health putting more effort to integrate mental health care into PHC although there are challenges. I think the Department of Health is trying to respond to the Act. The Act came at the right time although I think a lot need to be done.” (Interview P4)

4.7 THE ACTUALISATION AND PRACTICE OF POLICY ON INTEGRATION OF MENTAL HEALTH CARE INTO PHC (THE ACTION/INTERACTION STRATEGIES)

Participants cited the following strategies that are used at the clinic to ensure that integration of mental health care into PHC is implemented:

4.7.1 Screening of all patients for mental illness

Participants stated that where the one-stop approach is used all patients that come to the clinic are assessed for mental illness and if found to be mentally ill, they are managed by the same professional nurse or referred if it is beyond the scope of a professional nurse. Participants stated that where the supermarket approach is used, mentally ill patients are screened and then referred to a professional nurse who has a qualification in Psychiatric Nursing Science and who only manages mentally ill patients at the clinic. The following responses support the category:

“In this clinic all patients are screened for all the illnesses if they are found to be mentally or physically ill they are treated by all professional nurses. Although I don’t have the qualification in mental health but I do screen all the patients. We screen all patients in this clinic.” (Interview10)

“We screen all patients in this clinic for mental illness and treat all patients. We have a screening tool called PC101 which allows us to screen all patients.” (FGD 4)

“In this clinic, we screen all patients and then if the patient is mentally ill, then the patient is referred to a psychiatric nurse who sees all mental health users. We have a shortage of nurses with qualification in Psychiatric Nursing. It is such a problem when this psychiatric nurse is not around. If the

psychiatric nurse is not around, we allocate a nurse who sees these patients.”
(Interview P2)

4.7.2 Fast tracking of mental health care users

All participants indicated that at their clinics there is a fast tracking system in place. When mental health care users come to the clinic, screening is done and if the client is found to be mentally ill, they are re-routed to the mental health practitioner, who will provide further treatment or to a doctor who will prescribe medication. If the mental health care user is not stabilised they are referred to the next level of care which is a 72-hour assessment period which is available at the district hospital. The following responses supported the category:

“Management at the clinic involves assessment, counselling, health education, treatment and referral of patient to a 72-hour assessment for the next level of care at the district hospital.” (Interview FGD P7)

“When mental health users come to this clinic for chronic medication, they are fast tracked, we don’t want them to wait for a long time, we fast track them so that they don’t get angry. These patients get angry when they wait for a long time.” (FGD P32)

“Assessment, screening and referral are the main components of an integrated mental health care programme.” (Interview P2)

“Patients are given medication to stabilise them and then they are referred to the next level of care.” (P10)

4.7.3 Chronic management of patients at the clinic

Participants indicated that at their clinics, mental health care users that are on chronic medication are referred to a professional nurse who undertakes integrated management of chronic illnesses which includes management of mental illness. The following responses supported the category:

“Mental health care users are treated like any chronic patient at the clinic, the only thing we do for them, is to fast track them because they don’t want to sit in the queue for a long time, they get agitated.” (FGD P5)

“Patient is seen holistically, if they have hypertension and mental illness; they get all the treatment from the same professional nurse.” (Interview P9)

“In this clinic, all patients with chronic illness are treated the same. They are all checked and treated by a PHC nurse who does chronic patients. This is very good because nurses don’t only see one kind of patients; they get to see variety of all patients.” (Interview P5)

“I think all patients are seen at this clinic. Chronic patients, for the first time in this country have integrated all patients, it does not matter the patient has chronic physical illness or mental illness.” (FGD P24)

4.8 INTERVENING CONDITIONS

Analysis of the data revealed that integration of mental health care was influenced by either facilitative conditions or hindering conditions.

4.8.1 Facilitative conditions

4.8.1.1 Relationship between staff

Good working relationship between nurses, psychologists, psychiatrists and doctors emerged as important in the implementation of integration of mental health care into PHC. Participants further mentioned that a good working relationship allows them to freely ask for assistance if there is a need. The following responses supported the category.

“We have dedicated and motivated staff and we help each other at this clinic. You know if I have finished my work, I go and help others. We help each other at this clinic.” (FGD P20)

“We also have good relationship with social workers, doctors and psychologists. If we find the work is beyond our scope and we find it hard to deal with matter, we refer to other members of the multidisciplinary team. Social workers really assist nurses at the clinic, and I think this helps.” (Interview P6)

“We are short staffed at this clinic, but I must say the relationship we have with each other helps, because you don’t feel alone even when there are lots of patients to see because others come and assist you.” (FGD P24)

4.8.1.2 Involvement of multidisciplinary team

Most participants viewed a multidisciplinary team as being very important in implementing the integration of mental health care into PHC. This included involving nurses, psychologists, psychiatrists and doctors in care. The following responses supported this category:

“We have psychiatrist who comes once a week. The specialist psychiatrist come to our clinic to see complicated cases that are difficult for the

professional nurses to see and mental health care users are booked for these cases. All complicated cases are set aside for the specialist psychiatrist to see on Thursday. Our psychiatrist comes on Wednesday.” (Interview P1)

“We have a psychologist who sees all mental health care users who have been seen by a dedicated psychiatric nurse. If the psychiatric nurse cannot deal with the mental health care users, they are referred to psychologist who will then do counselling.” (Interview P3)

“Also if the mental health care has a medical condition, and if it is beyond our scope, we refer them to the medical doctor who is always there to see complicated cases. Patients are booked for this. We also have other members of the multidisciplinary team like dentist who comes once a week and mental health care users are also booked for this service if there is need.” (FGD P23)

“Visiting doctors really assist us in reducing work load and in managing all complicated patients; I think it helps a lot.” (FGD P7)

4.8.1.3 Organisation of the clinic

In clinics where a one-stop shop approach is used, mental health care users are prioritised first and seen before other patients. This allows mental health users not to be delayed. In clinics where a supermarket approach is used, mental health care users are screened for mental illness and thereafter re-routed further, should there be other treatment they need, for instance, tuberculosis. The following responses supported this category:

“In this clinic, after the patient has been assessed and has been found to have mental illness, they prioritised, seen first and everything is done for them fast so that they don’t wait for longer periods.” (Interview P5)

“Mental health care users are prioritised first and seen before other patients and they are re-routed further, if they need other forms of treatment.” (FGD P28)

“Mental health care are seen first and they are given all what they need in one and allowed to go back home. Thereafter they go for their medication.” (FGD P24)

“Professional nurses see patients and they are prioritised and seen first. They are then allocated to one professional nurse at the clinic who is responsible for mental health care users.” (Interview P8)

4.8.1.4 Availability of enough physical resources

Participants in urban clinics viewed availability of space and consulting rooms with privacy as an important aspect that facilitates the implementation of integration of mental health care into PHC. The following responses supported the category:

“Privacy is there because there is an adequate consulting room where one patient is seen one at a time; so there is privacy. It allows us to do counselling for our patients. Privacy is there because there are consulting rooms where one patient is seen one at a time.” (Interview P3)

“There are separate consulting rooms for mental health care users and this is important for the implementation of the policy on integration of mental health care into PHC.” (Interview P1)

4.8.2 Factors that hinder the implementation of integration of mental health care into PHC

4.8.2.1 Lack of staff training in mental health

Lack of staff training in mental health emerged as a constraint that hinders the successful implementation of the policy on integration of mental health care into PHC. The following responses supported the category:

“Not everyone who works in the clinic has Psychiatric Nursing Science qualification or has participated in the in-service training. A number of PHC nurses do not have a qualification in psychiatric nursing.” (Interview P7)

“Currently there is no trainer to assist staff in mental health training. Not every professional nurse is good in mental health care.” (Interview P9)

“Everyone that is in the institution at PHC level needs to be aware of mental health issues and be taught on how to recognise the signs that are associated with mental illness.” (Interview P1)

“When it comes to human resources, there are not enough resources to deal with all these things, staff that is willing to implement the policy. Nurses must be trained, at the moment if one person has gone for training, that person needs to come back and cascade the information at PHC level.” (Interview P2)

“.....Continuous in-service training of staff so that they continue to practice and not just go for training on once off basis and ongoing supervision of the staff to observe that they do implement the policy and integrate mental health.” (Interview P3)

“Institutions need to reform, perhaps take nurses to do Advanced Psychiatric Nursing so that nurses can be helpful. At the moment there is only

one nurse with Advanced Psychiatric Nursing in this clinic.” (FGD P10)

4.8.2.2 Limited access to mental health policies

Most participants reported that they have heard about the Policy on Integration of Mental Health Care into PHC but they have not seen a copy of this policy at the clinic. They further stated that they knew that there was a new Mental Health Act (No. 17 of 2002), which is different from the old one. The following responses supported the category:

“We don’t have access to policies. We have not seen the policy. I think not being aware of the policy, lack of access to information and policies is not good. I think managers should make sure that their staff should have access to information.” (FGD P32)

“We don’t have access to intranet. No one talks to us policies for mental health. We have HIV policies instead.” (FGD P7)

“We have no access to policies and Acts and most of us have not seen the policy and we don’t understand contents of these policies you are talking about.” (FGD P 30)

4.8.2.3 Resistance to change

Most participants indicated that nurses are used to doing things in a certain way and are reluctant to embrace change. The following responses supported the category:

“Some nurses do not like mental health, even if you train them; they continue to do wrong things.” (Interview P2)

“I feel that PHC nurses do not like mental health care, even if they are trained, they feel that is not their responsibility. I think mixing these patients is not good, I think mental health care users were happy separated.” (Interview P9)

“Training is not the only issue, resistant to change. I think things were ok when mental health care users were treated separately.” (FGD P20)

“I think nurses are reluctant to change. They feel that mental health care users must have their own institution where they are treated separately.” (Interview P32)

“Treating mental health care users is time consuming, and they are dangerous sometimes and I think it’s better if they were treated separately by their own staff.” (Interview P7)

4.8.2.4 Inadequate resources

Inadequate resources emerged as hindering the implementation of integration of mental health care into PHC. Participants from rural clinic reported shortage of space, consulting rooms, and medication to treatment of illness. This was different from clinics that are in urban areas who reported to have enough space and consulting rooms to maintain privacy. All clinics cited shortage of staff as the main factor hindering the implementation of integration of mental health care into PHC. The following responses supported the category:

“We have shortage of staff, only two professional nurses in OPD [Out Patients Department], if one goes for lunch or sick, only one is left alone. Shortage of psychiatrists and no advanced psychiatric nurses.” (Interview P8)

“There is inadequate space and consulting rooms suitable for counselling. We have inadequate staff and space in this clinic, no medication to give to mentally ill patients.” (FGD P10)

“There is shortage of staff, shortage of medication. At times some medication used by mental health care users is not in stock and this may lead to relapse of mental health care users.” (Interview P9)

4.8.2.5 Lack of communication

Lack of communication between management and staff emerged as a factor hindering the implementation of the integration of mental health care into PHC. The following responses supported the category:

“Not being aware of the policy and lack of access to information. Management is not communicating with staff, not informing staff about new policies.” (FGD 4)

“Managers do not communicate with us as staff members. No policies are communicated with us. It’s the first time somebody has spoken to us.” (FGD 17)

“I feel that managers should communicate with us, even if its once a month. At this clinic, we only work. They only communicate with us when they give us work.” (FGD P6)

4.8.2.6 Lack of skills

PHC nurses lack skills in identifying signs of mental illness, misdiagnosing, and giving wrong treatment or failure to treat leading to relapse of mentally ill patients, emerged as factors hindering the effective integration of mental health care into PHC. The following responses supported the category:

“Not every professional nurse knows how to nurse mental health care users. A number of professional nurses do not have skills and ability to diagnose and treat mentally ill patient.” (Interview P1)

“Lack of skills in identifying mental health care users, misdiagnosing them and this leads to treating them with medication that will not relieve the symptoms.’ (FGD P5)

“Lots of PHC nurses do not have qualification in psychiatric nursing and are unable to understand and deal with mental health care user.” (Interview P7)

4.8.2.7 Prioritising mental health care users

The approach used at clinics to prioritise mental health care users and treat them first, exposes them to other patients which bring up the issue of stigma. The following responses supported the category:

“This approach is not working; mentally ill patient feels that if they are called first, they are isolated.” (FGD P20).

“Everybody knows if you are called first, it means you are mentally ill.” (FGDP6)

“This approach is not working, patients don’t like it, they want to go back to separate clinics.” (FGD 4)

“This approach of mentally ill patients being prioritised and treated first exposes them to other patients which bring up the issue of stigma towards the mentally ill patients.” (FGD P30)

4.9 CONSEQUENCES – UNINTENDED AND INTENDED OUTCOMES OF THE INTEGRATION OF MENTAL HEALTH CARE INTO PHC AS VIEWED BY PHC MANAGERS, OPERATIONAL MANAGERS AND PROFESSIONAL NURSES

Participants reported the following intended and unintended consequences.

4.9.1 Intended consequences

4.9.1.1 Improving access to care

Improving access to mental health care to mental health care users at the nearest clinic where they live emerged as an advantage of integrating mental health care into PHC. The following responses supported the subcategories:

“Mental health care users are able to live in their homes and continue to work and live positively.” (Interview P5)

“Patients don’t feel discriminated. Mental health care users can be seen by anyone at the clinic.” (Interview P1)

“Chronic patients are now getting their treatment nearer to their homes. Mental health care users can go to one clinic and get all their medication they need.” (FGD P20)

4.9.1.2 Holistic management of mental health care users

Holistic management of mental health care users was viewed by participants as an important milestone. Holistic management was viewed as managing the patient as a whole being. The following responses supported the subcategory:

“Mental health care users can go to one clinic and get all their medication they need. Mental health care users can be seen by anybody at any time.” (Interview P8)

“It includes mentally ill patients being treated holistically without stigma and discrimination.” (FGD P28)

“It looks at the whole patient; we treat patient as whole in one consulting room. It does not matter what is wrong with the patient. Patients are getting all their treatment in one clinic, under one roof.” (FGD P10)

4.9.1.3 Capacity building for staff

Participants from one clinic indicated that integration of mental health care into PHC is also good for staff as well, because they have to assess and manage all patients with chronic illness including mental health care users. The following response supported the sub-category:

“I think this is good because psychiatric nurses as well as general nurses can learn from nursing a patient using holistic approach instead of only looking at one aspect of illness.” (Interview P9)

“Psychiatric nurses who used to only see mentally ill patients, now can see patients with medical or surgical problems. We learn a lot from treating patients as a whole.” (FGD P7)

“I think that general nurses at PHC clinic are now able to manage mentally ill patients and this is a good. It decreases workload.” (Interview P10)

4.9.2 Unintended consequences

Although the implementation of integration of mental health care into PHC has positive outcomes, unfortunately certain unintended consequences were cited by participants, such as those listed below.

4.9.2.1 Lack of space

Participants from rural clinics where a one-stop approach was used, cited lack of space to interview and counsel mental health care users at the PHC clinics. They indicated that it was better for mental health care users to be treated alone in their clinics instead of being mixed with other patients. Participants indicated that mental health care users need space for counselling. The following response supported the sub-category:

“In this clinic, we don’t have enough space; sometimes we have two professional nurses interviewing two patients in one consulting room.”
(Interview P8)

“We don’t have adequate rooms for patients to be counselled. At the moment a counsellor is working together with the nurse because there are no separate rooms to do appropriate counselling.” (FGD P15)

“We need more counselling rooms and consulting especially when there are visiting doctors.” (Interview P8)

4.9.2.2 Poor quality mental health care

It emerged that participants perceive that integration of mental health care into PHC resulted in poor quality mental health care that was given to mental health care users. Most participants believe that mental health care that was given in separate mental health clinics was good and psychiatric nurses had time to listen to mental health care users. The following response supported this category:

“Mental health care users are easily distracted and irritable and want to be seen as quickly as possible.” (FGD P7)

“Some mental health care users are attached to some specific nurses and they only trust that nurse and that makes it impossible if that nurse is not available.” (Interview P3)

“We do not have time to take detailed report or history and to do proper counselling, if you spend more time with one patient, other patients complain, and this result in misdiagnosing and failure to give correct treatment.” (FGD P4)

“Because there are so many patients, medication is finished quickly and mental health care users end up going home without medication and being told to come back on another day, and leads to relapse of mental health care users.” (FGD P7)

4.10 THE CONDITIONS THAT NEED TO BE IN PLACE FOR EFFECTIVE INTEGRATION OF MENTAL HEALTH CARE INTO PHC TO TAKE PLACE

Participants cited the following conditions to be in place before the effective integration of integration of mental health care into PHC can take place:

4.10.1 Enough space for mental health care users at the clinics

It emerged that participants perceived that enough space for consultation and counselling of patients to be an important condition that the clinic must have before effective integration of mental health care into PHC can take place. The following responses supported the category:

“Having adequate rooms for mental health care users to be counselled and consulted is very important to maintain privacy and confidentiality. Privacy should be ensured for patients coming to the clinic.” (Interview P2)

“Environment should be conducive and safe for counselling and management of patients’ space must be able to accommodate difficult patients and allows for management of agitated and aggressive patients in the clinic.” (FGD P11)

“We need more consulting rooms and bigger space especially when other members of the multidisciplinary teams visit the clinic; we really need more space to accommodate everybody.” (Interview P7)

4.10.2 Enough medication

Enough medication for mental health care users emerged as an important condition that was viewed by participants as important for the effective integration of mental health care into PHC to take place effectively. The following responses supported the category:

“There should be enough treatment available for all patients at the clinic. Enough medication needs to be stored in every consulting room even for night duty or weekends.” (Interview P1)

“Shortage of medication and at times some of the drugs used by mental health care users is not in stock. Medication is important for managing mental health care users all the time.” “Shortage of medication and at times some of the drugs used by mental health care users is not in stock.” (Interview P8)

“Having enough medication to cater for all mental health care users. At the moment we do not have enough and type of medication to cater for mental illness like the medication in institutions which are dedicated for mental health care.” (FGD P15)

4.10.3 Protocol and referral procedure for the management of mental health care users

It emerged that participants perceive protocol and referral procedure for the management of mental health care users as an important condition for the integration of mental health care into PHC. There should be protocols for implementation of the Policy on Integration of Mental Health Care into PHC as well as criteria for step-by-step referral of mental health care users. There should be policies and protocols available at the clinic on how to do screening of patients. The following response supported the category:

“There should be step-by-step protocols on how to manage and refer mental health care users in each clinic, and there must be enough resources to implement the protocol.” (FGD P25)

“If the mental health care user cannot be treated, then the mental health care user needs to be referred and there must be a proper protocol in place to determine when the patient must be referred.” (Interview P8)

“There should be protocols that are communicated throughout the department by management.” GD P14)

4.10.4 Involvement of stakeholders from the community

It emerged that participants perceive involvement of stakeholders from the community as an important condition for integration of mental health care into PHC. The following responses supported the category:

“....The community is not willing to accept mental health care users. The community needs to be educated about mental illness and new policies and the new Mental Health Act in place.” (Interview P9)

“I think we need to educate the community and police officers about the policy on integration of mental care into PHC.” (Interview P5)

4.10.5 All PHC nurses to have a qualification in Psychiatric Nursing Science and Primary Health Care Nursing

It emerged that participants believe that all PHC nurses must have a qualification in Psychiatric Nursing Science and Primary Health Care Nursing in order to have the necessary skills for the implementation of the policy on integration of mental health care into PHC. The following response supported the category:

“Every professional nurse at the clinic should have knowledge of mental illness and must be able to recognise signs of mental illness.” (Interview P1)

“PHC nurses must be trained in both Psychiatric Nursing Science and PHC to be able to understand and manage all patient including mental health care users.” (Interview P7)

“It’s important to train nurses in psychiatric nursing, so that they don’t misdiagnose mental illness.” (Interview P1)

4.10.6 A need for resident psychiatrists and advanced psychiatric nurses

More psychiatrists and advanced psychiatric nurses were viewed by participants as an important condition for the effective integration of MHC into PHC at clinics. It came out clearly that PHC nurses need support and mentoring from psychiatrists and advanced psychiatric nurses. The following response supported this category:

“I think that PHC nurses need support and mentoring from the psychiatrists or advanced psychiatric nurses. At the moment there is only one PHC nurse

with advanced psychiatry.” (Interview P7)

“The psychiatrist only comes once a week and this not enough. I think we are having problems to implement this policy because of lack of support.” (FGD P23)

“I think PHC nurses need specialist support for effective integration of mental health care into PHC.” (Interview P9)

4.11 SUMMARY OF THE CHAPTER

This chapter presented main categories as well as subcategories that emerged during analysis of the study. Chapter 5 will present discussions of the findings.

CHAPTER 5 : DISCUSSION OF RESULTS

5.1 INTRODUCTION

In this chapter, results of the study presented in Chapter 4 will be discussed. The discussion of the results will be guided by the objectives of the study.

The objectives of the study were to:

- Explore the understanding of the phenomenon, integration of mental health care into PHC.
- Analyse the process of the phenomenon, integration of mental health care into PHC.
- Identify and describe the causal conditions, intervening conditions or challenges, if any, that might be hindering the implementation of the Policy on Integration of Mental Health Care into PHC.
- Identify and describe consequences or outcomes for ineffective implementation of the Policy on Integration of Mental Health Care into PHC.
- Determine and document the degree of implementation of the Policy on Integration of Mental Health Care into PHC in KZN.
- Develop a practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

5.2 CONCEPTUALISATION OF INTEGRATION OF MENTAL HEALTH CARE INTO PHC

From the analysis of data obtained from one-on-one interviews and focus group interviews, integration of mental health care into PHC was viewed by all participants as provision of holistic care that is needed by all patients at the clinic. The major central category that emerged from data analysis was

comprehensive health care which is offered to mental health care users using either a supermarket approach or a one-stop-shop approach. This supports the outcome of the study conducted by Sibiya and Gwele (2009: 31) on an analysis of the meaning of Integrated Primary Health Care (IPHC) in the KZN PHC context, where it emerged that participants used three categories to describe the meaning of IPHC in South Africa, namely, comprehensive care, supermarket approach and one-stop-shop approach.

5.2.1 Comprehensive care approach

Participants viewed comprehensive care as an approach that cares for the whole mental health care user and all their needs, not just the medical and physical care. Comprehensive care is an approach that looks at the physical, social and psychosocial needs of the mental health care user. This is supported by Zamanzadeh *et al.* (2015: 214) who uphold that integrated social and medical care is an approach to providing holistic care and further state that integrated care is an approach to reducing admissions to institutions and to assisting patients to develop the ability to function effectively in the community. Guidelines from the Health Act No 63 of 1977 describe comprehensive health services as being promotive, preventive, curative and rehabilitative services. The Comprehensive PHC Services Package for South Africa is a package which provides types of services that should be offered at various levels of care (Department of Health 2001: 12). This is supported by Al-Khatami *et al.* (2013: 204) who state that integration of mental health care is successful in achieving provision of comprehensive services in PHC centres.

In South Africa, the Policy on Integration of Mental Health Care into PHC was developed in 1997 and 15 years later the National Mental Health Policy Framework and Strategic Plan 2013 to 2020 was developed. The policy on integration of mental care into PHC was developed with the aim of integrating

mental health care into general health care and to allow people with mental disorders to be treated in PHC clinics. This policy was also aimed at allowing mental health care users to have access to care near to the places where they live and work and for mental health care services to be accessible to all people, regardless of geographical location, economic status, race, gender or social condition (Department of Health 2013: 19).

According to Kigozi and Ssebunnya (2009: 37), providing mental health services in PHC involves diagnosing and treating people with common mental health disorders within the general framework of available services, putting in strategies to prevent disorders, ensuring that PHC workers are able to apply psychosocial and behavioural science skills and ensuring a referral system for mental health care users who require specialist service. Mental health care at PHC level aims to improve access, availability and affordability of services thereby producing good outcomes. These authors further state that the advantages of integrating mental health into PHC include reducing stigma for mental health care users, improving access to care, protection of human rights and reduction of chronicity of mental illness as well as improvement of social integration.

5.2.2 One-stop shop approach

Most participants viewed integration of mental health care as a one-stop shop approach to care; mental health care users are managed holistically looking at physical, social and psychological aspects of care by one nurse. If the mental health care user comes to the clinic, the nurse also checks for other diseases like tuberculosis and diabetes. This supports the study conducted by Sibiya and Gwele (2009: 35) that found that IPHC was viewed by participants as the provision of services by one nurse and that the patient receives comprehensive care in one clinic.

According to the PHC Comprehensive Package, clinics should provide comprehensive IPHC service through a one-stop approach for a minimum number of hours (Department of Health 2001: 12). Sibiya and Gwele (2009:36) argue that one can never be sure if a one-stop approach saves time or not and further state that it may take longer for one nurse to provide all the services. French *et al.* (2006: 202) state that a one-stop-shop approach is the provision of all services at one site which allows for clinic efficiency, is convenient for the patient, and allows patients to receive effective health care services. On the other hand, a one-stop-shop approach may result in staff being overloaded with work (Department of Health 2001: 12).

5.2.3 Supermarket approach

Some participants viewed integration of mental health care into PHC as being a supermarket approach. This implies the provision of all services that the mental health care user needs by different nurses or health care providers in one clinic. This means that the mental health care user moves from one consulting room to another for each condition needing to be treated (Sibiya and Gwele 2009: 35). All services for the mental health care user are provided under one roof. Sibiya and Gwele (2009: 35) state that the concept of a supermarket approach is not a health care invention; it originated in the retail sector. These authors further state that IPHC was conceptualised as a supermarket approach where patients requiring more than one service are seen by different nurses in different consulting rooms after joining different queues. Raynor (2009: 10) states that community nurses use a supermarket approach to improve productivity among them.

Harper (2006: 253) argues that a supermarket approach is difficult to define and further states that this approach was initiated in Tanzania and has been adopted in several east African countries. The emphasis in this approach is client centred provision of all services at each visit to the clinic. Netshandama

et al. (2005: 59) found that the introduction of a supermarket approach in the service provision has increased the workload and further states that this approach was introduced to respond to the need for provision of comprehensive services to all people including mental health care users.

Netshandama *et al* (2005: 63) explain that introduction of the supermarket approach to comprehensive care has resulted in an increased workload and has affected the quality of provision of health care services in the Northern Cape. Although this was a good initiative from government, Netshandama *et al* (2005: 59) state that the supermarket approach is only an excellent approach if there is enough staff and argue that the supermarket approach can cause stress to PHC nurses if it is not managed appropriately. This is supported by Vhuromu and Davhana-Maselesele (2009: 64) who explain that the supermarket approach of rendering health services involves treating patients as they arrive without grouping them to come to the clinic on a particular day or time. This is time consuming. These authors further mentioned that due to the supermarket method, one type of health education which is to be given to almost all patients is repeated many times and this can be time consuming and tiresome to PHC nurses.

5.3 CAUSAL CONDITIONS

Analysis of data from participants revealed that integration of mental health care into PHC arose as a result of stigma associated with mental illness, neglect of the mental health care users and isolation of the mental health care users from the general patients.

5.3.1 Stigma associated with mental illness

The majority of the participants reported that the implementation of the Policy on Integration of Mental Health Care into PHC was due to the stigma associated with mental illness. As previously discussed, the Mental Health

Care Act No. 18 of 1973 re-enforced stigma associated with mental illness as mental health care services were separated from the general health care and psychiatric services were stand-alone services and not integrated into PHC. It was only post 1994 that South Africa paid more attention to comprehensive care and integration of mental health care into PHC (Burns 2008: 47). This is supported by Kigozi and Ssebunnya (2009: 37) who state that irrespective of the various changes and opportunities with regard to policies in place in Ghana, integration of mental health care into PHC faces many challenges namely: PHC nurses not regarding their role as also involving management of mental health care users, negative attitude towards mental illness, and low interest in nursing mental health care users.

Currid *et al.* (2011: 23) argue that mental health is a public health issue that needs to be given the same status and recognition as physical health. These authors further state that mental health care users continue to experience inequalities in life opportunities. Mental health care nurses are perceived as less skilled, less dynamic, and less logical and less respected compared to other branches of nursing. Mental health professionals are subjected to unfair and negative stereotyping such as labelling mental health professionals as being mentally ill themselves, and mental health services as being facilities to lock up mental health care users and just give them drugs. Currid *et al.* (2011: 23) suggest that it is important that primary care nurses who mentor students embrace the value of mental health practice.

Kilborne, Keyser and Pincuss (2011: 549) argue that stigma attached to mental illness and diagnosis may also hinder many mental health care users from seeking care. This is supported by Lund *et al.* (2012: 404) whose findings revealed that discrimination and stigma against people with mental illness may contribute to defaulting on treatment.

Marais and Petersen (2015: 7) state that negative attitudes of PHC nurses towards mental health care are a barrier to integration of mental health care into PHC and propose that integrated management of chronic illness (ICDM) at PHC level would assist in reducing stigma because mental illness would then be seen as a chronic disease just like any other chronic disease. These authors state that mental health is still not a priority in the face of many other health needs, and mental health is seen as separate from other health needs. These authors further recommend education and awareness raising campaigns promoting the benefits of integration of mental health care into PHC, so as to facilitate buy in. Marais and Petersen (2015: 12) recommend strategies to reduce stigma in communities such as educational campaigns, use of mass media, and testimonials.

5.3.2 Neglect of mental health care users

The participants reported that the implementation of the policy on integration of mental health care into PHC was instituted to deal with the neglect of the mental health care users. This is supported by the Policy on Integration of Mental Health Care into PHC which states that integrating mental health services into PHC increases access to mental health care, screening, treatment, prevention of neglect of mental health care users as well as improving rehabilitation (Department of Health 2013: 10). The policy on integration of mental care into PHC is not yet fully institutionalised at all levels of care and mental health care is not receiving enough support (Kigozi and Ssebunnya 2009: 37). In support, Burns (2008: 47) states that human rights of the mental health care users are not inferior to the welfare of the country.

Currid *et al.* (2011: 23) argue that mental health care users continue to experience inequalities and exclusion; mental health care continues to be underfunded when compared to the disability it causes, and research into mental health care services is less funded compared to cancer and

neurological diseases, thus resulting in neglect of mental health care institution. Burns (2008: 48) confirms that mental health care has been neglected in South Africa and recommends political leadership and adequate funding for the transformation of health services.

Marais and Petersen (2015: 14) list insufficient budget and inadequate infrastructure as challenges for the management of mental health care users as compared to other health needs, and recommend that the government should address resource and capacity disparities in management of patients with different health needs.

5.3.3 Isolation of the mental health care users from general patients

The implementation of the Policy on Integration of Mental Health Care into PHC was put in place to prevent isolation of mental health care users from general patients. Findings of this study are consistent with the study by Lund *et al.* (2012: 404) whose findings revealed that discrimination and stigma against people with mental illness may contribute to social isolation. This is supported by Burns (2008: 104) who states that prior to 1994 psychiatric services were isolated, far from general health care and far from their homes especially in rural areas.

As previously discussed, the Mental Health Care Act No. 18 of 1973 in South Africa re-enforced isolation of mental health care users and it was only in 1997 when the White Paper for the Transformation of the Health System in South Africa and in 2002 when the new Mental Health Act No. 17 of 2002 were promulgated that mental health care users treated with respect and dignity and being treated near where they live. Kigozi *et al.* (2009: 38) state that the advantages of integrating mental health care into PHC in Uganda include improved access to care, protection of human rights, and improved social integration. Mental health care should be integrated with PHC and

mental health care users should be treated near to their homes and with their communities (Burns 2008:47).

5.4 THE CONTEXT WITHIN WHICH INTEGRATION OF MENTAL HEALTH CARE INTO PHC IS PRACTISED

Participants highlighted that the Act and policies that guided the implementation of integration of mental health care into PHC post 1994 included the Mental Health Care Act No. 17 of 2002, the White Paper for the Transformation of the Health System in South Africa which was published in 1997, guidelines on the management of the mental health care users at PHC level in South Africa which was published in 2006, and the National Mental Health Policy Framework and Strategic Plan 2013 to 2020 which was published in 2013.

The promulgation of the Mental Health Care Act No. 17 of 2002 brought changes to management of mental health care users including patients being referred to as mental health care users. Other aspects of the Act included that the health services offered to should include care, treatment and rehabilitation; human rights of the mental health care users are not inferior to the welfare of the country; and, mental health care should be integrated into PHC (Burns 2008: 47).

As previously reported, KZN was the first province to develop a strategic and implementation plan in 2003 for the delivery of mental health services. This stipulated the framework for integrated mental health services at primary, secondary and tertiary levels of care. The plan endorsed primary health services to treat mental health care users at community level at PHC, CHC and district hospitals (Burns 2008: 46).

The goals and objectives of the White Paper for Transformation of the Health System in South Africa included the unification of fragmented health services at all levels into a comprehensive and efficient integrated national health system, the reduction of disparities in health service delivery, and increased access to PHC services based on PHC principles (Department of Health 1997: 5). The Policy on Integration of Mental Health Care to PHC that was developed in March 1997 in South Africa identifies key principles that are important to transform mental health services in South Africa, including that mental health care should be integrated into general health care and mental health care users should be treated in PHC clinics near to the places where they live and work (Department of Health 2013: 19).

5.5 THE ACTUALISATION AND PRACTICE OF POLICY ON INTEGRATION OF MENTAL HEALTH CARE INTO PHC (THE ACTION/INTERACTION STRATEGIES)

Screening of all patients for mental illness, fast tracking of mental health care users and chronic management of all patients including mental health care users were cited by participants as strategies that were used at clinics to ensure that integration of mental health care into PHC was implemented.

5.5.1 Screening of all patients for mental illness

Clinics where a one-stop shop approach is used indicated that all patients that come to the clinic are assessed for mental illness and if found to be mentally ill are managed by a professional nurse or referred if it is beyond the scope of that nurse. Dube and Uys (2015 10) reported that lack of knowledge and skills among PHC nurses are factors that contribute to poor management of mental health care users and further argue that shortage of PHC nurses without a Psychiatric Nursing Science qualification lead to poor quality mental health care. This is supported by Draper *et al.* (2009: 342) who state that nurses in PHC clinics are poor in detecting and managing mental health conditions.

Peterson *et al.* (2011: 4) warn that despite the release of guidelines, there are gaps in the management of mental health care users at PHC clinics, especially in rural areas. They further state that there is insufficient support for PHC nurses and warn that poor identification of mental disorders at PHC clinics may increase the rate of health care service utilisation. Inadequate skills, poor support and training of PHC nurses is a major factor undermining successful integration of mental health care into PHC (Burns 2008:1). Xaba *et al.* (2012: 11) explain that factors that affect service delivery in a PHC setting have a negative effect on quality of care and recommend that nurses should be comprehensively trained in order to provide holistic care including mental health care to all mental health care users. This is supported by Hatting *et al.* (2006: 65 cited in Xaba *et al.* 2012: 6) who argue that health care workers should be appropriately qualified and must not be expected to render services that are beyond their level of training.

In clinics where a supermarket approach is used, mental health care users are screened and then referred to a professional nurse who has a Psychiatric Nursing Science qualification and who only manages mental health care users at the clinic. Some participants expressed concern regarding one professional being the only person who manages mental health care users and felt that this approach leads to those professional nurses being overloaded with work and also being labelled as mentally ill themselves because of the nature of the work they do. This is supported by Mkhize and Kometsi (2008: 7) who argue that despite integration of mental health care into PHC, there are concerns that non-psychiatric nurses sometimes opt to leave the task of attending to mental health care users to one person, who sometimes then feel stigmatised themselves by their colleagues due to the nature of their work.

One of the professional nurse participants who worked in a supermarket approach clinic said that she was tired of giving mental health care by herself and she raised concerns that there is no support and when she is on leave, the mental health users are seen by any professional nurse, even those who do not have a qualification in psychiatric nursing, and this may result in poor quality mental health care.

5.5.2 Fast tracking of mental health users

All participants indicated that at the clinic there is fast tracking system in place. When mental health care users comes to the clinic, screening is done and if the client is found to be mentally ill, they are re-routed to the mental health practitioner, who will provide further treatment or doctor who will prescribe medication. If the mental health care user is not stabilised they are referred to the next level of care which is 72-hour assessment period which is available at the district hospital. Fast que strategy is the name given to the service given to patients who need short consultations and who have already been seen in a hospital or clinic and who are coming for review and ongoing treatment (Department of Health 2001: 1).

According to Sokhela *et al.* (2013: 1), the fast queue strategy was introduced in South Africa to resolve challenges in a range of health care services, including PHC services, to reduce long waiting periods at the clinics. These authors further state that the fast queue strategy includes treatment and follow up of patients and their families with mental illness, referral of patients for drug abuse, sexual abuse, child abuse and other crisis situations. This is consistent with the study by Lund *et al.* (2012: 403) whose findings revealed that at primary care level, management of mental disorders such as schizophrenia consists mainly of symptom management through provision of follow up medication and further states that mental health care users who have been stabilised with treatment are referred back to primary care clinics for receiving

ongoing treatment and monitoring of their mental status as well as rehabilitation. These authors argue that PHC nurses are not well equipped to address these needs.

5.5.3 Chronic management of patients at the clinic

The results of this study revealed that all PHC clinics which participated in the study had processes in place that allowed mental health care users who are on chronic medication to be referred to a professional nurse who does integrated management of chronic illnesses which includes management of mental illness. This is consistent with the provisions of the model called “symptom based integrated approach” at PHC clinics (PC101) which was commissioned and published by the National Department of Health which provides guidelines for the management of all chronic illnesses including management of mental health care users who have chronic mental illness. The main aim of PC101 is to standardise the approach to adult patients who are presenting with chronic symptoms or those who came for review of their chronic conditions (Department of Health 2016: 2)

Marais and Petersen (2015: 10) explain that PC101 uses a health system approach which involves health service re-organisation at facility level, clinical management support at facility level, assisted self-management support at community level and strengthening of support systems as well as structures within the health system. These authors further state that PC101 has a potential to provide an enabling platform for the integration of mental health care into PHC.

Peterson *et al.* (2011: 5) maintains that PHC services prioritise the control of chronic diseases that decrease life expectancy above mental illness. This is supported by Dube and Uys (2015: 1) whose study revealed that PHC services are still not effective in managing mental health users despite

prevalence of mental health disorders. Awenza *et al.* (2012: 184) warn that PHC nurses do have time to provide quality mental health care.

5.6 INTERVENING CONDITIONS

Analysis of the data revealed that integration of mental health care was influenced by either facilitative conditions or hindering conditions. Facilitative conditions included good relationships between staff, involvement of multidisciplinary team, and organisation of the clinic and availability of enough resources. On the other hand hindering conditions included lack of staff training opportunities in mental health care, limited access to mental health policies, resistance to change, inadequate resources, lack of communication, lack of skills and lack of prioritising mental health care users.

5.6.1 Facilitative conditions

5.6.1.1 Good relationship between staff

Good working relationship between nurses, psychologists, psychiatrists and doctors emerged as an important factor in the implementation of integration of mental health care into PHC. Participants further mentioned that good working relationships allow them to freely ask for assistance if there is a need even when there is a shortage of staff. Staff morale and good relationships between staff has an important impact on the implementation of the policy on integration of mental health care into PHC. This is supported by Sokhela *et al.* (2013: 6) who explained that the attitude of health care workers providers has an impact on the care of health care users and may influence adherence to treatment.

Sobekwa and Arunachallam (2015:1) conducted a study on experiences of nurses caring for mental health care users on acute admission in a psychiatric hospital in the Western Cape. Findings revealed that nurses in the acute

admission section reported the importance of working as a team and assisting one another in overcoming the difficulties of each day. This is consistent with the study done by Totman *et al.* (2011: 4) in England whose study revealed that effective team work and good working relationship with colleagues are highly valued positive influences on morale. Khunou and Davhana-Maselesele (2016: 9) recommend that holistic comprehensive strategies be put in place to address issues of job satisfaction which include improvements in research, education, policies and nursing.

5.6.1.2 Involvement of multidisciplinary team

Most participants viewed a multidisciplinary approach as being very important in implementing the policy on integration of mental health care into PHC. Such an approach includes nurses, psychologists, psychiatrists and doctors. In order to provide comprehensive care, participants reported that it is important to incorporate other members of the multidisciplinary team. Incorporation of visits to clinics by doctors and other health professionals was one of the methods used in provision of comprehensive care. In most of the clinics where the study was conducted, the psychiatrist only came once a week to give support to PHC nurses. Effective comprehensive care can only be achieved through teamwork. This is supported by Burns (2008: 48) who argues that district hospitals and PHC clinics should have at least one medical officer with expertise in managing mental health care users and who is efficient in the practical application of the Mental Act No. 17 of 2002 as well as the associated policies. The author further recommended that every district hospital and PHC clinic should have full time psychiatric nurses, part time occupational therapists, psychologists and social workers and should motivate for outreach and support visits from regional and tertiary mental health care practitioners. Involvement of a multidisciplinary team is supported by Mkhize and Kometsi (2008: 10) whose study revealed that professional nurses need to be trained to identify mental illness and in the management of mental

health care users, and must be supported by specialists in mental health.

5.6.1.3 Organisation of the clinic

In clinics where a one-stop shop approach is used, mental health care users are prioritised first and seen before other patients. This means mental health users are not kept waiting. In clinics where a supermarket approach is used, mental health care users are screened for mental illness and thereafter re-routed should there be another treatment they need, for instance, tuberculosis. Mental health care users are seen first before other patients to prevent them from complaining of delays. Sokhela *et al.* (2013: 1) who conducted a study on the experiences of fast queue health care users in PHC facilities in eThekweni district found that good clinic organisation eliminated problems with the flow of patients at the clinic and effective health care user flow promoted good work processes and increased satisfaction among health care users. These authors recommended that there should be queue marshals to assist in directing health care users to different consulting rooms.

Organisation of the clinic includes principles of the fast queue strategy which is a service for patients who need short consultations and who have previously been seen in a hospital or clinic and who are coming for review and ongoing treatment (Department of Health 2001: 5). The findings of this study are consistent to the findings of the study conducted by Sokhela *et al.* (2013: 1) whose findings revealed that the fast queue strategy is used to reduce long waiting periods at the clinics.

5.6.1.4 Availability of enough physical resources

Participants in some urban clinics viewed availability of space and consulting rooms with privacy as an important aspect that facilitates implementation of integration of mental health care into PHC. Most urban clinics reported that they have enough space and consulting rooms as compared to rural clinics

where there was shortage of staff, equipment, space, and consulting rooms. The researcher in the previous chapter reported that districts selected included two rural districts and two urban districts and argued that it is often assumed that health facilities which are located in urban areas are better resourced than facilities located in rural areas. The results of this study proved the assumption that urban clinics are better resourced than rural clinics. Lack of infrastructure especially in rural areas undermines the successful implementation of integration of mental health care into PHC (Burns 2008: 11). Considering the fact that the White Paper for the Transformation of the Health System in South Africa in 1997 and the promulgation of the Mental Health Act No. 17 of 2002, one would argue that rural areas still face the same challenges that they faced prior to 1994.

The results of this study is consistent with the findings of study conducted by Marais and Petersen (2015: 14) whose findings revealed that participants reported that there is no dedicated mental health budget and there are constraints with regard to quantity and quality of existing infrastructure including space to allow counselling of mental health care users in privacy. This is supported by Mkhize and Kometsi (2008: 10) whose study identified limited resources, lack of infrastructure and inadequate support as challenges impacting on effective integration of mental health care into PHC in KZN. Lack of resources compromises the integration of mental health care into PHC (Bhana *et al.* 2010; Lund *et al.* 2012; Petersen *et al.* 2009). Figure 5.1. is a schematic representation of the conditions that facilitate integration of mental health care into PHC in KZN.



Figure 5.1: Schematic representation of the facilitative conditions for integration of mental health care into PHC

5.6.2 Factors that hinder the implementation of integration of mental health care into PHC

5.6.2.1 Lack of staff training opportunities in mental health

Lack of training emerged as a constraint that hinders the successful implementation of mental health care into PHC. The study revealed that the majority of PHC nurses that were managing patients at the clinic were not adequately trained to offer all the services that are offered in clinics where a one-stop approach was used. This is supported by Lund *et al.* (2012: 15) who reported that some mental health care users are seen by registered nurses who do not have a qualification in Psychiatric Nursing Science and further argue that this practice may lead to mental health care users being misdiagnosed and lead to relapse of mental illness.

Dube and Uys (2015: 8) explored practices used by PHC nurses in the management of mental health care users at selected PHC clinics in uThungulu District in KZN. The findings of their study revealed that there was no evidence of thorough assessment of mental health care users and argued that this could be attributed to PHC nurses lacking knowledge and skills in managing mental health care users. Xaba *et al.* (2012: 11) and Burns (2008: 46) also highlight lack of training and support of staff in providing comprehensive care as a negative outcome of the study, and further recommend that health care workers should be appropriately trained and supported to render services that are beyond their level of training.

Marais and Petersen (2015: 6) conducted a study on health system governance to support integrated mental health care in South Africa. Findings revealed that participants reported insufficient training related to the Mental Health Care Act as well as a lack of clarity regarding responsibilities of different sectors. These authors further mention that there was no guidance on servicing people with disabilities and suggested strategies for addressing

these challenges which include addressing clarification regarding roles and responsibilities in terms of the Mental Health Act No. 17 of 2002, as well as training to facilitate implementation and enforcement. District and community health workers require regular training updates on the Mental Health Act No. 17 of 2002 and the use of forms (Burns 2008: 48).

5.6.2.2 Limited access to mental health policies

Limited access to policies was cited as a limiting factor in failing to implement the Policy on Integration of Mental Health Care into PHC. In some clinics where the researcher visited, some staff members expressed concern that they have heard that there are new policies and a new act but they have not seen them. This is supported by Dube and Uys (2015: 7) whose findings revealed that mental health guidelines, including the Mental Health Care Act No. 17 of 2002 were not available in four of the study sites in South Africa.

In contrast to the findings of this study, Marais and Petersen (2015: 16) reported that size and remoteness of some provinces and districts make access to services difficult. Disparity between districts and a lack of qualified staff to provide mental health care services create a barrier to access and recommend that integrated mental health care into PHC could increase access to care. According to Marais and Petersen (2015: 17) indicators for mental health in the health information system are also not sufficient in terms of quantity or quality and so they recommend inclusion of mental health in the health information system.

5.6.2.3 Resistance to change

Resistance to change and being comfortable with what the nurses have been doing for many years were seen as hindering factors for the implementation of integration of mental health care into PHC. This was attributed to the fact that most nurses that participated in the study had been doing the same thing for a

long time. Some nurses who did not have the qualification in Psychiatric Nursing Science did not see the need to see mental health care users.

Batch, Castaneda and Farah (2013: 13) argue that understanding resistance to change may enable managers to reduce conflict and increase collaboration and further recommend that leaders and managers must be trained and educated to overcome resistance to change. Managers should prepare employees to be active contributors to the success of change in the organisation. Batch, Castaneda and Farah (2013: 113) reported that the issue of resistance to change occupies a crucial role in the context of change management. Organisations should be aware of the human element and its implications. The success of change management depends on the organisational structure, availability of resources, vision and mission of the organization and willingness of employees to change. These authors warn that managers who ignore change management guarantee themselves an uphill battle and the role of leadership in driving organisational change is important. Negative attitude and resistance of staff to change and to treat mental health care users is a challenge and training and orientation of graduates about comprehensive care and change management is needed to facilitate change (Marais and Petersen 2015: 15).

5.6.2.4 Inadequate resources

Inadequate resources emerged as hindering the implementation of integration of mental health care into PHC. Participants from rural clinic reported shortage of space, consulting rooms, and medication to treat mental illness. This was different from participants from clinics that are in urban areas who reported having enough space and consulting rooms to maintain privacy. Lack of space result in lack of privacy which interferes with the ability of staff to counsel mental health care users.

All clinics cited shortage of staff (especially psychiatric nurses, specialist psychiatrists and advanced psychiatric nurses) as the main factor hindering the implementation of integration of mental health care into PHC. In some clinics, a psychiatrist only comes once a week and in some clinics a general practitioner sees all patients including mental health care users. The findings of this study are supported by Mkhize and Kometsi (2008: 7) who reported that poor infrastructure, limited funding, insufficient supplies and equipment hinder the provision of mental health care services at PHC level especially in rural areas. These authors further recommend that general nurses should be trained to identify signs of mental illness and should be mentored and supported by advanced psychiatric nurses and psychiatrists. Two issues facing the South African health care system in general are shortage of nursing staff and lack of skills among health care staff to provide quality patient care (McIntosh and Stellenburg 2009: 11). According to Shihundla, Lebesse and Maputle (2016: 7), the Department of Health management should put in strategies to retain their staff to prevent shortage of staff and increased workload.

Vhuromu and Davhana-Maselesele (2009: 60) conducted a study on the experiences of PHC nurses regarding the implementation of integrated management of childhood illnesses (IMCI) strategy at selected clinics in Limpopo. Their findings revealed that PHC nurses had difficulty in rendering IMICI services due to lack of resources and poor working conditions and recommended the following to policy makers before implementing IMCI strategy:

- Planning for resources should be conducted before a new policy is formulated and a special budget should be provided for implementation of the policy.
- Continuous monitoring of the implementation process and support should be arranged to ensure that problems are identified and addressed immediately.

The findings of this study are consistent with the study conducted by Marais and Petersen (2015: 6) whose findings revealed that participants reported insufficient capacity training as a result of staff shortages and skills deficits, and were unable to translate policies into plans. Participants also reported inadequate resources and facilities at operational level to implement the Mental Health Act No. 17 of 2002 as well as the Policy on Integration of Mental Health Care into PHC. According to Igumbor *et al.* (2016:7), innovative strategies are necessary to combat shortage of health care professionals and improve the health care system in South Africa.

5.6.2.5 Lack of communication

Lack of communication between management and staff emerged as a factor hindering the implementation of the integration of mental health care into PHC. The participants were of the opinion that there was a communication gap between managers and staff at grass roots level. This is supported by Mkhize and Kometsi (2008: 108) who conducted a study on integration of mental health care into the PHC system in South Africa and found that bureaucratic and technocratic approaches to management persist, and strict divisions between various categories of staff exist.

Mmamma, Mothiba and Nancy (2015: 4) conducted a study of the experiences of nursing unit managers regarding the turnover of professional nurses at Mokopane Hospital in Limpopo. Their findings revealed that professional nurses experienced a lack of support from top management during the execution of nursing duties at the hospital. These authors further suggest that top management has to support staff members instead of intimidating them. This is consistent with the results of the study conducted by Lambrou *et al.* (2014: 1) which was a systemic review investigating nurses' perceptions of their working environment in relation to job satisfaction. Findings revealed that managers' ability, leadership and support for nurses

were found to be the characteristics of the practice environment that had most bearing on job satisfaction. This is consistent with the findings of Sojane, Klopper and Coetzee (2016: 1) who found that nurses felt unsupported and undervalued and these authors suggest that nurse managers can improve job satisfaction by giving praise and recognition at work.

Vhuromu and Davhana-Maselesele (2009: 69) reported that communication strategy is important for all stake holders, including the community, to encourage them to buy in and support the strategy. Oakland (2008: 1) argues that peoples' attitudes could be influenced by lack of communication, and failure to communicate could create conflict which could result in confusion, loss of interest, and decrease in quality of work. The author recommends that open communication should occur at all levels of care. This is supported by Sokhela *et al.* (2013: 1) who conducted a study on the experiences of fast queue health care users in PHC facilities in eThekweni district. The results of the study revealed that effective communication is important and good communication is associated with good care and can lead to patient satisfaction.

The findings of the study conducted by Temane, Poggenpoel and Myburg (2014:1) on advanced psychiatric practitioner ideas and needs for supervision in private practice in South Africa revealed that a supervisor should have specific facilitative communication skills. These authors further explained that facilitative communication skills involve knowing how to listen, talk, ask questions and establish a rapport with people and guide them to achieve desired outcomes. Specific facilitative communication skills include highly developed questioning techniques, giving and receiving of feedback, and listening skills.

Marais and Petersen (2015: 14) reported a lack of communication about the policy on integration of mental health care into PHC at district level; this can

be improved by including strategic planners in development plans. These authors further suggest that there should be capacity to translate policies into plans at provincial and district levels. Ngxongo and Sibiya (2013:6) recommend open communication at all levels of care and in all directions to ensure access to information and policies.

5.6.2.6 Lack of skills of PHC nurses

Lack of skills among PHC nurses emerged as a factor hindering the implementation of the integration of mental health care into PHC. PHC nurses lack of skills in identifying signs of mental illness, misdiagnosing and giving wrong treatment or failure to treat leading to relapse of the mental health care users, emerged as a factor hindering the effective integration of mental health care into PHC. This is supported by Xaba *et al.* (2012: 6) whose study revealed that there is a shortage of PHC nurses, psychologists and psychiatrists at clinics and newly qualified nurses are left alone who still need support and mentoring. Poor support, and lack of skills in identifying patients with signs of mental illness, was cited by Burns (2008: 1) as an important factor undermining the implementation of integration of mental health care into PHC. This is in support of Currid *et al.* (2011: 21) who reported that PHC nurses in London have poor skills in detecting and treating people with mental disorders. Al-Khatham *et al.* (2013: 204) argue that if mental illness is not detected, it can lead to difficulties in management of mental illness.

According to Lund *et al.* (2012: 400), the key challenges at the PHC level is the training and supervision of staff in detection and management of mental health care problems, and the development of community based psychosocial rehabilitation programmes for people with severe mental illness. These authors recommend that continuity of care with primary and secondary care is required to prevent a revolving door syndrome which involves mental health care users being discharged from district, regional and tertiary hospitals and

then being re-admitted again. The information system that is required to monitor and evaluate mental health care services is inadequate and there is a need to develop indicators of routine mental health service delivery at primary and secondary level and to integrate these indicators into the district health management information system (Lund *et al.* 2012: 404).

Marais and Petersen (2015: 14) reported that there is insufficient capacity to translate policies into plans due to a lack of skills and staff shortages, but this can be improved by having champions at the national office who will advocate for mental health care. These authors further recommend use of district mental health teams as units for planning at local level.

5.6.2.7 Prioritising mental health care users

The approach used at clinics to prioritise mental health care users and treat them first exposes them to other patients who bring up the issue of stigma. Participants reported that mental health care users who are receiving chronic medication and those who are diagnosed are fast tracked and seen first and given medication. Participants reported that this was done to prevent mental health care user not having to wait for a long period because they tend to complain if they wait for longer periods. This approach unfortunately makes some mental health care users feel uncomfortable because everyone knows at the clinic that if you are fast tracked, it means you are mentally ill. The findings of this study are in contrast to the studies conducted which are related to fast tracking of patients. Sokhela *et al.* 2013: 1) state that the fast queue strategy was introduced in South Africa to resolve challenges in a range of health care services including PHC services to reduce long waiting periods at the clinics. In support of Sokhela *et al.* (2013:1), Lund *et al.* (2012: 403) revealed that at PHC level, management of mental disorders such as schizophrenia consists mainly of symptom management through provision of follow-up medication and further state that mental health care users who have

been stabilised with treatment are referred back to primary care clinics for receiving ongoing treatment and monitoring of their mental status as well as rehabilitation and when they come to the clinic, they are prioritised and this reduces waiting time.

5.7 CONSEQUENCES – UNINTENDED AND INTENDED OUTCOMES OF THE INTEGRATION OF MENTAL HEALTH CARE INTO PHC AS VIEWED BY PHC MANAGERS, OPERATIONAL MANAGERS AND PROFESSIONAL NURSES

According to Strauss and Corbin (1990: 106) consequences are referred to as both intended and unintended outcomes.

5.7.1 Intended consequences

5.7.1.1 Improving access to care

Improving accessibility to mental health care for mental health care users at the nearest clinic where they live emerged as an advantage resulting from integration of mental health care into PHC. Accessibility as described by Hatting, Dreyer and Roos (2006: 121) is the provision of equitable health services within easy reach of all citizens in the community. The goal for the White Paper for the Transformation of the Health System in South Africa was for unification of fragmented health services at all levels into a comprehensive and efficient integrated national health system, reduction in disparities in health service delivery and increase in access to PHC services based on PHC principles (Department of Health 1997: 5).

The results of this study are consistent with the study conducted by Marais and Petersen (2015: 11) who reported that advantages of integrating mental health care into PHC include access to mental health care. This is supported by the White Paper for the Transformation of the Health System in South

Africa, whose aim was to improve access to mental health care, nearer to where people live (Department of Health 1997: 5). One of the objectives of the policy framework for the integration of mental health care into PHC: 2013 to 2020 is to improve access to mental health care at PHC level (Department of Health 2013: 6).

In South Africa, a policy on national health insurance was established in 2010 by the National Department of Health. The objectives of the policy was to provide improved access to quality health services for all South Africans irrespective of whether they are employed or not, procure health services on behalf of the entire population, and strengthen the under-resourced and strained public sector in order to improve health systems' performance (Department of Health 2010: 2).

According to Kigozi and Ssebunnya (2009: 37), integration of mental health care at PHC level aims to improve access, availability and affordability of services thereby improving outcomes. These authors further state that the advantages of integrating mental health into PHC include reducing stigma for mental health care users, improving access to care, protection of human rights and reduction of chronicity of mental illness as well as improvement of social integration.

5.7.1.2 Holistic management of the mental health care users

Holistic management of mental health care users was viewed by participants as an important milestone to attend to the health needs of individuals. Maharaj and Cleland (2005: 314) report that holistic management of patients has positive consequence. Petersen (2009: 1) argues that although nurses understand a holistic approach to care which includes physical, social, and psychological, this knowledge is not being put into practice because they are overworked and do not have the necessary skills to deal with mental illness.

Holden *et al.* (2014: 357) acknowledge the importance of holistic care which considers physical, mental, emotional and behavioural problems and further recommends the holistic management of patients to reduce mental health disparities and promote better mental health and the well-being of ethnic minority individuals, families and communities.

According to Zamanzadeh *et al.* (2015: 214), holistic care is a comprehensive model of caring. Holistic care emphasises that for the human being the whole is greater than the sum of its parts and that mind and spirit affect the body. These authors further state that holistic care recognises interdependence between biological, social, physiological and spiritual aspect of human beings.

5.7.1.3 Capacity building for staff

Participants from one clinic indicated that integration of mental health care into PHC is good for staff as well because they have to assess and manage all patients with chronic illness including mental health care users. This is supported by French *et al.* (2006: 206) whose findings revealed that the advantages of the one-stop approach for staff was the potential to increase staff job satisfaction due to extended role, improve career opportunities, more of a team approach to care, and greater management flexibility.

5.7.2 Unintended consequences

Although the implementation of policy on integration of mental health care into PHC has positive outcomes, participants also cited unintended consequences as discussed below.

5.7.2.1 Lack of space

Participants from rural clinics where a one-stop approach was used cited lack of space to interview and counsel mental health care users at the PHC clinics.

Limited space was viewed as a consequence of overcrowding in clinics due to increased access and transfer of patients from hospitals to the clinics. Introduction of free health services and a supermarket approach to health care has led to PHC nurses having to manage large volumes of patients at one clinic (Netshandama *et al* 2005: 11).

Findings of this study are consistent with the study conducted by Marais and Petersen (2015: 10) who reported lack of space for allowing privacy for counselling of mental health care users as a challenge facing mental health care workers. This is supported by Mkhize and Kometsi (2008: 7) whose study revealed that for the integration of mental health care into PHC to be successful, enough space for consulting needs to be allocated to the community or PHC clinics and not just to hospitals.

5.7.2.2 Poor quality mental health care

It emerged that participants perceive that integration of mental health care into PHC resulted in poor quality mental health care being provided to mental health care users. Most participants believe that mental health care that was given in separate mental health clinics was good and psychiatric nurses had time to listen to mental health care users. This is supported by Netshandama *et al* (2005: 12) who cites that due to increased workloads PHC nurses find it difficult to correctly assess the patient and this leads to inadequate PHC and poor quality care for patients, and to PHC nurses developing burnout and stress.

Dube and Uys (2015: 8) found no evidence of thorough assessment of patients and therefore poor management of mental health care users leading to poor quality mental health care which could be attributed to lack of knowledge and skills. According to Mkhize and Kometsi (2008: 107), PHC nurses are overworked and do not have time to give quality care to mental

health care users. Excessive workload of PHC nurses and inadequate resources makes it impossible for PHC nurses to give good quality mental health care (Burns 2008: 1). According to Eygelaar and Stellenburg (2012: 1), barriers to quality patient care in rural district hospitals included lack of human resources, consumables and equipment and this affected the ability of staff to give quality care. Kilbourne, Keyser and Pincuss (2011: 549) state that despite guidelines for the management of mental disorders, quality care and outcome remains poor as a result of poor quality in detection, treatment, and follow-up care.

In response to improved health care which includes mental health care, the Department of Health established a Ten Point Plan in 2009, which makes provision for the establishment of a quality management and accreditation body as well improving the quality of health services. The four performance areas include improved life expectancy, improved mother and child health, reduced impact of HIV and TB as well as improved health system effectiveness (Department of Health 2009: 2). In fulfilling national strategic objectives, the Department of Health developed national core standards to set the benchmark for quality care in 2011. The purpose of national core standards is to develop a common definition of quality care which should be available in all health institutions in South Africa; establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised; and provide for the national certification of compliance of health establishments with mandatory standards (Department of Health 2011: 2).

5.8 THE ENABLING ENVIRONMENT THAT WILL ALLOW THE POLICY ON INTEGRATION OF MENTAL HEALTH CARE INTO PHC TO TAKE PLACE EFFECTIVELY

The participants cited conditions that need to be in place for the implementation of the Policy on Integration of Mental Health Care into PHC to be effective to include enough space or consulting rooms for patients at the clinic, enough medication for all patients, protocol and referral procedure for the management for the mental health care users, qualification in Psychiatric Nursing Science and Primary Health Care Nursing Science for all nurses working at the clinic, and there should be more psychiatrists and advanced psychiatric nurses. The schematic presentation of the environment that will enable implementation of the policy on integration of mental health care into PHC is outlined below in Figure 5.2.

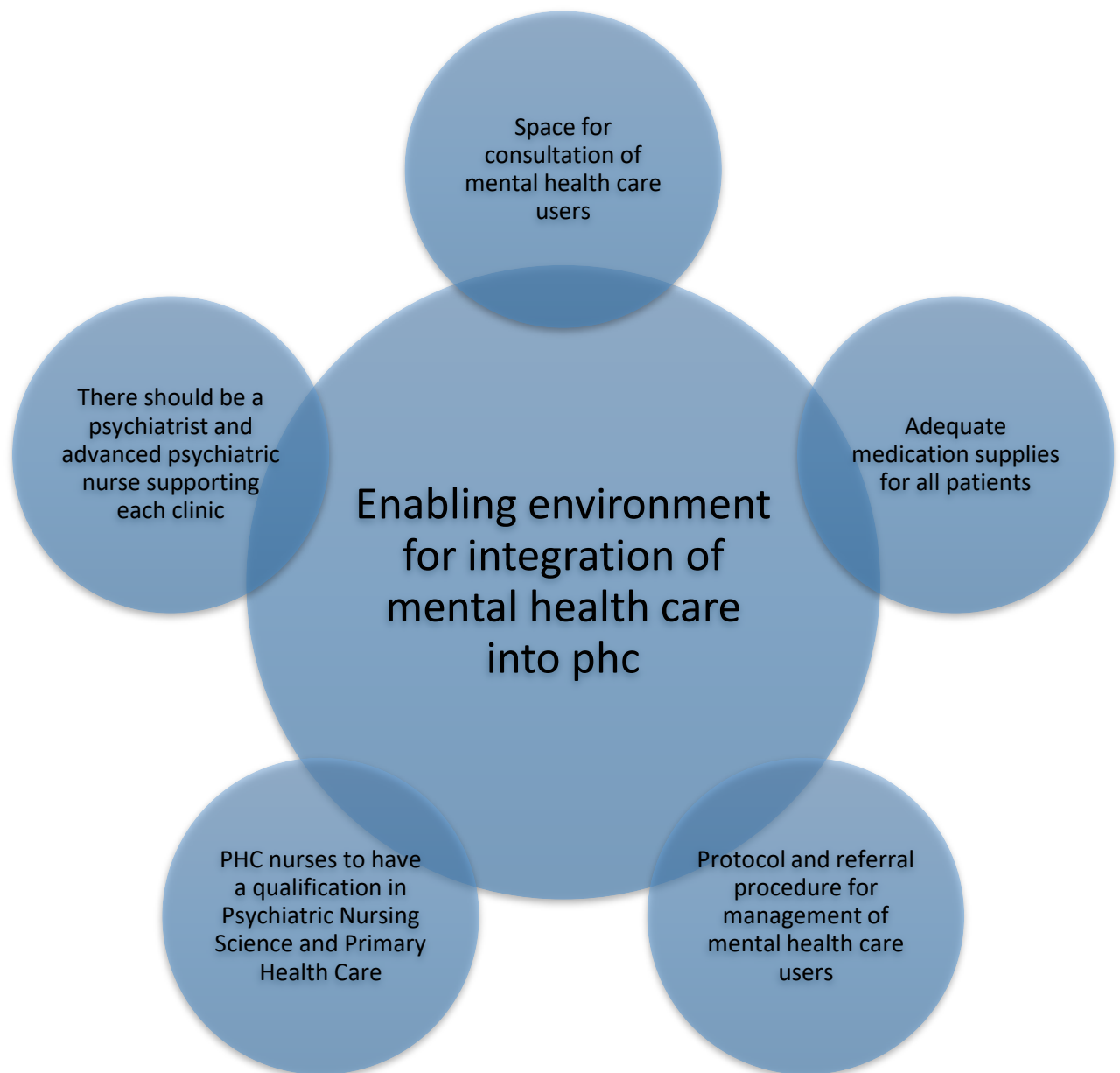


Figure 5.2: Schematic representation of the enabling environment for integration of mental health care into PHC

The findings of this study are consistent with findings of the study by Kigozi and Ssebunnya (2008: 39), who recommended that the conditions or environment necessary for the integration of mental health care in Uganda should include the following:

- The presence of political will and commitment to policy.
- Separate budget for mental health services.
- Good leadership in mental health care.
- Increase in supply of medicines.
- Availability of health workers to be trained in mental health care.
- Involvement of other stakeholders.
- Decentralisation of health care system.
- Increase in community participation.

This is supported by Bhana *et al.* (2010: 600) who recommended that the necessary actions for the integration of mental health care to take place include: availability of psychotropic medication at PHC clinics, education of the public, provision of human resource, and establishment of protocols and policies. Conditions that will enable integration of mental health care in KZN are discussed below.

5.8.1 Adequate space or consulting rooms for patients at the clinic

Adequate space and consulting rooms for counselling and interviewing clients was viewed as an important condition that needs to be in place before integration of mental health care can place. Participants cited that enough space and consulting rooms provide adequate privacy and allow for confidentiality of information between mental health care users and health workers. Marais and Petersen (2015: 10) cite space as being an important aspect for counselling of mental health care users and that there is a need for a dedicated space for counselling of all patients. This is further supported by Mkhize and Kometsi (2008: 7) whose study revealed that for the integration of

mental health care into PHC to be successful, resources such as CHCs, financial resources, personnel and enough space for consulting need to be transferred to the community or PHC clinics instead of to hospitals.

5.8.2 Adequate medication for all patients

Adequate medication supplies for all patients were viewed as an important condition that needs to be in place before integration of mental health care can take place. The participants stated that enough medication supplies allow PHC nurses to give treatment to mental health care users and prevent relapse and re-admission to mental institutions. Kilbourne *et al.* (2011: 549) state that quality mental health care and outcomes remain poor and this is the result of poor quality in detection, ineffective treatment and follow-up care.

Marais and Petersen (2015: 10) state that major challenges with regard to medicines and technologies relate to the supply of psychotropic medicines at district level. In most instances this is attributed to a breakdown in communication between the hospitals, clinics and pharmacies. These authors further state that poor medication supplies lead to mental health care users defaulting which may lead to relapse.

5.8.3 Protocol and referral procedure for the management for the mental health care users

Protocols and referral procedures for the management of mental health care users was viewed as an important condition that needs to be in place before integration of mental health care can place. The participants stated that they feel there must be step-by-step procedures put in place by management for mental health care users and that this must be communicated to all staff at the clinic. They further recommended that there should be engagement of community members and other stakeholders in the community including police on how to manage mental health care users so that they support the

policy. This is supported by Vhuromu and Davhana-Maselesele (2009: 69) who report that a communication strategy is important for all stake holders and community members to encourage them to buy in and support the policy.

Burns (2008:48) recommends that treatment protocols for managing mental disorders should be developed for distribution to districts and PHC clinics. These authors further recommend that local South African Police Services and Emergency Medical Rescue Services (EMRS) personnel should receive regular training regarding requirements of the Mental Health Act No. 17 of 2002, and on how to manage mental health care users. Such training should be made available in each district.

5.8.4 Qualification in Psychiatric Nursing Science and Primary Health Care for all nurses working at the clinic

Qualification in Psychiatric Nursing Science and Primary Health Care for all nurses working at the PHC clinic was viewed by all participants as an important condition that needs to take place before integration of mental health care into PHC can be achieved. Participants cited that each and every nurse at PHC clinics should have the necessary skills to be able to manage mental health care users. This is supported by Mkhize and Kometsi (2008: 7) who recommend that general nurses should be trained to identify signs of mental illness and should be mentored and supported by advanced psychiatric nurses and psychiatrists.

The findings of this study are consistent with the findings of the study conducted by Marais and Petersen (2015:17), whose findings revealed: there is a shortage of health professionals and specialists to implement the policy; high workload; high staff turnover; and inflexibility of existing staff structures to accommodate creation of new posts for district mental health teams. These authors recommended that training of health workers should be adapted so

that it is more PHC focused. This is supported by Lund *et al.* (2012: 404) who found that the resources required to deliver mental health services, including human resource services and budget to be inadequate. Van Wijk, Traut and Julie (2014: 8) and Awases, Bezuidenhout and Roos (2013: 1) recommend that managers and leaders in nursing should ensure that staff receive training and in-service training to increase their knowledge and skills in mental health care.

5.8.5 Availability of Psychiatrists and Advanced Psychiatric nurses to support PHC nurses at the clinic

Participants stated that the availability of Psychiatrists and Advanced Psychiatric nurses to provide support and mentoring of PHC staff who do not have qualification in psychiatric nursing would provide an enabling environment for effective integration of mental health care into PHC. All clinics cited shortage of staff especially psychiatric nurses, specialist psychiatrist and advanced Psychiatric nurses as the main factor hindering the implementation of integration of mental health care into PHC. In some clinics, a Psychiatrist only comes once a week and in some clinics a general practitioner sees all patients including mental health care users. This is supported by Marais and Petersen (2015: 15) whose findings revealed that there is insufficient specialist capacity to provide training and support for PHC nurses at clinics to implement PC101, and lack of clarity regarding the responsibility for supervising and monitoring the implementation of PC101. These authors recommend that PHC nurses trained in PC101 need mentoring and support in implementing mental health aspects and district mental health teams need to provide support and mentoring. According to Ngako, Van Rensburg and Matabonge (2012: 8), mentoring of professional nurses can increase knowledge and skills necessary for the management of patients as well as create a supportive environment for professional nurses as well as patients.

5.9 SUMMARY OF THE CHAPTER

This chapter discussed how integration of mental health care into PHC is practised in KZN. In KZN, integration of mental health care is regarded as comprehensive care that is offered through a one-stop approach or a supermarket approach, depending on the availability of staff with basic Psychiatric Nursing Science. Isolation, stigma and neglect were raised as factors that led to the development of policy on integration of mental health care into PHC. Strategies used in KZN for the implementation of the policy were discussed. Challenges as well as an enabling environment for the integration of mental health care in KZN were presented. It is clear from the discussion that irrespective of various opportunities available, there are challenges regarding the implementation of the policy on integration of mental health care into PHC. The two approaches that emerged from the data analysis namely, a) a supermarket approach, and b) a one-stop shop approach will be analysed further in Chapter 6.

CHAPTER 6 : A PRACTICE FRAMEWORK FOR THE INTEGRATION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE SERVICES

6.1 INTRODUCTION

The results of the current study were discussed in the previous chapter. The aim of the study was to analyse the implementation of Policy on Integration of Mental Health Care into PHC with the ultimate aim of developing a practice framework that will enhance the implementation of the policy in the province of KZN in South Africa. The practice framework that will be presented in this chapter will be based on the concepts that were discussed in Chapter 4 and Chapter 5. The phenomenon in this study is the integration of mental health care into PHC.

6.2 THE PURPOSE OF THE PRACTICE FRAMEWORK

The purpose of the practice framework is to enhance the implementation of the Policy on Integration of Mental Health Care into PHC. This practice framework will reveal the meaning of integration of mental health care into PHC as the phenomenon under study, strategies used to implement integration of mental health care into PHC, and the enabling environment that will allow integration of mental health care to take place effectively. The practice framework can be used by the Department of Health to enhance the implementation of the Policy on Integration of Mental Health Care into PHC. The key concepts that would enhance the implementation of policy on integration of mental health care into PHC in KZN that have been identified are presented in Figure 6.1.

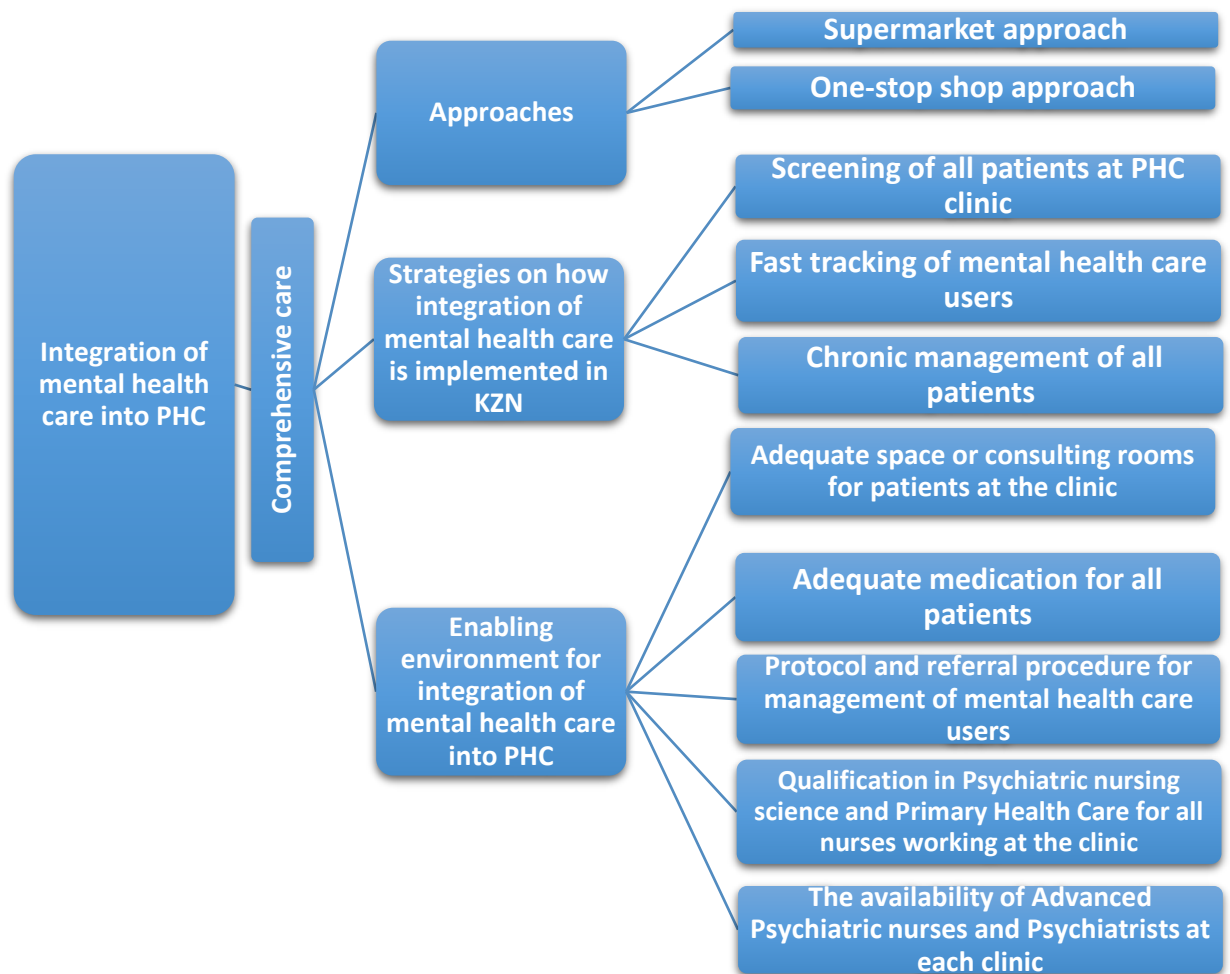


Figure 6.1: The practice framework for integration of mental health care into PHC

6.3 CATEGORIES OR CONCEPTS USED IN THE FRAMEWORK

The results of the study have highlighted where improvements are required. The practice framework identifies comprehensive health care offered to mental health care users using either a supermarket approach or a one-stop-shop approach. The practice framework describes strategies that must be used to implement the Policy on Integration of Mental Health Care into PHC as well as the enabling environment for integration of mental health care into PHC.

6.4 DESCRIPTION OF CONCEPTS IN THE PRACTICE FRAMEWORK

In KZN, the approaches for the delivery of comprehensive care at PHC clinics should include supermarket and one-stop shop approaches with the approach depending on the availability of professional nurses with a qualification in Psychiatric Nursing Science.

6.4.1 Supermarket approach

A supermarket approach can be used for the provision of mental health care services at PHC clinics in KZN where there is a lack of professional nurses with Psychiatric Nursing Science qualification. This means the provision of all services that a patient needs by different nurses or health care providers in one clinic. This approach means that the patient moves from one consulting room to another one depending on their health need, for instance, after receiving mental health care if there is a need for family planning then they will join another queue for that service. This approach needs a good relationship between staff and collaboration between PHC nurses and other members of the team. Nurses are allocated according to their specialties. The professional nurse that is allocated to mental health care users must have a basic qualification in Psychiatric Nursing Science.

6.4.2 One-stop shop approach

A one-stop approach to care for mental health care users can be used if all PHC nurses have a qualification in Psychiatric Nursing Science. In this approach, patients are managed holistically by one nurse, taking into consideration the physical, social and psychological aspects of care. If the client comes with mental illness, the nurse also checks for other diseases. The one-stop-shop approach allows for clinic efficiency, is convenient for the patient, and allows patients to receive effective health care services. This approach requires a nurse who is multi-skilled and comprehensively trained and can provide comprehensive care (Department of Health 2001: 12).

6.5 THE STRATEGIES USED FOR INTEGRATION OF MENTAL HEALTH CARE INTO PHC AT KZN

The following strategies can be used at PHC clinics in KZN to ensure that integration of mental health care into PHC is implemented: a) screening of all patients for mental illness, b) fast tracking of mental health care users, and c) chronic management of all patients including mental health care users.

6.5.1 Screening of all patients for mental illness

In clinics where a one-stop shop approach is used, all patients that come to the clinic should be assessed for mental illness and if found to be mentally ill, they must be managed by the same professional nurse or referred if it is beyond the scope of that nurse. All professional nurses who are working at one-stop PHC clinics should have a Psychiatric Nursing Science qualification. In clinics where a supermarket approach is used, mental health care users should be screened and then referred to a professional nurse who has a Psychiatric Nursing Science qualification and who only manages mental health care users at the clinic.

6.5.2 Fast tracking of mental health users

All PHC clinics should have a fast tracking system in place. When mental health care users come to the clinic, screening should occur and if the client is found to be mentally ill, they should be re-routed to a professional nurse with a Psychiatric Nursing Science qualification who will provide further treatment or to a doctor who will prescribe medication. If the mental health care user is not stabilised they are referred to the next level of care which is 72-hour assessment period which is available at the district hospital (Department of Health 2001: 2).

6.5.3 Chronic management of patients at the clinic

In all PHC clinics, mental health care users that are on chronic medication should be referred to a professional nurse who does integrated management of chronic illnesses which includes management of mental illness. This is consistent with the provisions of the model called the symptom-based integrated approach at PHC clinics (PC101) which was commissioned and published by the Department of Health which provides guidelines for the management of all chronic illnesses including management of mental health care users who have chronic mental illness (Department of Health 2016: 1).

6.6 THE ENABLING ENVIRONMENT THAT WILL ALLOW INTEGRATION OF MENTAL HEALTH CARE INTO PHC TO TAKE PLACE EFFECTIVELY

6.6.1 Adequate space or consulting rooms for patients at the clinic

Each PHC clinic must provide adequate space and consulting rooms for counselling and interviewing clients which will allow effective integration of mental health care into PHC. Adequate privacy allows for confidentiality of information between the mental health care user and health worker. This is supported by Mkhize and Kometsi (2008: 7) who maintain that for the

integration of mental health care into PHC to be successful, adequate space for consulting needs should be prioritised for community or PHC clinics rather than hospitals. According to Marais and Petersen (2015: 10), private space is important for counselling of mental health care users and to allow confidentiality of information.

6.6.2 Adequate medication for all patients

Each PHC clinic should have adequate medication supplies for all patients for effective integration of mental health care to take place. Adequate medication supplies allow PHC nurses to provide quality treatment to mental health care users to prevent relapse and re-admission to a mental institution. Poor quality mental health care results from poor detection, ineffective treatment and follow-up care (Kilbourne *et al.* 2011: 549). According to Marais and Petersen (2015: 10), poor medication supplies lead to mental health care users defaulting which may lead to relapse.

6.6.3 Protocol for the management and referral procedure for the management of mental health care users

Protocol and referral procedure for the management of mental health care users is an important condition that needs to be in place before integration of mental health care can place. In each clinic, there must be step-by-step procedures for the management of mental health care users and this must be communicated to all staff at the clinic. Community members and other stakeholders in the community including police should be engaged with and trained how to manage mental health care users so that all stake holders support the policy.

Burns (2008: 48) recommends that treatment protocols for managing mental disorders should be developed for distribution to districts and PHC clinics. This should be distributed to local South African Police Services and

Emergency medical personnel and they should receive regular training in respect of how to manage mental health care users, and regarding the requirements of the Mental Health Act No. 17 of 2002. This must be carried out in each district.

6.6.4 Qualification in Psychiatric Nursing Science and Primary Health Care Nursing for all nurses working at the clinic

Qualifications in Psychiatric Nursing Science and Primary Health Care Nursing for all nurses working at the PHC clinic is an important condition that needs to take place for integration of mental health care into PHC to be effective. Each and every nurse at PHC clinics should have the necessary skills to manage mental health care users. Mkhize and Kometsi (2008: 7) recommend that general nurses should be trained to identify signs of mental illness and should be mentored and supported by advanced psychiatric nurses and psychiatrists.

6.6.5 The availability of Advanced Psychiatric nurses and Psychiatrists at each clinic

In each PHC clinic there must be Psychiatrists and Advanced Psychiatric nurses to provide support and mentoring of PHC staff that have a basic qualification in Psychiatric Nursing Science, and PHC nurses who do not have such a qualification. According to Marais and Petersen (2015: 15) there is insufficient specialist capacity to support professional nurses who have basic qualification and those who do not have a qualification in psychiatric nursing.

6.7 ASSUMPTIONS

Assumptions refer to opinions, experiences, opinions and attitudes of people. The research paradigm for this study was influenced by symbolic interactionism. According to Chenitz and Swanson (1986: 5), symbolic

interactionism is a theory which focuses on the meaning of interactions and human behaviour. This research aimed to study the meaning of integration of mental health care into PHC from the point of view of PHC managers, operational managers and professional nurses. The researcher believed that interacting with PHC nurses was able to provide understanding of issues surrounding implementation of the Policy on Integration of Mental Health Care into PHC in the province of KZN.

6.8 USEABILITY OF THE PRACTICE FRAMEWORK

As previously reported in previous sections, this practice framework will be used to enhance implementation of the policy on integration of mental health care into PHC. This practice framework can also be used to guide clinical nursing practice, nursing education as well as future research. This is supported by Chenitz and Swanson (1986: 153) who maintained that grounded theory leads to new insight into the phenomenon under study and it should suggest new ways for future research and enquiry.

6.9 SUMMARY OF THE CHAPTER

Chapter 6 has presented the practice framework to enhance the implementation of the policy on integration of mental health care into PHC in KZN. The practice framework includes approaches for the delivery of mental health services at PHC clinics in KZN which depends on the availability of professional nurses with basic qualification in Psychiatric Nursing Science. The strategies and enabling environment to be used to enhance implementation of the Policy on Integration of Mental Health Care into PHC was also presented. Summary of the findings, limitations of the study, conclusion and recommendations will be discussed in Chapter 7.

CHAPTER 7 : SUMMARY OF FINDINGS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

This chapter provides a brief overview of the study, limitations of the study, conclusions and recommendations. The year 2017 marks 20 years since the publication of the White Paper for the Transformation of the Health System in South Africa in 1997 and 11 years since the National Department of Health released guidelines on the management of mental health care user at PHC level in South Africa (Department of Health 2006a: 17). South Africa has made significant achievements at the level of policy development and legislation.

Since the publication of these policies, there has been insufficient information to guide PHC nurses on the implementation of the policy (Bhana *et al.* 2010: 602). Despite the release of guidelines, there are gaps in the management of mental health care users at PHC clinics especially in rural areas and insufficient support for PHC nurses may lead poor identification of mental disorders (Petersen *et al.* 2012: 4). This study attempted to analyse the implementation of the policy on integration of mental health care into PHC with the ultimate aim of developing a practice framework that will enhance the implementation of the policy in KZN, South Africa.

7.2 RESULTS

The research results are presented according to objectives of the study.

7.2.1 The understanding of the phenomenon, integration of mental health care into PHC

The major central category that emerged from data analysis was comprehensive health care. Integration of mental health care into PHC was reported as provision of comprehensive care that is needed by all mental health care users at the clinic. This comprehensive care emerged as a service being offered to mental health care users using either a supermarket approach or a one-stop-shop approach at PHC clinics.

7.2.2 The process of the phenomenon, integration of mental health care into PHC

Strategies that are used at the PHC clinic in KZN to ensure that integration of mental health care into PHC is implemented include screening of all patients that come to the PHC clinic for mental illness, fast tracking of mental health care users once they have been assessed and found to be mentally ill, and chronic management of all patients, including mental health care users, using the PC101 model.

7.2.3 Identification and description of the causal conditions, intervening conditions or challenges if any that might hinder the implementation of the Policy on Integration of Mental Health Care into PHC

This research study revealed that integration of mental health care into PHC came into being as a result of stigma that was associated with mental illness, and the neglect that mental health care users used to experience due to

mental illness and the resultant isolation of mental health care users from the general patients and the community.

It was reported that integration of mental health care was influenced by either facilitative conditions or hindering conditions. Facilitative conditions included good relationship between staff, involvement of multidisciplinary team, organisation of the clinic, and availability of enough resources. On the other hand, hindering conditions included lack of staff training opportunities in mental health care, limited access to mental health policies, resistance to change, inadequate resources, lack of communication, lack of skills, and lack of prioritisation of mental health care users.

7.2.4 Identification and description of consequences or outcomes for ineffective implementation of the Policy on Integration of Mental Health Care into PHC

Consequences for ineffective integration of mental health care into PHC were reported as unintended or intended outcomes of the integration of mental health care into PHC. Intended consequences reported included improving access to care, holistic management of mental health care users and capacity building for staff members that are now exposed to a variety of patients instead of only managing mental health care users. Although the implementation of the Policy on Integration of Mental Health Care into PHC has positive outcomes, participants reported unintended consequences such as lack of space for consulting mental health care users, and perceived poor quality mental health care.

7.2.5 The enabling environment for the implementation of the Policy on Integration of Mental Health Care into PHC in KZN

Participants reported that conditions which need to be in place for the implementation of the Policy on Integration of Mental Health Care into PHC to be effective include: enough space or consulting rooms for patients at the clinic; enough medication for all patients; protocols and referral procedures for management of mental health care users; qualification in Psychiatric Nursing Science and Primary Health Care Nursing for all nurses working at the clinic; and, more psychiatrists and advanced psychiatric nurses to be available for support and mentoring.

7.2.6 Practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into PHC in KZN

The practice framework identifies comprehensive mental health care being offered to mental health care users using either a supermarket approach or a one-stop-shop approach depending on the availability of staff with a qualification in Psychiatric Nursing Science. The practice framework describes strategies that should be used to implement the policy on integration of mental care into PHC as well as the enabling environment for integration of mental health care to take place using comprehensive, supermarket and one-stop-shop approaches.

7.3 LIMITATIONS

Limitations of this study are that it did not include mental health care users and their families as they are the custodians of integration of mental health care into PHC. It would be of great interest to see how mental health care users perceive and understand integration of mental health into PHC. Another area of great interest would be including general patients who are receiving treatment at PHC clinics together with mental health care users; it would be

interesting to see how they perceive this policy. The study also excluded professional nurses with less than two years' experience and community service professional nurses who are working at PHC clinics that were involved in the study. KZN has 11 districts and this study only looked at two rural districts and two urban districts so the generalisability of these results is limited. The model presented still needs to be implemented tested and refined if there is a need.

7.4 RECOMMENDATIONS

Despite the limitations which might impact on the generalisability of the results, the following recommendations with special reference to nursing practice, nursing education and future research, are based on the findings of the study.

7.4.1 Nursing practice

Based on the findings of this study, there is evidence that there is a lack of communication between management and operational staff. Despite benefits as a result of implementation of the policy on integration of mental health care into PHC, lack of communication regarding policies and provisions of the Mental Health Act may have a serious effect on the implementation of the policy. Therefore, KZN needs to have protocols, guidelines and communication strategies on how to implement the policy. Managers need to be capacitated with needed skills in order to provide leadership in this matter. Lack of supervision by specialists can also hamper the provision of quality mental health care at PHC level. Therefore, it is recommended that at least there must be a resident psychiatrist and advanced psychiatric nurses who will supervise and mentor PHC nurses in providing quality mental health care. Lack of resources, space, equipment, lack of political will, and increased workload were identified as major factors hindering the implementation of the policy. Therefore, it is recommended that PHC facilities should receive an

increased budget because of additional services that are now offered at PHC clinic. The researcher recommends more studies to be done on outcomes of integrated care, best practice related to implementation of the framework

7.4.2 Nursing education

In response to the increased work load due to the increase in services that need to be provided by PHC nurses and the increased burden of disease as well as growing population in South Africa, the training of sufficient nurses with adequate skills is important. The current study recommends that there is an urgent need to relook at the PHC curriculum so that new PHC graduates will understand integration of mental health care into PHC, their roles, and how to function in such an environment.

7.4.3 Future research

This study has revealed that Policy on Integration of Mental Health Care was put in place to address stigma associated with mental illness, neglect of mental health care users, and isolation of mental health care users from general patients. The researcher recommends future research could be done on the effect of the implementation of the policy on integration of mental health care into PHC to mental health care users and their families. The researcher also recommends the evaluation of this practice framework for the integration of mental health care into PHC services when it is implemented in PHC clinics in KZN.

7.5 SUMMARY OF THE CHAPTER

This study attempted to analyse the implementation of the Policy on Integration of Mental Health Care into PHC with the ultimate aim of developing a practice framework that will enhance the implementation of the policy in KZN, South Africa. The practice framework identifies approaches

used to provide mental health care, the strategies that are currently used and the enabling environment for the implementation of the policy on integration of mental health care into PHC in KZN, South Africa.

The developed practice framework could assist PHC nurses in improving the quality of mental health care at PHC clinics in KZN, South Africa. Despite the challenges pertaining to PHC nurses' ability and skills to implement the Policy on Integration of Mental Health Care into PHC, it should be remembered that PHC nurses should engage in lifelong learning. Therefore, PHC nurses should be encouraged to further their knowledge, skills and competence throughout their professional lives through the use of workshops, conferences and future studies.

In conclusion it was envisaged in the Alma Ata Declaration that health services will be available to all those who need care in primary health care level, however this study has identified a number of factors which are impacting on successful implementation of integration of mental health services into PHC system in KZN. While advances at the level of policy and legislation are recognized, further effort and political will is needed to address issues that has been raised from the study to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

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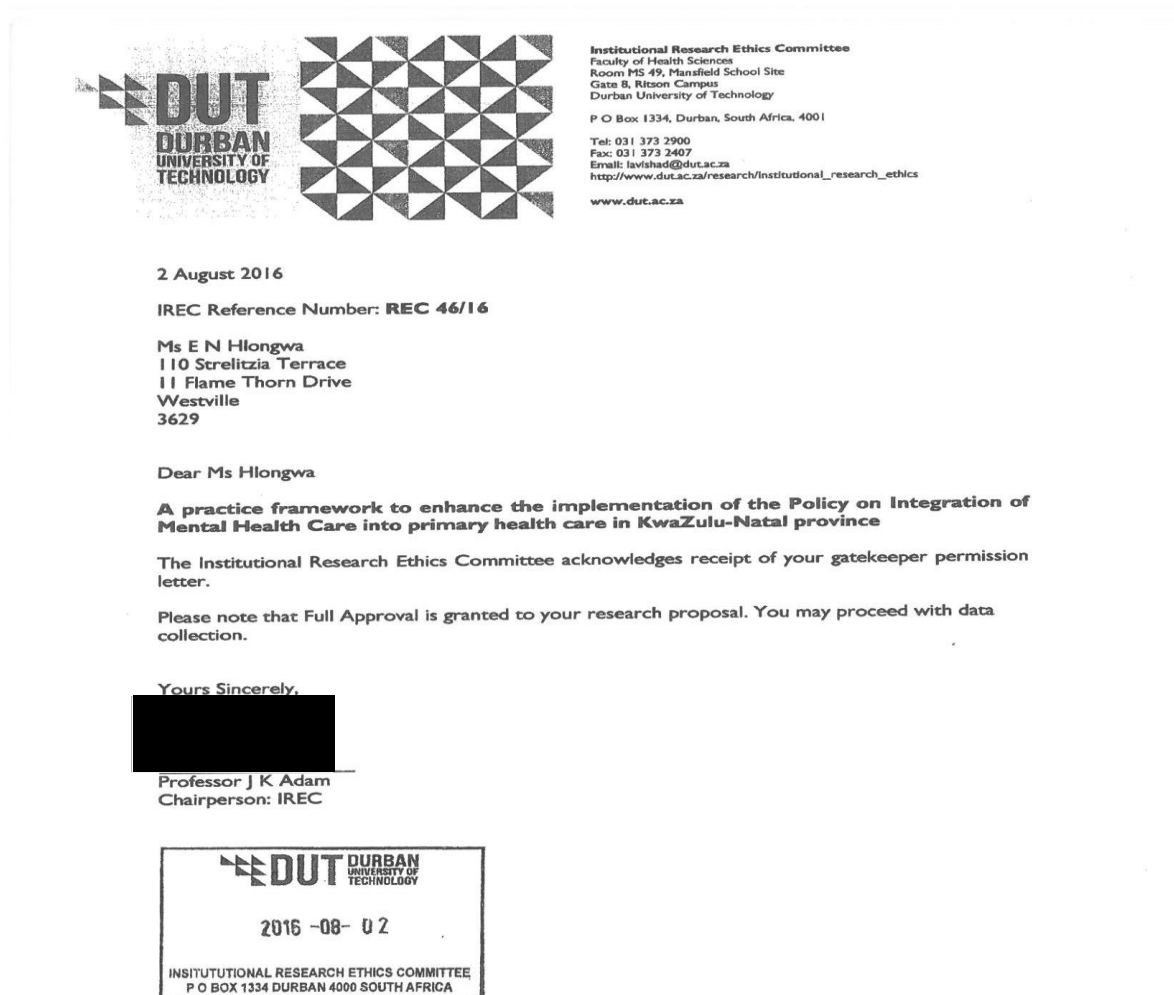
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APPENDICES

Appendix 1: DUT ethics clearance



Appendix 2a: Permission letter to KZN Department of Health

110 Strelitzia Terrace
11 Flame thorn Drive
Westville
3629

Health Research and Knowledge Management Component
Department of Health
Natalia Building
Room 102, South Tower
PIETERMARITZBURG
3200

Dear Dr Lutge

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am registered for a Doctoral Degree in Nursing at the Durban University of Technology. Permission is requested to undertake a research project in your District. The title of the study is '*A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into primary health care in KwaZulu-Natal Province*'.

The aim of the study is to analyse the implementation of the Policy on Integration of Mental Health Care at primary health care (PHC) clinics in KwaZulu-Natal province in South Africa and ultimately to develop a practice framework for PHC nurses to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

A three stage selection planning will be applied from the accessible population. The first stage will be selecting districts which will be involved in the study. The researcher will purposefully choose districts according to their geographical location namely eThekweni, iLembe, uMgungundlovu and uGu districts. The second stage of selection will be to select clinics located within districts of eThekweni, iLembe, uMgungundlovu and uGu. The third stage of selection will be selecting participants who will take part in the study. Purposeful sampling and theoretical sampling will be used to select participants. Sample will consist of PHC Programme Managers of each District selected, PHC Operational Managers and professional nurses who are employed at the selected clinics.

One to one interviews will be used to collect data from PHC Managers and PHC Operational Managers. Focus group discussions will be conducted with the professional nurses. The researcher will interview and guide the

discussion according to the guide.

Please find enclosed a copy of the proposal for perusal. Should you have any queries please do not hesitate to contact my supervisors Professor MN Sibiya on 031-373 2606 or e-mail her at nokuthulas@dut.ac.za

Yours Sincerely

Esther Nelisiwe Hlongwa (Ms)
D Nursing Student at DUT
E-mail: Esther.Hlongwa@kznhealth.gov.za
Phone: 033-897 3508 (W)
Cell no: 084 549 8894

Appendix 2b: Approval letter from KZN Department of Health



Reference: HRKM192/16
KZ_2016RP58_949

30 June 2016

Dear Ms N E Hlongwa
(Durban University of Technology)

Subject: Approval of a Research Proposal

1. The research proposal titled 'A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at KwaDabeka, Ndwendwe, Imbalenhle & Gamalakhe Community Health Centres

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

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee

Date: 01/07/16

Fighting Disease. Fighting Poverty. Giving Hope

Appendix 3: Permission letter to the Health District Managers

110 Strelitzia Terrace
11 Flame thorn Drive
Westville
3629

The District Manager
eThekweni District
Ugu District
iLembe District
uMgungundlovu District

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am registered for a Doctoral Degree in Nursing at the Durban University of Technology. Permission is requested to undertake a research project in your District. The title of the study is '*A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province*'.

The aim of the study is to analyse the implementation of the Policy on Integration of Mental Health Care at primary health care (PHC) clinics in KwaZulu-Natal province in South Africa and ultimately to develop a practice framework for PHC nurses to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

A three stage selection planning will be applied from the accessible population. The first stage will be selecting districts which will be involved in the study. The researcher will purposefully choose districts according to their geographical location namely eThekweni, iLembe, uMgungundlovu and Ugu districts. The second stage of selection will be to select clinics located within districts of eThekweni, iLembe, uMgungundlovu and uGu. The third stage of selection will be selecting participants who will take part in the study. Purposeful sampling and theoretical sampling will be used to select participants. Sample will consist of PHC Programme Managers of each District selected, PHC Operational Managers and professional nurses who are employed at the selected clinics.

One to one interviews will be used to collect data from PHC Managers and PHC Operational Managers. Focus group interview will be conducted with the professional nurses. The researcher will interview and guide the discussion according to the guide.

Please find enclosed a copy of the proposal for perusal. Should you have any queries please do not hesitate to contact my supervisors Professor MN Sibiya on 031-373 2606 or e-mail her at nokuthulas@dut.ac.za

Yours Sincerely

Esther Nelisiwe Hlongwa (Ms)
D Nursing Student at DUT
E-mail: Esther.Hlongwa@kznhealth.gov.za
Phone: 033-897 3508 (W)
Cell no: 084 549 8894

Appendix 3a: Approval letter from eThekweni District Manager

From:

To: 00333947238

06/06/2016 15:21 #052 P.001/001

FAX: 033 394 7238

ATTN: MS. HLONGWA



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:

PO Box 571 Durban 6002
Kwazulu-Natal, Kwa-Dobeka Township
Tel: 031 714 3713 Fax: 031 714 3767 Email: info@kznhealth.gov.za
www.kznhealth.gov.za

KWADABEKA COMMUNITY HEALTH CENTRE

Reference	Nelisiwe 1/2016
Enquires	Dr. Hogue
Date	13 November 2015 6/6/2016

To

Esther Nelisiwe Hlonga (Ms)

DUT

RE: PERMISSION TO CONDUCT RESEARCH AT KDC : A Practice framework to enhance the implementation of the policy of mental Health Care into PHC in KZN Province.

I have pleasure in informing you that permission has been granted to you by Kwadabeka CHC to conduct the above research.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once YOU PROVIDE THE FINAL ETHICAL CLEARANCE FROM THE Ethics committee.
3. Please ensure this office is informed before you commence your research.
4. The Kwadabeka CHC (Facility) will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Facility.

Thanking you

Sincerely

.....
CLINICAL MANAGER

Appendix 3b: Approval letter from uGu District Manager



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 41 Bisset Street, Nelson Mandela Drive
Postal Address: P/Bag X 735 Port Shepstone 4240
Tel: 0396883000 Fax: 0396826296 Email: ntokozi.mkhize@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

OFFICE OF THE DISTRICT
MANAGER

Enquires : Mrs N.C Mkhize

Date: 26/05/2016

To :
Mrs EN Hlongwa

PERMISSION TO CONDUCT RESEARCH IN UGU DISTRICT

Dear Mrs Hlongwa

I have pleasure in informing you that permission has been granted to you by Ugu District Office to conduct research on "A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into primary health care in KwaZulu-Natal province."

Please note the following:

- a) Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health.
- b) This Research will only commence once this office has received full approval and confirmation from the Health Research and Knowledge Management Committee in the KZN Department of Health.
- c) Please ensure that this Office is informed before you commence with your research.
- d) The District Office/ Facility will not provide any resources for this research.
- e) You will be expected to provide feedback on your findings to the District Office/ Facility.

Thank You


Mrs N.C Mkhize
Ugu District Manager

Appendix 3c: Approval letter from iLembe District Manager



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ILEMBE HEALTH DISTRICT OFFICE

Postal Address: Private Bag x 10620, KwaDukuza, 4450
Physical Address: OK Mall, 36/40 Cnr Mahatma Gandhi
& Chief Albert Luthuli St, KwaDukuza
Tel. 032 437 3500, Fax : 032 551 1590
Email: thenjiwe.thwala@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries : Ms T.Thwala
Telephone : 032 – 437 3503
Date: 06 June 2016

Ms E.N Hlongwa
110 Strelitzia Terrace
11 Flame Thorn Drive
Westville
3629

RE: PERMISSION TO CONDUCT RESEARCH AT DISTRICT/FACILITY

I have pleasure in informing you that permission has been granted to you by the District to conduct research on:

a) A PRACTICE FRAMEWORK TO ENHANCE THE IMPLEMENTATION OF THE POLICY IN INTERGRATION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE IN KWAZULU NATAL PROVINCE

Please note the following:

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

Thanking you


Mr. S.G. Vikiyahle
District Director
Ilembe Health District

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 3d: Approval letter from uMgungundlovu District Manager



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 171 Hoosen Hofajee, Pietermaritzburg, 3219
Postal Address: Private Bag X9124, Pietermaritzburg, 3200
897 1002 Fax: 033 897 1078 Email: Thula Kunene@kznhealth.gov.za

UMGUNGUNDLOVU DISTRICT OFFICE

DISTRICT MANAGERS OFFICE

Enquiries: Mrs. N. M. Zuma-Mkhonza
31 May 2016

TO: MS E.N HLONGWA
VICE PRINCIPAL: SOUTHERN REGION
KZN COLLEGE OF NURSING

Dear Ms Hlongwa

RE: A PRACTICE FRAMEWORK TO ENHANCE THE IMPLEMENTATION OF THE POLICY ON INTEGRATION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE IN KWAZULU-NATAL PROVINCE.

Your correspondence regarding the letter of approval to conduct the research on: *A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province*: refers:

I have pleasure in informing you that permission has been granted to you by the District Office to conduct investigation on: *A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province*, will be conducted in Umgungundlovu District.

PLEASE NOTE THE FOLLOWING

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

Thank you,


MRS N.M. ZUMA - MKHONZA
DISTRICT MANAGER
UMGUNGUNDLOVU HEALTH DISTRICT

Appendix 4: Letter of information for one-on-one interviews



Dear Participant

Warm greetings to you. You are invited to participate in my research study. Details of the study are provided below.

Title of the Research Study: A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province.

Principal Investigator/s/researcher: Ms E.N. Hlongwa, M Cur.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiyi, D Tech: Nursing (Supervisor).

Brief Introduction and Purpose of the Study: In South Africa, a Policy on Integration of Mental Health Care into Primary Health Care (PHC) was developed in 1997, and only 9 years later, the National Mental Health Policy Framework and Strategic Plan: 2013 to 2020 was developed. Although South Africa has made significant achievement at the level of policy development and legislation, there have been several challenges with regard to implementation of policies. Ineffective implementation of the Policy on Integration of Mental Health Care into PHC has resulted in mental health care users being seen at PHC clinics but PHC nurses are not able to manage mental health care users and identify clients with mental health problems and this may result in high numbers of admissions to mental health institutions which could have been treated in PHC clinics.

Purpose of the study: The purpose of the study is to analyse the implementation of the Policy on Integration of Mental Health Care into PHC in KwaZulu-Natal (KZN) province and develop a practice framework for Primary health care nurses to enhance the implementation of the policy on integration of mental health care into Primary health care.

Outline of the Procedures: You are requested to participate in an interview. The interview will take approximately one hour. I will facilitate the interview and I therefore, kindly request to record the interview and to take notes as a backup during the interview.

Risks or Discomforts to the Participant: There will be no risk of discomfort.

Benefits: The developed model may be used to guide nurses in providing mental health care at the PHC clinics to enhance the quality of mental health care services rendered by nurses in KZN.

Reason/s why the Participant May Be Withdrawn from the Study: The researcher foresees no reason for withdrawing of participants. Participation is voluntary, so the participants may withdraw at any time or point. A participant who is ill in any way and is unable to take part in face to face interview may withdraw from the study.

Remuneration: None.

Costs of the Study: There are no costs when participating in this study.

Confidentiality: The information provided during the interview will be kept confidential. Your name will not appear on any documents. A code will be allocated to you to protect your identity. All data will be kept in a secure place; no unauthorised persons will have access to the information.

Research-related Injury: None.

Persons to Contact in the Event of Any Problems or Queries: Should there be any queries please contact the researcher: Miss E.N. Hlongwa, cell number 084 549 8894. Email esther.hlongwa@kznhealth.gov.za. Should you still not satisfied please contact my supervisor: nokuthulas@dut.ac.za. Should you require further information please contact Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the Research Director, Prof Moyo on 031-373 2576 or moyos@dut.ac.za

Appendix 5: Letter of information for focus group discussions



Dear Participant

Warm greetings to you. You are invited to participate in my research study. Details of the study are provided below.

Title of the Research Study: A practice framework to enhance the implementation of the Policy on Integration of Mental Health Care into Primary Health Care in KwaZulu-Natal Province.

Principal Investigator/s/researcher: Ms E.N. Hlongwa, M Cur.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing (Supervisor).

Brief Introduction and Purpose of the Study: In South Africa, a Policy on Integration of Mental Health Care into Primary Health Care (PHC) was developed in 1997, and only 9 years later, the National Mental Health Policy Framework and Strategic Plan: 2013 to 2020 was developed. Although South Africa has made significant achievement at the level of policy development and legislation, there have been several challenges with regard to implementation of policies. Ineffective implementation of the Policy on Integration of Mental Health Care into PHC has resulted in mental health care users being seen at PHC clinics but PHC nurses are not able to manage mental health care users and identify clients with mental health problems and this may result in high numbers of admissions to mental health institutions which could have been treated in PHC clinics.

Purpose of the study: The purpose of the study is to analyse the implementation of the Policy on Integration of Mental Health Care in PHC clinics in KwaZulu-Natal (KZN) province and ultimately to develop a practice framework for PHC nurses to enhance the implementation of the Policy on Integration of Mental Health Care into PHC.

Outline of the Procedures: You are requested to participate in the focus group discussion, which will take approximately one hour. I will facilitate the discussion and I therefore, kindly request to record the interview and to take notes as a backup during the focus group discussions.

Risks or Discomforts to the Participant: There will be no risk of discomfort.

Benefits: The developed model may be used to guide nurses in providing mental health care at the PHC clinics to enhance the quality of mental health care services rendered by nurses in KZN.

Reason/s why the Participant May Be Withdrawn from the Study: The researcher foresees no reason for withdrawing of participants. Participation is voluntary, so the participants may withdraw at any time or point. A participant who is ill in any way and is unable to take part in face to face interview may withdraw from the study.

Remuneration: None.

Costs of the Study: There are no costs when participating in this study.

Confidentiality: The information provided during the interview will be kept confidential. Your name will not appear on any documents. A code will be allocated to you to protect your identity. All data will be kept in a secure place; no unauthorised persons will have access to the information.

Research-related Injury: None.

Persons to Contact in the Event of Any Problems or Queries: Should there be any queries please contact the researcher: Miss E.N. Hlongwa, cell number 084 549 8894. Email esther.hlongwa@kznhealth.gov.za. Should you still not satisfied please contact my supervisor: nokuthulas@dut.ac.za. Should you require further information please contact Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the Research Director, Prof Moyo on 031-373 2576 or moyos@dut.ac.za.

Appendix 6: Consent



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms E.N. Hlongwa about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 46/16,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant Date

Time

Signature / Right

Thumbprint

I, Esther Nelisiwe Hlongwa herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Esther Nelisiwe Hlongwa

Full Name of Researcher

Date

Signature

Full Name of Witness (If applicable)

Date

Signature

Full Name of Legal Guardian (If applicable)

Date

Signature

Appendix 7: Interview and focus group discussion guide

Participant Number:

Date of interview: -----

Questions that will be asked during a one to one interview will be:

- What is your understanding of the concept integration of mental health care into PHC?
- What are the causal conditions that must be in place in order for integration of mental health care into PHC to take place?
- What are the intervening conditions that must be in place in order for integration of mental health care into PHC to take place?
- What are the challenges if any that might be hindering the effective implementation of the Policy on Integration of Mental Health Care into PHC.
- What are the consequences if any for ineffective implementation of the Policy on Integration of Mental Health Care into PHC?

NB: Probing questions will be asked based on the responses from the participants.

Appendix 8: Certificate from a professional editor

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BA, HDE, MTech(Hom)

HOMEOPATH

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EDITING CERTIFICATE

Re: Esther Nelisiwe Hlongwa

**Doctoral thesis: A PRACTICE FRAMEWORK TO ENHANCE THE
IMPLEMENTATION OF THE POLICY ON INTEGRATION OF MENTAL
HEALTH CARE INTO PRIMARY HEALTH CARE IN KWAZULU-NATAL
PROVINCE**

I confirm that I have edited this thesis and the references for clarity, language and layout. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). During my 13 years as a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology I supervised numerous Master's degree dissertations.

Dr Richard Steele

23 May 2017

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