

**EXPERIENCES OF PRIMARY HEALTH CARE NURSES PROVIDING MENTAL
HEALTH CARE SERVICES AT PRIMARY HEALTH CARE CLINICS IN
ETHEKWINI SOUTH SUB-DISTRICT, KWAZULU-NATAL**

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Health), School of Nursing and Public health, College of Health Sciences, University of
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DECLARATION

I, Cynthia Nomthandazo Glover, declare that this dissertation entitled “**EXPERIENCES OF PRIMARY HEALTH CARE NURSES PROVIDING MENTAL HEALTH CARE SERVICES AT PRIMARY HEALTH CARE CLINICS IN ETHEKWINI SOUTH SUB-DISTRICT, KWAZULU-NATAL**” is my own work and has not been submitted for any other degree or examination in any other university either than the University of KwaZulu-Natal. I have given complete acknowledgment to the resources referred to in the study.

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Cynthia Glover

Date

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Date

(Supervisor)

DEDICATION

This dissertation is dedicated to my late parents, Edward and Clementine Dlamini, and to all my family members, especially my daughter, Yolanda, my study mate.

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Thank you awesome God, you are faithful and merciful.

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ABSTRACT

Primary Health Care (PHC) is a basic mechanism that brings healthcare close to the people. PHC promotes access to holistic care and improves the health of the population. The integration of mental health care into its package of services aimed at closing the treatment gap. However, successful integration requires well trained innovative nurses and a supportive government agenda that facilitates capacity.

Aim

This study explored the experiences of PHC nurses, within PHC clinics, in the planning and provision of mental health care services in EThekweni district, KwaZulu-Natal.

Methodology

A qualitative descriptive study design used individual semi structured interviews to collect data from nurses within two PHC clinics. Interviews focused on the experiences of the PHC nurses rendering care to the MHCUs.

Results

Although the PHC nurses viewed the integration of mental health care into PHC as positive, they reported the integration process as poorly planned and implemented too quickly. Nurses felt unprepared for integration and apprehensive about their preparation. In addition, ongoing support, specifically experienced resources and service collaboration was reported as lacking.

Conclusion

Integrated services were, in principle, acknowledged by participants as cost effective and having the potential to improve mental health care outcomes. However, its introduction happened quickly and the nurses felt ill equipped to institute their roles. Integration is said to improve the overall effectiveness of the health system thus benefiting the health of the population by addressing the health problems in a holistic manner (WHO, 1996).

Key words: Primary Health Care, Mental health care, integration.

ABBREVIATIONS

ACRONYM

NAME IN FULL

AIDS	Acquired Immune Deficiency Syndrome
CCGs	Community Care Givers
CHCs	Community Health Centres
CMD	Chronic Mental disorders
DOH	Department of Health
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
MHCU	Mental Health Care User
PHC	Primary Health Care
SASH	South African Stress and Health study
SA	South Africa
TB	Tuberculosis
WHO	World Health Organization
WHR	World Health Report

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CHAPTER ONE

INTRODUCTION OF THE STUDY

1.1 Introduction

This chapter presents the introduction and the background to the study. It includes a brief overview of concepts and background information. In addition, the problem statement, purpose of the study, study objectives, research questions and operational definitions are presented. The chapter concludes with a description of the conceptual framework that guided the study.

1.2 Background to the study

Primary health care (PHC) is currently viewed as an important component of an effective health care system. It is a people centred approach that brings health closer to where the people live, work and socialize (Van Rensberg, 2004; World Health Organization (WHO) & United Nations Children's Fund (UNICEF1978). PHC is argued to be people centred, accessible, affordable, equitable and capable of achieving better health outcomes, specifically for the disadvantaged, resulting in an effective coordinated health care system (Baum, 2007; Funk & Ivbijaro, 2008; Saracerno, van Ommeren, Batniji, Cohen, Mahoney Sridhar & Underhill, 2007; WHO, 2001a).

International community at the Alma Ata conference highlighted evidence of inequitable health care systems across the globe (WHO & UNICEF, 1978). This conference focused on several core issues related to health care, which included inequities in the health status of people, the rights of people to participate in the implementation of their health care, the importance of economic and social development in health care systems as well as the implementation of a PHC approach to health care (Funk & Ivbijaro, 2008; WHO, 2007). The resultant signed declaration embodied a commitment to PHC and 'Health for All' by the year 2000. This Alma Ata declaration continues to influence international and national legislation of the 134 countries and 67 non-governmental organizations who were signatories (Brown, Cueto & Fee, 2006; Mkhize & Kometsi, 2008; Petersen, 2004; Saracerno et al., 2007; Skeen, Kleintjies, Lund, Petersen, Bhana & Flisher, 2010; WHO, 2004). This stirring consensus between rich and poor, a power sharing between governments, aimed at adopting PHC services that elaborated on a

universal community based preventative, curative and rehabilitative model aimed at reducing the disease burden (Bhana, Petersen, Baillie & Flisher, 2010; Burns, 2008; Kautzy & Tollman, 2008; Omar, Green, Bird, Mirzoev, Flisher, Kigozi Lund, Mwanza & Ofori-Atta, 2010; Uys & Middleton, 2004; WHO & UNICEF, 1978; World Bank Report, 2003).

Renewal and improvement of the South African (SA) health care system was influenced by SA's Reconstruction & Development programme (1994) and the WHO's recommended National Health Plan policy (1997). SA's health care restructuring, reflected in national legislation, called for a comprehensive community based health service that included decentralization of mental health care from hospitals to community based care (Mental Health Care Act no 17, 2002; National Health Act no 61, 2003; SA Department of Health, 1997a; SA White paper transformation, 1997b; SA Department of Health, 2004). The legal and policy framework for rendering PHC in SA was initiated through a district health care system at the level of local government according to the Municipal Structures Act No 33 of 2000 as well as the Municipal Systems Bill of 2000 (De Haan, Dennill & Vasuthevan, 2005).

Current literature upholds that PHC services should embrace prevention and treatment of illnesses, especially mental illness, within the mainstream of the health care system (Du Mortier, Bullen & Guillouz, 2010; Saracerno et al., 2007; WHO, 2005). Literature clearly suggests that decentralization and integration of mental health care into PHC have been well supported in the international arena through the publication of integration guidelines and research evidence of improved mental health care outcomes (Lund, Stein, Flisher & Mehtar, 2007; WHO, 2007). However, several countries, including South Africa, failed to include mental health care within the PHC model, resulting in the WHO making specific recommendation regarding mental health care inclusion (Burns, 2010; WHO, 2001a, 2004). The WHO argues that mental illness is a prominent cause of disability worldwide and the WHO's published disability adjusted life years (DALYs) indicate that neuro-psychiatric conditions are rated third in their contributions to the burden of disease, after HIV/AIDS, pulmonary tuberculosis and other infectious diseases (WHO, 2009).

In addition, epidemiological studies suggest that 16,5% of adults and 17% of children and adolescents in South Africa suffer from mental disorders (The World Health Report, 2003;

WHO, 2009). The results of the South African Stress and Health Study (SASH), conducted between 2003 and 2004, state that the projected lifetime risk of any mental disorder is 47.5% (Herrman, Stein, Seedat, Heeringa, Hash, Moomal, & Williams, 2009). The study was the first large scale descriptive epidemiological study of mental health on SA. The SASH study revealed a 16.5% 12 month prevalence of chronic mental disorders (CMD). These predisposes a MHCU with a life time prevalence of impulse control and substance use disorders (Herrman, Saxena, & Moodie, 2005). The greatest difference between anticipated jeopardy and prevalence was observed for anxiety disorders, 30.1%, 15.8%, a difference of 14.3%, followed by major depressive disorder of 13%, 9.5% anxiety and 21% suicide (Herrman, et al., 2009). This local quantification of the potential disease burden of mental ill-health was an important event in light of mental health's lack of clear recognition within the Millennium Development Goals (WHO, 2001b; Miranda & Patel, 2005; Uys & Middleton, 2004). In addition, recognition that physical and mental illnesses are interwoven and cannot be separated and that there is a relationship between poverty and mental ill-health have also added weight to the need to address mental health care needs of communities (Hanlon, Wondimagen & Alem, 2010; Herrman, et al., 2009; Patel & Kleinman, 2003; Saracerno et al., 2007; Ssebunnya, Kigozi, Kiza & Ndyabaningi Bhana, 2010; van Deventer, Couper, Tumbo & Kyeyune, 2008). The WHO, in assessing mental health systems, links successful decentralization into PHC to a supportive management agenda that focuses attention on improved infrastructure; adequate budget allocation; sufficient and adequately trained human resources; and appropriate information dissemination as part of a National Health Policy (Patel, Araya & Chatterjee, 2005; Saracerno, et al., 2007; WHO, 2005).

Current literature, both local and international, points to difficulties and slow progress in the transition from centralized to decentralized mental health care service delivery (Lund, Kleintjies, Campbell, Mjadu, Petersen, Bhana, Kakuma, Flisher & Mlanjeni, 2008; Petersen, 2004; Saracerno et al., 2007). These authors suggest that the financial implications of communicable diseases within the SA context took precedence over the development of effective transformation processes and that mental health was largely ignored (Miranda & Patel, 2005; Lund, et al., 2008; Saracerno et al., 2007; Uys & Middleton, 2004). In addition, it is argued that, despite policy guidelines for restructuring and decentralization of mental health care, the biomedical model orientation not only influences national focus and funding, but also the orientation of mental health care services offered (Petersen, 1999). It has been suggested that

services currently rendered do not meet the needs of the mental health care consumers (Mkhize & Kometsi, 2008). Although SA national and provincial Department of Health focus on capacity building, specifically the improvement of PHC nurses' mental health care knowledge and skills, decentralization of mental health care into PHC remains problematic, specifically as it is suggested that PHC nurses are rendering less than effective mental health care services (Petersen & Lund, 2011; WHO, 2009). Currently, PHC nurses working with mental health care users (MHCUs) are reported to be experiencing problems related to poor infrastructure. These include inadequate pharmacy facilities and services, inadequate transport, lack of space in the clinics to conduct interviews and poor staff/MHCU ratio, resulting in minimal time spent in MHCU counselling and consultation (Ramlall, Chipps & Mars, 2010).

In addition, authors suggest that the lack of consultation with PHCNs has impacted negatively on the smooth integration (Lund, et al., 2007; Petersen, 2006; Saracerno et al., 2007). These authors concur that this negative impact is not only regarding effective services at PHC clinics, but also in the establishment of community facilities, specifically lack of resources to aid families in the development of skills and knowledge required to facilitate the MHCUs' recovery and rehabilitation (Lund, et al., 2007; Petersen, et al., 2009; Saracerno, et al., 2007; WHO, 2009). Finally, current literature illustrates that the expectation or 'promises' of deinstitutionalization and decentralization of mental health care services, increased mental health literacy, improved medical care for MHCUs, reduction of structural discrimination and reduced alienation and stigmatization of MHCUs have not been realized (Adewuya, Roger & Makanjula, 2008a; Burns, 2008; Funk & Ivbijaro, 2008; Prince, Patel, Maj, Maseko, Phillips, 2007; WHO, 2009).

Local and international authors seem to accept that mental health care services at PHC clinics are not very effective and thus negatively impact on health care outcomes for MHCUs (Kakuma, Kleintjies, Lund, Drew, Green & Flisher, 2010; Freeman, Nkomo, Kafaand & Kelly, 2007; WHO, 2009). However, it is suggested that there is a need to explore more deeply PHC nurses' experiences regarding delivery of care to MHCUs within their clinics. In addition, authors firstly assert that physical and mental illnesses are interwoven and cannot be separated, and secondly admit the relationship between poverty and mental ill-health (Hanlon, et al., 2010; Herrman, et

al., 2007; Saracerno et al., 2007; Ssebunnya, et al., 2011; van Deventer, Couper, Wright, Tumbo, & Kyeyune, 2008).

1.3 Problem statement

Despite international and national health care guidelines and recommendations for the integration of mental health care into PHC services, this process remains problematic (Patel et al., 2007; Petersen, Ssebunnya, Bhana & Baillie, 2011). It has been suggested that mental health care services at PHC clinics are not proving effective mental health care (Baum, 2007; Petersen, Lund, Bhana & Flisher, 2011; South African Department of Health, 1998). Local and international authors are questioning implementation mechanisms (Flisher, 2009; Petersen, et al., 2009; Saracerno, et al., 2007; WHO, 2007). Research suggests that nurses are carrying the burden of this implementation and yet there is limited research relating to the experiences of these PHC nurses regarding the implementation process and the provision of mental health care within the PHC clinic setting (Ssebunnya, Kigozi & Ndyabangi, 2010). Local research has focused on PHC nurses' knowledge and skills, and on structural descriptions related to resource availability (Petersen, 2004; Saracerno, 2007; Uys & Middleton, 2004). As the National Department of Health focuses on reengineering PHC, research of PHC nurses' experiences of integration implementation, specifically in the provision of mental health care, can offer valuable feedback to district and provincial planners (Petersen et al., 2011; WHO, 2008).

1.4 Purpose of the study

This study purpose was to explore and describe the experiences of PHC nurses working in PHC clinics as they relate to the implementation of integrated mental health care within PHC clinics, and the provision of mental health care services within PHC clinics in the EThekweni district of KwaZulu-Natal.

1.5 Significance of the study

Research in the area of integration of mental health care services into PHC clinics is suggested to be particularly valuable at this time when public mental health policy is focused on deinstitutionalization of mental health care services as a way of facilitating reintegration of MHCUs into the community and facilitating recovery (Burns, 2010; Saracerno et al., 2007;

Ssebunnya et al., 2011; Verschoor, Fick, Jansen & Viljoen, 2007). Furthermore, the focus of the SA national and provincial Departments of Health on the 're-engineering of PHC' is one of the core themes presented at the recent national Mental Health Care Summit (April 2012).

The implementation of mental health care services into PHC is said to be dependent on implementation mechanisms as well as the practice of PHC nurses. Thus, it is suggested that increased knowledge and understanding of the PHC nurses' experiences of this integration and the provision of mental health care services in the PHC clinics is pertinent to inform implementation of the policy. In addition, knowledge related to this particular geographical context may specifically inform district policy and procedure, while at the same time providing knowledge that may be applicable to other contexts.

Results of the study may inform nurse educators' reflection and innovation in determining curriculum solutions (Roberts, 2010). Increased knowledge may also inform district and provincial training Programmes (Booyens, 2nd Ed). It is possible that involvement in this research study may result in participants becoming critically reflective of their practice, which could result in improved clinical practice. Research has been conducted with regards to perceptions of integration (Chopra, Lawin, Sanders, Barron, Karim, Bradshaw, Jenkes, Karim, Flisher, Mayosi, Tollman, Churchyard & Coovadic, 2009; Mkhize & Kometsi, 2008; WHO, 2008). However, PHC nurses' experiences of the implementation of the integration process and the provision of mental health care services within a PHC setting have not been extensively explored. This study aims to facilitate an in-depth understanding of PHC nurses' experiences that is contextually relevant to KZN, rather than generalizable, which may be used to identify further research questions.

1.6 Research Objective

The study had one research objective facilitated by 2 research questions (point 1.7., pg. 7)

1.6.1. To explore PHC nurses' experiences as they relate to the initial implementation of integrated mental health care within PHC clinics, and the ongoing provision of mental health care services within these settings.

1.7 Research Questions

Research questions are

1.7.1. What experiences do PHC nurses described regarding the initial integration of mental health care services into the PHC clinic where they work?

1.7.2. What experiences do PHCN's describe related to their provision of mental health care at the PHC clinics where they work?

1.8 Operational definitions

Exploration: According to South African Oxford dictionary, exploration means to examine or investigate a subject or idea carefully (South African Oxford Secondary School Dictionary, 2006).

Primary Health Care Clinic: For the purpose of this study, a PHC clinic is any clinic that is included in the EThekwini district health care office's list of PHC clinics (EThekwini District Department of Health, 2012).

Primary Health Care Nurse: For the purpose of this study, a PHC nurse is any nurse registered with the SANC as a registered general nurse and currently employed in one of the PHC clinics in the EThekwini district.

Mental Health Care Services: For the purpose of this study, mental health care services include any and all services provided to a mental health care user (MHCU) identified within the Mental Health Act no 17, of 2002 at a PHC clinic setting.

1.9. Conceptual Framework and its application to this study

The constructs of Donabedian's (1998) tripartite conceptual framework were utilized by the researcher to facilitate content analysis of the data obtained during the individual interviews. Donabedian (1998) identified three constructs that relate to the quality of a service; structure, process and outcome standards. Structure standards refer to resources that enable practice, such as human resources (number, knowledge, skill and attitudes), equipment, legislation and policy that facilitate service provision. Process standards refer to the actual practice, the actions and behaviours, of the provider. Outcome standards are measurements of changes in health care

status and health care behaviours. Donabedian argues that less than effective service delivery can result from a lack in structure or process standards (Donabedian, 1998).

Mental health care outcomes are reported in current local literature, but do not fall within the scope of this study (Bhana, Petersen, Baillie & Flisher, 2010; Flisher et al., 2010; Petersen, et al., 2009; Saracerno et al., 2007; South African Department of Health, 1998; WHO and UNICEF, 1978, 2007). Donabedian's structure and process standards were considered in the content analysis process.

1.10 Summary of the chapter

This chapter presented the background to the integration of mental health services integration into PHC. Highlighting that despite international and national guidelines for integration, the implementation of mental health within PHC services remains problematic. The problem statement also suggested that nurses, suggested to be the main agent for effective integration, seem to not be included in the planning of implementation mechanisms. The purpose, research objective and questions are presented, as is the potential significance of the study.

CHAPTER TWO

REVIEW OF THE LITERATURE

2.1 Introduction

This chapter begins by exploring the prevalence and burden of mental illness. This is followed by a discussion on the evolution of primary health care (PHC), the inclusion of mental health care within PHC services and nurses as the mental health care professionals charged with this integration.

A literature search was conducted using electronic databases CINAHL, PUBMED, Medline and EBSCO Host. Search phrases included ‘primary health care’; ‘mental health care’; ‘mental health integration into primary health care’; and ‘reasons for integration of mental health into primary health care’. The search was restricted to articles published in English from 2002 to 2013.

2.2 Mental illness, its prevalence and burden

Current literature places more emphasis on mental health than mental illness. Mental illness is defined in the Diagnostic and Statistical manual where indicators for mental illness are listed according to a biomedical model (DSM IV-TR, 2000). The WHO, (2005) describes mental illness as ‘any illness experienced by a person that affects their emotions, thoughts or behaviour; and is out of keeping with their cultural beliefs and personality; and produces a negative effect on their lives or the lives of their families’. Although there are several definitions of mental health, there is little distinction between mental health and health. The definition of health dates back from the 1940s, and its meaning is still incredibly unchanged (Jadad & O’Grady, 2008, in Ameermia, 2009, pg. 24). The WHO defines health as “the state of complete physical, mental and social well-being and not merely the absence of the diseases and infirmity” (WHO, 1948, pg. 100, in Ameermia, pg. 24). Ameermia (2009, pg. 27) in her study titled *The integration of psychological services into PHC in SA tensions in theory, policy and practice* defines mental health according the WHO (2001a) definition as “a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. This author quotes Herman’s 2005 concerns related to this definition, that “while defining mental health is, by its

very nature, inherently problematic, it is believed that this definition has the ability to be understood across cultures, without restriction of its implementation” (Ameermia, 2009, pg. 27).

This author, and others, further argue that the definition of mental health should be construed in a positive sense, with mental health being seen as the foundation for overall wellbeing, which clearly implies that mental health is more than the absence of a mental disorder (Ameermia, 2009). These definitions affirm the importance of integrating mental and physical ailments under a ‘one stop shop’. It therefore follows that mental health integration into PHC should improve mental health care outcomes for all (WHO, 2006, 2008). Supporting such a comprehensive approach is the report by the WHO (2005) which states that mental illness may be suspected when the health complaints are not attributable to a clear physical disease (WHO, 2005). Herman et al., (2009) maintain that mental health is still perceived as a luxury despite the WHO’s continued commitment to the prioritization of mental health, specifically in low and low to middle income countries. This organisation stresses that mental health is increasingly seen as a critical foundation to both physical health and quality of life (Mkhize & Kometsi, 2008; WHO, 2011).

WHO (2009) reports that mental illness is always accompanied by one or more chronic medical diseases; for example, 30-40% of mentally ill patients are suffering from cardiac problems (WHO, 2009). It has been noted that four chronic diseases are responsible for 60% of deaths world-wide. These are cardiovascular, diabetes, cancer and respiratory illness, and 80% of these deaths are happening in the poorest populations (WHO, 2011). In addition, it has been suggested that there are direct links between specific mental illness labels and physical illness (Burns, 2010). This is concurred in the Mental World Health Report, who argues that many individuals with chronic medical conditions have untreated co-morbid mental illnesses or substance use disorders. This confirms that long-term illness can have a strong effect on an individual’s mental and emotional status (WHO, 2010). The World Federal Report of Mental Health (2010) had previously noted that 85% of people with mental illness remain untreated of chronic physical illnesses, especially in low and middle income countries. More specifically, research has shown that depression, reported prevalence of 10-25% in women and 5-12% in men, often causes changes that can worsen a medical condition, diabetes for example, and reduce the level of energy needed to cope with changes and treatment schedules, creating a vicious cycle of

worsening physical and emotional health (WHO, 2008b; World Mental Health Day Report, 2009).

The WHO estimates that, globally, 450 million people are experiencing mental, neurological, and behavioural health conditions (WHO, 2008 b). In addition, the WHO estimated that in 2002, mental disorders accounted for approximately 13% of the global burden of the disease (Omar, et al., 2010; WHO, 2005). The high prevalence rates in developing countries has been attributed to scarcity of resources (Petersen, et al., 2010; WHO, 2008). It has been suggested that resources remain insufficient to meet the escalating burden of these conditions, specifically in low and low to middle income countries (WHO, 2011). In addition, the WHO reports that resources remain unevenly distributed, the gap being higher in countries where these are mostly needed (WHO, 2011). A review of mental health spending has revealed that this is limited to 1% of the health budget in many low and low to middle income countries (Saxerna, Sharon, Cumbreda & Saracerno, 2006), compared to high income countries, where spending is said to be approximately 5% of the health budget (Hamid, Abdulla, Bauta & Haung, 2008; Omar et al., 2010; WHO, 2008b).

With the link between mental illness and social disadvantage being globally accepted, it is clear that countries with limited resources are in most need of effective services (Ameermia, 2009; Funk & Ivbijaro, 2008). In South Africa (SA), the public sector has been struggling to address inequalities in resource distribution within the health care system (Department of Health (DoH), 1996). These have been rectified, however, through the adoption of the National Health Act 61 of 2003, whereby comprehensive health care delivery is ensured in national, provincial and district levels. Although SA has no published evidence specific to the burden of mental illness, the South African Stress and Health Study SASH, 2002-2004, which was part of the World Mental Health (WMH) epidemiological studies, states that mental health disorders are equivalent to those of developed countries (Herrman, et al., 2009; WHO, 2007), suggesting that psychiatric conditions rank third in contribution to SA burden of the disease, following HIV/AIDS and other infectious diseases (WHO, 2006). Local and WHO epidemiological studies report that 16,5% of adults in SA suffer from common mental disorders such as depression, anxiety and substance abuse (WHO, 2008).

Local studies are beginning to provide data related to prevalence, including specific conditions, and treatment rates. The most common mental illness disorders reported are major depressive disorder (4.9%), agoraphobia (4.8%), and alcohol abuse or dependence (4.5%) (WHO, 2007). A study done amongst adults in the rural part of the Western Cape (Mooreesburg District) reported that 27% of people in the community suffered psychiatric diseases, with depression and anxiety being most prevalent (Lund & Flisher, 2009; WHO, 2007). Similarly, a study done in KwaZulu-Natal (Kwa-Dedangendlale) found that 24% of people within the community suffered with depression and anxiety (Mkhize & Kometsi, 2008; Petersen, 2004). These prevalence figures give an indication of health care needs, specifically mental health care services required. It was reported that only 28% of adults with a severe or moderately severe disorder received treatment provided by the general medical sector, as compared to 24% of mild cases (Petersen, 1999; WHO, 2008).

It has been emphatically stated that efforts to achieve equity in mental health service provision will remain static if the SA government fails to recognise that SA is in the middle of intense health changes that are influenced by a quadruple burden of communicable, non-communicable inclined diseases (Drew, et al., 2011). This is concerning when seen in the context that SA neuropsychiatric disorders are estimated to contribute to 5.9% of the global burden of disease (WHO, 2008). Current literature suggests that MHCUs are more vulnerable to physical illnesses due to use of psychotropic medication, persistent, unavoidable stress and a failure to acknowledge or assess physical health in the traditional psychiatric setting (WHO, 2009). It has been argued mental and physical health interact in an intricate connection. Consequently, people with mental health problems require to be treated within the clinics because poor physical health results in mental health problems and vice versa (Skeen et al., 2010).

The global burden of disease is measured by the WHO as disability adjusted life years (DALYs) and is derived from international health policy (Bradshaw, Norman & Schneider, 2007). DALYs are calculated as a sum of years lived with a disability and include not only years of life lived, but also years of life lost due to a disability (Haagsma, Havelaar, Janssen & Bonsel, 2008; Lopez, Mathers, Ezzati, Jamison & Murray, 2006; WHO, 2008). The WHO (2006) argued that the outcome of mental ill health is envisaged to bring about painful suffering, diminished efficiency and reduced efficacy to individuals with mental illness and their families, impacting

negatively on the whole population (Moosa & Jeena, 2008; WHO, 2006). These reports further predict that by 2020, mental health difficulties would include 15% of the gross burden of diseases if nothing is done to curtail the present inequalities (Moosa & Jeena, 2008).

2.3 The evolution of PHC

To address problems within the health sector, the Department of Health (DoH) developed policies in the White Paper for the Transformation of the Health Sector in South Africa, which was released in April, 1997. The white paper lays out the vision of the department and the Ministry of Health, the mission and goals of the department, and the structure of the national health system, including training of the PHC nurses (Lund & Flisher, 2009; Petersen, 2004; Ramlall, 2012; Walley, Low, Tinker, Francisco, Chopra Rudan, Bhutta & Black, 2008). The SA health care system contains three levels, national, provincial and local. The National Department of Health is responsible for the development of policy and legislation (Department of Health, 1997a). Provinces are responsible for developing and implementing mental health plans, as well as providing services. However the legal and policy framework for execution of PHC services ought to be executed through the district health care system (De Haan, et al., 2005; Department of Health, 1997b). Therefore, the district health system is the cornerstone of the national health care system and is the vehicle through which a comprehensive range of PHC can be provided, which include, amongst others, preventive, promotive, curative and rehabilitative services (Department of Health, 2004-2007). Consequently, it takes the responsibility for developmental functions, providing inexpensive and responsible integration of inter-sectorial services that have an influence on health issues, such as water, sanitation, housing and environmental management (De Haan, et al., 2005).

It was only in 1978 that the PHC approach achieved global recognition when the World Health Organisation outlined the underlying philosophy of primary health care in its Alma-Ata declaration. Ameermia (2009), in her study, demarcated the principle features of comprehensive PHC based on the Alma Ata declaration. She indicated that firstly, PHC is accessible; secondly, it is participatory; thirdly, it is comprehensive, culminating in care that is integrated, multidisciplinary and inter-sectorial; fourthly, it is holistic, which means health care must incorporate health promotion aspects as well as preventative, curative and rehabilitative aspects; and finally, that PHC is equitable.

PHC is defined as “essential health care that is made available, affordable and universally accessible to individuals and families in the community by means acceptable to them through the full community participation at the cost that they can afford” (De Haan, et al., 2005) and as “the crucial part of comprehensive health service that has been regarded as the answer to the health problems” (De Haan, et al., 2005). The aim of PHC is to prevent duplication of services, and promote supportive health resources and relationships between numerous service providers (Van Rensberg, 2004). This approach is viewed as the first level of access into the health care system by providing acceptable and accessible services to the individuals. Furthermore, this strategy is said to reduce stigma attached to specific undesirable illnesses, such as mental health disorders, lessen human rights violations, improve equity of access to health services and improve the health status of all the citizens (Burns , 2010; Lund & Flisher, 2009 ; WHO, 2008). Access to health care for rural communities, especially those classified as ‘black’, was historically difficult in SA as many rural clinics had very limited access to medical doctors and expensive medications were not always available at public health facilities (DoH, 1996; Tlabyane, 2000).

To institute changes in SA, the governing party (the African National Congress) developed a National Health Plan for South Africa, the aim of which was to design a unitary, comprehensive, equitable and integrated national health system. A comprehensive programme for South Africans was deliberated to compensate social and economic injustices, eradicate poverty and reduce waste, as well as to increase competence and promote greater control by communities and individuals over all aspects of their lives (National Health Plan for South Africa, ANC,1994). In the health sector this involved the complete transformation of the national health care delivery system and all relevant institutions. Legislation and organizations related to health were revised to bring about transformation within the health care system. To address the previous tradition in the health sector and in accordance with its recognition of fundamental human rights, the South African Constitution has, in Section 27 (1a), included the right of access to health care services. However, SA is struggling to incorporate changes as there are barriers hindering the progress.

Although the vision of PHC is echoed world-wide, mental health care has not been recognised fully in some countries (Flisher, 2009; Petersen, et al., 2009). Various factors contribute to this lack of support ranging from poor management of the government agenda, abused health care services, resistance to the policy makers and lack of support at the implementation level, where,

in some instances, the health care workers have impeded the development of the health care services (WHO, 2005a; Burns, 2010). It must however be acknowledged that positive attempts have been made in South Africa post 1994 when the new government not only utilised the PHC approach as the health strategy, but also developed the White Paper on Transformation (1997b) and the National Health Care Act (2005) to ensure that PHC is delivered using the district health system.

However, it must also be acknowledged that these attempts have been bedevilled by budget cuts, staff shortages and the biomedical model of training nurses, to mention but a few (Chopra et al., 2009; Flisher, 2009; WHO, 2008). In addition, SA faces a quadruple burden of disease which includes HIV/AIDS, tuberculosis, violence, trauma and injuries, and perinatal and maternal diseases and deaths, which impede the government's aim to improve the health status in the medium term (WHO, 2010). These health care challenges facing SA add to the compelling evidence for integrating mental health services within PHC, which will result in closing the treatment gap and meeting the mental health care needs of the community (Kakuma & Flisher, 2009; Lund & Flisher, 2009; Omar, et al., 2010; WHO, 2008).

2.4 Mental health care integration into PHC

Funk & Ivbijaro (2008) cited seven reasons for integrating mental health into primary care. Firstly, as stated earlier in the chapter, the burden of mental disorders is great. Mental disorders are widespread in all cultures and generate an extensive personal burden for people with mental illness and their families. Secondly, mental and physical health problems are interwoven. Many people suffer from both physical and mental health problems. Joined primary care helps to guarantee that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders. Thirdly, the treatment gap for mental disorders is enormous. In all countries, there is a significant gap between the prevalence of mental disorders and the number of people receiving treatment and care. Coordinating primary care and mental health helps close this gap. Fourth, primary care settings for mental health services are reported to enhance access. When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping families together and allowing them to maintain their daily activities. Integration also facilitates community outreach and mental health promotion, as well as long-term monitoring

and management of affected individuals. Fifth, delivering mental health services in primary care settings reduces stigma and discrimination. Sixth, treating common mental disorders in primary care settings is cost-effective and, lastly, the majority of people with mental disorders treated in collaborative primary care settings are reported to have good outcomes, mostly when linked to a network of services at a specialty care level and in the community (Funk & Ivbijaro, 2008).

As these reasons relate to this study, they are explored through the use of local evidence. Historically, in the 1970s, mental health care was based on institutionalised care, which violated the rights of MHCUs (WHO & UNICEF, 1978). In addition to the human rights issues related to institutional care, there were, and still are, issues of accessibility to care. Within the SA context, psychiatric institutions were placed in urban settings leaving rural communities with no psychiatric resources (Burns, 2010). Such situations resulted in transfer of rural MHCUs to the specialised services away from their relatives causing greater isolation and emotional detachment, not only for the MHCUs, but also for their families and communities (Burns, 2008; Omar et al., 2010; Petersen. et al., 2009). It became apparent that transformation of the health care facilities needed to take place to promote equity in health care. Big asylums closed down and nurses were trained to ensure that they possessed adequate skills for a successful integration (Petersen, et al., 2009; WHO, 2008). Recommendations by the WHO were that even in circumstances where total health resources are constant, the reformed health care system would address the mental health needs of the entire populace by moving psychiatric inpatients out of the mental institutions and redirecting available resources towards mental health (Patel et al., 2007; WHO, 2010).

Ameermia, (2009, pg. 2) argues that the adoption of the PHC approach in South Africa envisaged that the “users would be able to access all their health care requirements under the umbrella of an integrated health care system at critical points, namely in communities where people live” (Ameermia, 2009; Mkhize & Kometsi, 2008). Further, that mental health services, including services for substance abuse, were to be integrated into PHC to ensure that users would receive both medical and mental health in one visit (Ameermia, 2009, pg. 2; Mkhize & Kometsi, 2008). According to local researchers and local health policy, regional hospitals should have a psychiatric unit comprising 4% of the hospital beds, with district hospitals providing 10% of the beds within the general wards to psychiatric care (Lund & Flisher, 2009; Petersen, et al., 2009;

WHO, 2007). Consequently, specialised hospital care is limited to those who require in-patient treatment, such as rehabilitation of patients who abuse alcohol and other substances or treatment of resistant psychotic symptoms (Mkhize & Kometsi, 2008).

As stated earlier, the holistic approach to service delivery was also central in response to studies confirming that serious medical conditions such as delirium, meningitis and metabolic disorders were often missed or misdiagnosed resulting in medical neglect of the MHCUs and complications of untreated medical conditions (Burns, 2009; Lund & Flisher, 2009; Petersen, 2004; Saracerno, 2007). Current literature suggests that MHCUs from low and low to middle income communities frequently expressed problems in accessing medical care, specifically rural and immigrant populations. This is associated with limited resources, increased health costs, poverty and lack of employment (Petersen, 2004; WHO, 2008a). These authors describe specific barriers as factors such as language, limited medical literacy, geographic inaccessibility and lack of medical insurance (WHO, 2011).

It is argued that integrating mental health care into PHC settings is the most valuable way of bridging the treatment gap for the untreated mental illnesses (Jack-Ide, Uys & Middleton, 2012; WHO, 2008a). Petersen & Lund (2011) argue that the mental health service cannot survive in isolation as it is inherently intertwined with other health services and that inter-sectorial collaboration will assist in the integration process (Burns, 2010; Petersen et al., 2010). In addition, these authors argue that integration is more successful when mental health is incorporated in health policies and governmental frameworks, supplemented by enough resources which inform the development of a comprehensive mental health care delivery system which will in turn assist to achieve better health outcomes (Burns, 2009; Petersen, Ssebunnya, Bhana & Baillie, 2011; WHO, 2008). This process should also be accompanied by appropriate training of appropriate personnel (WHO, 2008; Petersen, et al., 2009).

Petersen (2000), in Ameerma (2009, pg. 37) believes that the ideals for comprehensive integrated PHC will remain a pipedream as long they are located in a biomedical oriented approach to PHC. While a national health system underpinned by a vision of a universal primary health care has been promulgated in South Africa, this has been too narrowly interpreted. Firstly, as an add on of psychiatric services and secondly, in terms of identification and follow up of

psychiatric patients at PHC level (Petersen, 1998). Petersen argues that this approach to mental health care indicates neither a shift of discourse in care from a treatment and curative stance to the vision of comprehensive discourse of care which demands an awareness of context and the self-agency of the patient in the treatment process. The WHO (2008; 2010) concurs that this can be attained through training general health care workers, specifically PHC nurses, in skills that would allow them the opportunity of identification and management, with or without medication, especially where psychosocial rehabilitation programmes are needed (Smith & Middleton, in print) and to identify suitable referral of the mental health care users as delineated by Mental Health Gap Action Programme (mhGap) guidelines (WHO, 2011). Current literature suggests that the shortage of trained psychiatric nurses contributes to the mental health burden and that the training of health care workers, especially the PHC nurses, has an impact on the care rendered within the clinics (Petersen, 2004; WHO, 2001; 2003b). The fragmented history of mental health care supports the lack of commitment and illustrates the absence of mental health care from the government's agenda. Clearly this lack of focus is potentially problematic for the health care of communities (WHO, 2001b) .

2.5 Current local initiatives for mental health integration

An up-to-date review on decentralised community-oriented care in Africa submits that many countries experience difficulties in implementing essential strategies for decentralised community-based care (Petersen & Lund, 2011). There has been momentous advocacy for increasing mental health services and epidemiological studies showing the impact of mental illness in Africa, yet mental health is not included in the United Nation's Millennium Development Goals (Miranda & Patel, 2005). There is still pronounced fragmentation within the mental health care systems in sub-Saharan countries as these low and middle income countries face difficulties in safeguarding best mental health services (Saracerno, et al., 2007). Presently, in SA, national mental health is divided into two departments, which generates division (WHO, 2006). Literature confirms that community mental health departments are monitored under the jurisdiction of PHC and district offices whereas psychiatric hospitals are administered within the hospital setting and provincial offices. PHC services in each province are responsible for all initial patient contact and emergency care as well as supervision and monitoring of stable patients on long-term medication (WHO, 2008).

Furthermore, there are barriers to financing the expansion of mental health services. Transformation of the health care system entailed the closure of long term psychiatric institutions and this came with a price to the not so fully prepared South African public to receive their relatives because of inadequate preparation and scanty resources (Petersen, 2009). These authors argue that limited financial resources in the past resulted in psychiatric hospitals remaining old-fashioned, falling into disrepair, and often being unfit for human use; lack of mental health professionals; inability to develop vitally important tertiary level psychiatric services (such as child and adolescent services, psychogeriatric services, neuropsychiatric services, etc.); and underdeveloped community mental health and psychosocial rehabilitation services (Petersen, et al., 2012). Burns (2010) argues that despite legislative commitments MHCUs continue to be institutionalised for care, rehabilitation and successful community integration strategies remaining limited.

Since 1994, the year of liberation from Apartheid rule, emphasis has been placed on building and developing primary care, and reorienting hospitals as referral facilities for severe cases that require secondary and tertiary level care (Flisher et al., 2007). The Mental Health Care Act (17 of 2002) was a milestone for change within mental health care services. The central drive of this new legislation was to deliver the care, treatment and rehabilitation of mentally ill individuals and to set out different measures to be followed in the admission of the MHCUs and to establish review boards in respect of every health institution (WHO, 2010). This act brought significant change in the treatment trajectory. The main aims of the Act were to promote the human rights of people with mental disabilities, to utilise the PHC system to improve mental health care services, to accentuate community care and to safeguard the well-being of the community (Burns, 2010; Van Rensburg, 2004). Specifically provision of 72-hour certification of the MHCUs at district level, awarding MHCUs the opportunity to be stabilised within their own communities (Flisher, 2009; Jack-Ide, Uys & Middleton, 2012). Institution of this mental health policy and legislation has fallen to provincial and local health planners have been challenged to manage the transformation from hospital-based to community-based care. More specifically, they have been challenged to integrate mental health into general health services, to secure a satisfactory number of trained health workers, and to expand mental health prevention and promotion initiatives (Hanlon et al., 2010).

International reports point to success, reporting that, SA has relatively well resourced mental health services, including human resources, facilities and available psychotropic medications (WHO, 2007). However, it has been suggested that legislation related to nurses' scope of practice restricts the effective functioning of nurses by limiting their prescriptive authority in the treatment of MHCUs. Although nurses are the most plentiful available human resource in the health care system, PHC nurses are precluded from prescribing Schedule 5 medications and above by the South African Nursing Act (33 of 2005) and the Pharmacy Act (53 of 1974).

Furthermore, various authors have reported that approved manuals on the management and treatment of mental disorders are available in the majority of PHC clinics to follow as guide when rendering care within the clinics. However, although these serve as directives in rendering care to the MHCUs (Drew, et al., 2011; Petersen, et al., 2009; WHO, 2011), they are seldom consulted and implemented (Chopra et al., 2009; Kleintjies, Lund & Flisher, 2010), which may be due to the daunting patient-nurse ratios within PHC clinics. The introduction of free health care for all has led to overcrowding at the PHC clinics, giving nurses less time to spend with the patients. Health workers have felt pressurised into limiting the consultation time, which has resulted in job frustration (Petersen, 2004).

Reports from the various provinces in South Africa suggest continued problems and innovations in attempts to overcome these. According to Lund, Flisher & Steiner (2007), the progress of integration has not been revised in the Western Cape and the provincial government has started reviewing the effects of the Mental Health Care Act for hospitals and are currently evaluating the seclusion facilities in district hospitals. An active Mental Health Review Board has been established to ensure that hospitals are compliant with the Act and that patients are provided with access to trained staff. The national standard of care is used to assess the current quality of care in health facilities, through accreditation agencies or review boards (Lund et al., 2007).

The practice of Primary Health Care is not new in Kwa-Zulu Natal. Internationally funded PHC started in the Pholela district, an area outside Pietermaritzburg, in the 1940s, before the Alma Ata Declaration, but this initiative failed due to poor resources and lack of local government support (Mkhize & Kometsi, 2008). The Pholela Health Centre model was a portent to community-oriented primary care (COPC), and was amongst the first to inform and define the practice of

PHC (Mkhize & Kometsi, 2008). The Department of Health in KwaZulu-Natal selected a task team with the aim of restructuring these services, especially the previously disadvantaged organizations, into one functional unit. They were required, amongst other things, to scrutinise all available documents on mental health in the province and to come up with a new document, which would serve as the 'Strategic and Implementation Plan for Delivery of Mental Health Services in KwaZulu-Natal' (Mkhize & Kometsi, 2008; WHO, 2007).

More recently, a health summit was held in Durban, Kwa-Zulu Natal in September, 2011. This summit highlighted concerns on health related issues and the need for support from the Department of Health. Amongst other things, it extended commitment to the principles and beliefs of the Provincial Sukuma Sakhe strategy (2009), which was initiated by the Premier of KwaZulu-Natal as an essential component of PHC. The aim of this strategy was to promote healthy lifestyles in all sectors of communities and to reduce the scourge of all diseases and suffering. This approach, together with the PHC outreach teams, was viewed by as an ideal means for the promotion of health and prevention of disease, as well as a channel for taking preventive services to the populace of Kwa-Zulu Natal (Drew, et al., 2011).

However, although Primary Health Care has been given such prominence in KwaZulu-Natal and it is the only province to have a psychosocial rehabilitation strategy, mental illness is still not well supported by the government agenda. Local authors have suggested that despite national and local legislation related to the referral pathway, the poorly functioning review boards, whose aim is to explore human rights abuses and neglect of the MHCUs, have failed to address issues of inadequate infrastructure and resources that contribute to admission to district rather than tertiary hospitals and the lack of a useful communication system throughout all levels (PHC, district, tertiary) of the mental health care system (Lund et al., 2007; Ramlall, Chipps & Mars, 2010). Likewise within the Western Cape, which has the bulk of tertiary psychiatric hospitals, it was found that 22% of MHCUs were being admitted directly to tertiary institutions and avoiding the district hospital 72-hour observation period (Lund et al, 2007; WHO, 2008). Clearly, within these provinces and possible others, the integration of mental health within the PHC setting has created problems with the infrastructure based on the shortage of beds for acutely and chronically ill MHCUs, deflating the effective implementation of the care (Lund et al, 2007; Ramlall et al., 2010; WHO, 2008). Problems of infrastructure have left the MHCUs in the hands

of the district hospital staff, who have limited training and therefore have problems in managing potentially dangerous patients in a sub-standard clinical environment (Ramlall, 2012).

Mental health care services still receive a modest budget, which is a clear indication of the lack of priority allocated to patients with mental illness. Until something is done, mental health will continue to lag behind in the poverty stricken countries (Burns, 2009; Lund, Breen, Flisher, Kakuma, Corrigal & Joka, 2010; Mkhize & Kometsi, 2008; Petersen, et al., 2009).

2.6 The nurses' role in the integration of mental health into PHC

Mental health must be unified in the initiatives and strategies to address health, one of which is to ensure adequately trained staff (Petersen, 2004). In rendering care to the MHCUs, the PHC nurses use the management model of care, where a mental health care staff member is designated as a care manager, which necessitates the training of registered nurses (Zeiss & Karlin, 2007). The incongruity between the global burden of mental disorders and accessibility of mental health resources raises concern, with budgetary constraints and fewer trained staff (WHO, 2005b). The neglect in mental health needs in health policies leads to neglect in research, funding, services and infrastructure (for example, the improvement of a skilled mental health workforce, especially in the underprivileged communities (WHO, 2001a; 2001b).

In South Africa, a reorientation programme for PHC nurses was instituted within the PHC setting, which was a strategy to educate PHC nurses to deliver mental health care (Petersen, 1999). The framework of this programme conceptualised the PHC nurses' roles in the delivery of district-based mental health care as being threefold. Firstly, according to the model, the PHC nurses are expected to provide tertiary level of care, which entails provision of follow up care to chronically ill MHCUs through monitoring compliance to prescribed medication, psycho-social rehabilitation and issuing of repeat medication. Secondly, provision of secondary prevention through (i) identification and referral of serious mental disorders requiring specialised care; (ii) managing minor mental disorders and psychosocial problems through problem solving counselling and (iii) the provision of emergency treatment for aggressive and psychotic patients. Thirdly, PHC nurses would be expected to provide primary prevention in collaborative with the community care givers (CCGs) through psychosocial education to ensure multisectorial development programmes (Petersen, et al., 2009).

PHC nurses, who had previously expressed feelings of frustration in caring for the MHCU due to lack of skills and had expressed feelings of helplessness were empowered by the re-orientation programme (Petersen, 1999). PHC facilities provide standards of mental health care according to the Mental Health Care Act (17 of 2002), and provincial legislation and protocols map the treatment path and package, and is aimed at facilitating care within the PHC clinics.

Literature confirms that PHC nurses assess patients for mental health problems, conduct interviews with MHCUs, make decisions on the referral needs of individual patient and provide ongoing care to patients with stable mental disorders (Petersen, 1999; WHO, 2008). The current referral process includes existing and new cases and PHC nurses provide routine follow-up medication to patients who have stabilised, chronic psychiatric conditions as part of their service (WHO, 2007). In addition, each monthly visit includes assessment by the PHC nurse and, if necessary, cases are referred to the mental health nurse with an accompanying form stating the reasons for referral and the support that is needed (WHO, 2006). As part of their daily routine, PHC nurses transfer patients to regional hospitals for further management of psychiatric conditions (Lund & Flisher, 2007). Although PHC nurses are not legally permitted to prescribe psychotropic medications, which limits their scope of practice, they are responsible for giving repeat medication that has been prescribed by the doctor who comes on site weekly. No new treatment is prescribed or changed by the nurses at the clinic (WHO, 2005). However, nurses have limited information with regards to the management of the MHCUs during hospitalization when they are discharged and referred back to the clinics (Petersen, et al., 2009). In addition, Petersen (1999) argues that SA nurses have been trained under biomedical care, which has made them to function under the jurisdiction of the doctors, which favoured institutionalised care to MHCU. Integration therefore is necessary to assist in establishing the relationship between physical and mental illness to ensure that the growing burden of the disease is addressed and to narrow the treatment gap between these diseases (Lund et al, 2010).

2.7 Summary of the chapter

This chapter provides an in-depth review of the research evidence that supports deinstitutionalization and the integration of mental health care services within PHC. National and provincial research related to potential barriers, specifically infrastructure, are presented.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology and outlines the steps that were followed in the implementation process, the sampling procedure, and the process of data collection and analysis (Burns & Groove, 2009; Polit & Beck, 2008). In addition, the philosophical underpinnings and research design are described, as well as the steps taken to ensure ethical compliance, rigour and credibility of the study (Burns & Grove, 2009; Emmanuel, Wendler & Grady, 2004; Pilot & Beck, 2008).

3.2 Philosophical underpinnings

The study is underpinned by constructivist ontology and interpretivist epistemology, which posit that reality varies for different people in different contexts, motives and human practices (Crotty, 1998; Holloway & Wheeler, 1996). This philosophical stance stresses the need for an understanding of the participants' experiences and interpretation of their world as they describe them, in this instance, the rendering of care to MHCUs within PHC clinics (Burn & Grove, 2009). In this study, the PHC nurses verbalised their insights and understandings within their own social setting, which gave an opportunity for the researcher to understand the participants' experiences (Parahoo, 2006).

3.3 Research design

This study adopts a qualitative descriptive design, which is centred in understanding the way in which human beings make sense of their subjective reality and the meaning they attach to it (Burn & Grove, 2009). This approach allowed the researcher to use participants' own words in illustrating their individual and collective beliefs as they related to their subjective reality of the initial integration of mental health care service into their work setting, and ongoing provision of mental health care (Babbie & Mouton, 2009; Burns & Grove, 2009; Polit & Beck, 2008; Sandelowski, 2010). This enabled the researcher to obtain an in-depth understanding of the participants' experiences in offering care to MHCUs within PHC clinics (Burns & Grove, 2009; Parahoo, 2006; Polit & Beck, 2008).

3.4. Research Setting

The research settings were selected using purposive convenience sampling, please see point (3.6, pg. 26). The researcher had proposed to include three clinics, urban, peri-urban and rural, for this study. However, Clinic C, the peri-urban clinic, did not give the researcher permission to conduct the study. On discussion with the supervisor, it was agreed that the researcher should continue with data collection in clinics A and B. The researcher thus conducted this study in two clinics situated in the EThekwini District of Durban, central KwaZulu-Natal, SA, and these are described in detail. The number of clinics within the EThekwini South sub-district stretch over a geographical area from Durban central to the peripheral areas of the south. The boundaries of the district used in this study are, measuring from Durban central, 8 km east to Cato-Manor, 50 km north to Pinetown, New Germany and Botha's Hill and 17 km east and west includes Umzamo and Kwa-Dabeka. These given in (table 3.1, pg. 26) list of clinics given as an (Annexure E, pg. 81) obtained from EThekwini District Health office (February, 2012).

3.4.1 Description of the selected clinics

Clinic A is situated in a rural area of the EThekwini South sub-district, while clinic B is situated in an urban area. There are 25 professional nurses working at clinic A, who manage all the patients coming to the clinic. It is situated in an area of Durban where the population is predominantly black African. Professional nurses deal with cases of mental illness as there is no psychiatry department dedicated to handling these cases. If the member of staff has not been trained in mental health, a second opinion is obtained from a person who has been trained and the MHCU can be transferred to the district hospital if necessary. Clinic A has a mobile clinic that goes out to various out-reach clinics. Although these categories were not included in the study, the clinic has additional support staff, which consists of one enrolled nurse and one nursing assistant for each department. There is also a team that works in the teaching area of the clinic, which gives classes to people who are to be initiated on anti-retroviral treatment. There are no doctors and social workers permanently on site, these practitioners come to the PHC from the Community Health Centre (CHC) each Wednesday.

Clinic B is an urban clinic and is bigger than the Clinic A, having fifty-two (52) registered nurses who are divided into the various services that are offered by this clinic, which receives all people

residing in the nearby areas. The clinic has a small psychiatric unit where the MHCUs get their repeat medication, but all the patients are overseen by the professional nurses. However MHCUs who are actively psychotic are referred from the clinic to the district hospital that is allocated to its catchment area.

3.5 Population and target population

For the purpose of this study, the population included PHC nurses working in PHC clinics designated as providers of mental health care services. The target population included PHC nurses working in PHC clinics designated as providers of mental health care services within the EThekwini South sub-district.

3.6 Sample and Sampling procedures

The researcher used purposive convenience sampling to select three PHC clinics, within the EThekwini south sub-district. As mentioned in the description of the research setting, the researcher had selected a rural, a peri-urban and an urban clinic, but the peri-urban PHC clinic manager did not respond to requests for participation and therefore potential participants could only be selected from the rural and urban PHC clinics. This is illustrated in table 3.1 below.

Table 3.1: Sample and participating clinics

PHC clinic	Clinical nurse managers	No of professional nurses in each clinic	Category of the clinic
Clinic A	1	25	Rural
Clinic B	1	52	Urban

The researcher selected clinics within the district that were geographically accessible to her and where she had established relationships with the clinic managers. Purposive non-probability sampling was used to select potential participants within the two sampled clinics. The clinical nurse managers from the two clinics that took part in the study assisted the researcher in identifying those PHCNs who were actively involved in the provision of mental health.

The researcher aimed to achieve a 10% sample within each PHC clinic, although this was guided by data saturation (Parahoo, 2006).

Participants had to be registered nurses who were employed full time at the PHC clinics. They had to have a minimum of 2 years working with the MHCUs within the PHC clinic and be available on the day of data collection. No category of staff other than the professional nurses were used for this study.

3.7 Description of the participants

A total of fourteen (n=14) PHC nurses were selected to participate in the study, eight from clinic A and six from clinic B.

Table 3.2 : Participants' demographic information

Participant	Age Years	Gender	Years of clinical experience	Qualifications	Years Involved in mental health care
1	58	Female	15	General nursing	4
2	53	Female	19	General nursing	6
3	37	Female	7	General nursing	4
4	35	Female	9	Integrated course	4
5	38	Male	9	Integrated course	3
6	51	Female	14	General nursing	8
7	47	Male	12	Integrated course	6
8	47	Female	13	General nursing	9
9	46	Female	12	Integrated course	5
10	35	Male	8	General nursing	3
11	61	Female	35	General nursing	10
12	48	Female	9	B. Cur	3
13	38	Female	10	B. Cur	6
14	53	Female	13	Integrated course	9

The demographics of this sample are illustrated in table 3.2 above. These include the age and gender of the participants, which clinic they work at, their level of experience in the clinical area, their qualifications and the number of years they have been involved with the MHCUs.

The table shows that 11 participants were female, six from clinic A and 5 from clinic B. The sample consisted of three male nurses, two from clinic A and one from clinic B. The ages of the participants ranged between 35 to 61 years old. Participants' level of clinical exposure varied according to their years of experience. Their level of experience in general nursing ranged from 7-35 years and their involvement with MHCUs ranged from 3-10 years. Participants are all qualified registered nurses, some participants had done integrated course while others had studied degree in nursing.

3.8 Positioning of the researcher

The researcher's interest to conduct this study arose during a discussion in an advanced research contact session with other mental health students, the lecturer and the research supervisor. The researcher is a psychiatric nurse working as a nurse educator within a college of nursing. This position necessitates doing student accompaniments in the hospitals and clinics. Since the closure of mental institutions and integration of mental health care into PHC settings, MHCUs are seen by the PHC nurses and resources and treatment processes have changed. For example, the researcher has noted that actively psychotic patients remain in the community and there seems to be little assistance for their families. In addition, the clinic facilities and nurses seem ill-equipped for the assessment of acutely ill MHCUs, particularly those with psychotic illnesses. The majority of PHC nurses that the researcher meets are not trained in mental health nursing. This raised the researcher's empathy and interest into finding out more about the feelings of the nurses who have been working with the MHCUs since the integration.

3.9 Interview schedule and data collection

The researcher used a semi structured scheduled interview, with open-ended questions as a guide for collecting data. The question schedule is reflected in (Annexure A, pg. 69). As posited by Burns & Grove (2009), the structured interview was constructed around three main questions, with the researcher exploring participants' views through probing and clarifying questions (Brink, 2011). The questions were determined from current literature pertaining to the integration

of mental health care services into PHC clinics, specifically nurses' experiences (Bhana et al., 2010; Braun & Clarke, 2006; Burns & Groove, 2009; Lund et al., 2010; Petersen et al., 2009; Polit & Beck, 2008; WHO, 2008). Data were collected through the use of an audio tape recorder during individual face to face interviews lasting between 45 and 60 minutes (Burns & Grove, 2009; Parahoo, 2006). Collection of data, explained in detail under the data collection process below, continued beyond the point of saturation of information, which is when no new data were obtained and there was repetition of data (Polit & Beck, 2008). The reason for the researcher continuing after the point of saturation point with the interviews was a result of participants' interest. As described in the data collection process (point 3.9, pg. 29), it had been announced within the participating clinics that the researcher was collecting data and the nurses were enthusiastic about participating. The researcher, therefore felt obliged to accommodate all who wanted the opportunity to participate. She was, however, mindful of redundant information.

3.10 Data Collection process

After the researcher had obtained ethical approval from the UKZN Ethics Committee (Annexure I, pg. 85) she sent a letter, accompanied by the research proposal, to the Provincial Department of Health, requesting permission to conduct the study (Annexure B, pg. 70). The researcher then wrote to the managers of each clinic requesting access to the clinics (Annexure C, pg.71). These were hand delivered to both managers. Letters of approval were obtained from both clinic A (Annexure G, pg. 83) and clinic B (Annexure H, pg. 84). These were then followed up with a face to face meeting with the clinic managers. At this meeting the researcher explained the purpose of the study and the proposed data collection process and arranged suitable times for interviews and the use of a venue to conduct the individual interviews. The clinic managers were informed about the estimated length of each interview and the most appropriate day and time to conduct the interviews were negotiated with them. The information and consent sheets (Annexure D, pg. 72) were hand delivered at this meeting and these were subsequently given to the PHC nurses working at the clinics by the clinic manager.

The researcher met with the potential participants at a second visit to the clinic. At this meeting the information and consent sheets were again made available and the floor was opened up for questions. Issues related to anonymity, confidentiality, time and venues were highlighted during this time. Participants wanted to know if interviews were to be conducted during on duty or off

duty time and were reassured that permission had been granted by the clinic manager for the interviews to occur during duty time, but that they were not going to be removed from work. On asking about the interview process, potential participants were informed firstly, that there were no right or wrong answers; secondly, that they had the right to withdraw at any time during data collection; and lastly, that the length of the interview would be between 45 and 60 minutes. The process of data collection was explained, including the use of the tape recorder to capture information. All those who agreed to participate in the study were requested to sign the informed consent (Annexure D, pg. 72) before the interview began. Before beginning each interview, the researcher provided an opportunity for participants to ask questions and to re-affirm the information. *Member checking* was done as a means of verifying data provided by the participants. The researcher conducted the interviews at both clinics over the period of two weeks at an average of one to two individual interviews per day, which was dependant on the availability of participants. The verification of data collected was completed the next day before the next interview session (Creswell, 2008).

Although not all participants were willing to attend confirmatory sessions believing that this was not necessary, confirmatory interviews were conducted with two participants from clinic A and one participant from clinic B, all of whom were in agreement that the data represented was what they wanted to say.

3.11 Data analysis

According to Burns & Grove (2009), written transcriptions of data from audio recording should be done concurrently with data collection and data analysis should be done during the data collection process to facilitate recognition of data saturation. However, the researcher completed data collection then transcribed the data. The reason for this was time constraints. Data collection times were limited and the researcher was conducting individual interviews with no time to transcribe and begin analysis. The researcher was able to recognise when data saturation had been reached as the interviews were packed into such a short space of time that content was remembered by the researcher. The researcher used the thematic data analysis framework espoused by Braun & Clarke (2006). This analysis process follows six steps and assisted the researcher to identify, analyse and report patterns as they emerged during the data collection

process. While this chapter includes a brief discussion of the steps in the process and their application, a more comprehensive explanation is deliberated in Chapter 4.

The first steps within Braun & Clarke's (2006) data analysis process involves *familiarizing oneself with the data* through data transcription and reading and reading the data while noting down original concepts. The second step is the *generation of initial codes* by writing down the list of ideas and the interesting themes that emerged when familiarizing self with the data. The researcher generated codes by organising all the data into meaningful groups, without losing any valuable information. The third step is *searching for themes*, which involves firstly sorting different categories into potential themes and then finding relationships between categories. In the fourth step, the researcher *reviews the themes*, using a generated thematic map to check if themes worked in relation to the extracted data. Once the themes have been confirmed, the fifth step requires the researcher to *define and names the themes*, refining each theme by manually naming them and reviewing the analysis process to generate clear definitions. The sixth and final step undertaken by the researcher is to *produce the report*, which should include a selection of substantial extracts from the data to illustrate the presentation and analysis of the data. This report is provided in Chapter four.

3.12 Trustworthiness and academic rigor of the study.

Trustworthiness in qualitative research is determined through credibility, transferability, dependability, and conformability, which are used to establish the integrity of the study (Lincoln & Guba, 1985; Polit & Beck, 2008). Burns & Grove (2009) state that the value of good qualitative research occurs in trustworthiness and in the fairness of the decisions and the results that represent the study. The researcher included thematic mapping to ensure *rigour* in this study (Annexure F, pg. 82).

Credibility: Lincoln & Guba (1985) described credibility as an evaluation of whether or not research findings represent a trustworthy theoretical interpretation of the data drawn from a participant's original data. Strategies to ensure credibility included member checking described in point 3.10, (pg. 30), the inclusion of the raw data (Annexure E, pg. 75), for review as well as the thematic mapping (Annexure F, pg. 82), allowing the reader to reach conclusions related to credibility. In addition, an independent review of the raw data and implementation of the

qualitative data analysis process was conducted by the research supervisor (Lincoln & Guba, 1985). The researcher assured *credibility* or confidence in the ‘truth’ of the data collated by ensuring that the research data was presented accurately (Holloway & Wheeler, 2003).

To achieve *dependability* within the research study, the researcher has provided an audit trail by including the raw data and annexures detailing the descriptions of the data collection process (Annexure E, pg. 75), to allow the reader to follow the data collection, transcription and analysis processes (Braun & Clarke, 2006).

Confirmability was compared to objectivity or neutrality (Tobin & Begley, 2004) and referred to as the objectivity of the data. The researcher listened to the raw data audio transcripts, transcribed them verbatim, and then read the transcripts while listening to the audio recording to ensure accuracy. Confirmation of data collection occurred via *member checking*, this process is described in the data collection process (point 3.10, pg. 29). The researcher also had on-going evaluation and feedback from an objective research supervisor who is an expert in research and a specialist in mental health, and who reviewed raw data independently of the researcher (Creswell, 2009).

Transferability within qualitative research refers to the suggestion that research findings in one context can be transferred to similar situations (Burns & Grove, 2009; Holloway & Wheeler, 2003; Lincoln & Guba, 1985; Polit & Beck, 2008). The researcher gave a detailed description of the research setting (point 3.4, pg. 25) and the sample (Table 3.1, pg. 26) in order that readers of the study can determine the context and thus the transferability of the findings of the study. A detailed description of the sample is provided in chapter 4, together with the description of the research findings so as to allow the reader to evaluate the applicability of these findings to other settings to ensure transferability (Burns & Grove, 2009).

3.13 Ethical considerations

In undertaking this study, the researcher was aware of the obligations to apply principles set out in the research guidelines which protect the participants’ rights to self-determination, privacy, anonymity and confidentiality, fair treatment and protection from discomfort and harm (Burns & Grove, 2009). This study was carried out in accordance with the ethical guidelines described by

Emmanuel et al., (2004). These authors stated that there is a greater risk of exploitation in the developing countries, which is not only attributed to limited health care facilities, illiteracy, cultural and linguistic differences, but also to lack of support and guidelines for ethical research. After obtaining ethical clearance from UKZN, the researcher requested, and obtained, permission to conduct the study from the eThekweni district office, the KZN provincial office (Annexure B, pg. 70), the managers of the two PHC clinics (Annexure C, pg. 71), as well as informed consent from the participants themselves (Annexure D, pg. 72).

Favourable risk ratio benefit, anonymity and informed consent

According to Emmanuel, (2004), clinical research should offer participants a favourable risk - benefit ratio. The researcher understood that she was answerable for her actions and minimized the elements of exploitation by being completely transparent. The participants' right to full disclosure of information was addressed by the providing of an information sheet that outlined the purpose of the study, the data collection process and the dissemination of information from the study (Annexure D, pg. 72). Signing the *informed consent form* implied that the participants were fully aware of what the study entailed when they agreed to participate and that they had not been not coerced in any way (Emmanuel et al., 2004; Polit & Beck, 2008).

Respect for autonomy was reflected in participants' freedom to participate in the study on a voluntary basis. They were assured that they had the right to withdraw from the study at any time and, that if they did, it would will not be used against them (Burns & Grove, 2009).

Although the interviews were audio recorded, the researcher referred to participants by numerical codes when transcribing and no names of participants or clinics were included. In this way, the participants' *anonymity* was protected. The researcher clarified that there would be no risk to their employment status and that they would remain completely anonymous.

Independent review, confidentiality and privacy.

The researcher collected all the data for this study personally so was the only one who came into contact with the participants. Although the research supervisor acted as co-coder, she had no access to participants' identities. To ensure privacy and protection of data during the interviews, the researcher had access to a vacant consultation room in clinic A, while in clinic B, she was

allowed to use the clinic boardroom. This ensured that *privacy* and *confidentiality* were maintained during the collection of data. Only the researcher and research supervisor had access to the raw data during data analysis. On completion of the transcriptions, the audio recordings were wiped clean and the electronic copies of the transcribed data were kept securely in the researcher's personal computer, which was protected by a password (Burns & Grove, 2009).

3.14 Data management

On completion of the transcription the audio recordings were wiped clean and although the researcher's supervisor had access to the raw data, to protect confidentiality, she did not know the participant's identities as the transcripts were all coded as clinic A and B. No other person had access to the data collected. These transcriptions are currently stored on a disc in the research supervisors' office according to UKZN protocol. Hard copies of the transcriptions have been destroyed by fire.

3.15 Dissemination of findings

Once the dissertation has been finalised copy of the research findings will be made available to the UKZN library. A report will also be prepared for the Provincial Department of Health, and the district office. The researcher is hopeful of publishing the research findings in a peer reviewed journal and presenting the findings at future conferences in KwaZulu-Natal.

3.16 Summary of the chapter

This chapter outlined the research methodology, which is aligned with the exploratory design of this study. The chapter also included details of how the sample was selected, the data collection process and the steps of data analysis. The researcher also deliberated her obligation to apply ethical principles outlined in ethical guidelines and presented the process she followed to enhance academic rigor.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

Qualitative data analysis is a multifaceted and pioneering process which is interactive, inductive, reflective and on-going (Gerrish & Lacey, 2009). As mentioned in Chapter 3, the researcher used the data analysis process as outlined by Braun & Clarke (2006) in order to capture the unique experiences of participants as they relate to providing mental health services at PHC clinics. The presentation of the results begins with a description of the sample before presenting themes. Verbatim quotations from the interviews that were transcribed from the audio recordings are included to illustrate emergent themes. A copy of the raw data can be found in (Annexure E, pg. 75).

4.2 Data analysis process

The researcher utilised the inductive data analysis process to capture important themes from the data that related to the research question (Braun & Clarke, 2006). The researcher presents a detailed description of how she followed the six steps outlined by these authors during the analysis process.

Researcher began by *familiarising herself with the data and generating the initial codes*. During this stage of data analysis, the researcher carefully listened to the audio recording of the participants' individual interviews and transcribed the information herself, using her personal computer (Walley, et al., 2008). She repeatedly read and re-read the electronic version of the transcribed data noting down initial concepts until statements and phrases expressed by the participants were identified as potential categories relevant to the research questions. These statements were then changed to italics, bracketed and highlighted to identify emerging codes. Content was read and analysed on the basis of possible relevance to the research objectives. A copy of the raw data is included in (Annexure E, pg. 75).

The researcher then began *searching for themes* within the highlighted codes. Several themes emerged from looking at the collective descriptions. The researcher grouped together the content

connected to the emergent themes that were pertinent to the two objectives of the study in order to formulate meanings (Burns & Grove, 2009; Cresswell & Plano, 2007).

The identification of potential themes was followed by a *reviewing process* that culminated in *defining and naming themes*. During this phase, the researcher met with her research supervisor. In preparation for the meeting to discuss the emergent themes, the research supervisor had been provided with a copy of the raw data. At this meeting the themes were agreed upon and named. The researcher was tasked to review the raw data, initial codes and emergent themes. The result was that the list of previously obtained themes was changed and regrouped as follows: training and support; preparation for integration; challenges in the care of MHCU; advantages of integration; and resource constraints.

The next section presents the final report and includes extracts from the participants to illustrate the themes. The researcher has attempted to ensure that the report is concise, logical, non-repetitive and interesting to read (Braun & Clarke, 2006). Within the report each theme is presented and a table included to illustrate the categories and sub-categories that were identified and led to the defining and naming of the theme.

4.3 Presentation of results

4.3.1 Theme 1: Training and support

The first theme that was identified was training and support. In assessing mental health systems, the WHO links successful decentralization into PHC to a supportive management agenda that focuses attention on improved infrastructure; adequate budget allocation; sufficient and adequately trained human resource; and appropriate information dissemination as part of a National Health Policy (WHO, 2001a; 2005).

The South African government's commitment to improve the quality of education and training finds expression in a range of policy and legislative frameworks developed since 1994. The Nursing Act, 2005 (Act 33 of 2005) creates a legislative framework for the review of the scope of practice for the different categories of nurses to ensure that the practice of nurses in South Africa is aligned to the needs of the health care system (Republic of South Africa, 2005).

However, the current scope of practice for nurses has placed constraints on the capacity of nurses to deliver care in the South African health care system. The two categories that were identified with respect to the theme of training and support were poor clinical assessments and treatment, with its sub-category, lack of mental health training; and not enough attention given to training of mental health nurses due to budget constraints, with its sub-category, other programmes given more priority than psychiatry.

Table 4.1 : Theme 1 - Training and support

THEME 1	CATEGORIES	SUB-CATEGORIES
Training and support	1.1: Poor clinical assessments and treatment. 1.2: Training of mental health nurses less attention, no budget.	1.1.1: Lack of mental health training. 1.2.1: Other programmes given more priority than advanced psychiatry.

Participants had a general concern about the lack of training and support from the authorities. Three of the participants did not have basic psychiatric nurse training, but although this was mentioned, participants’ training issues tended to be specifically related to their concern regarding their ability to conduct clinical assessment adequately, as they felt unable to achieve this. This is illustrated in the following excerpts;

“... if you are not skilled enough like being trained, you are not going to be able to understand their behaviour and you mismanage them and miss important aspect of health care”.

“In the clinic you are supposed to see all the patients since the integration was commenced without training in mental health it makes it hard to get by”.

Some participants expressed that, in some instances, other training programmes take priority over the advanced mental health programmes, giving an indication that mental health is not considered as urgent in the budget, which makes it hard to assess patients with challenging behaviours.

“There is not a single person trained in advanced psychiatry in this clinic. Advanced midwives are given a wider scope for training than us”.

“..... most the PHC clinics nurses are not trained in mental health so you find that when you are psychiatric trained you will feel the burden because you are overloaded”.

Not only does the lack of training of mental health care nurses somewhat compromise the care of the MHCUs, nurses reported that they rush attending to MHCUs before having to go out with the mobile clinic. They felt that having to cover the mobile clinics caused them to hurry through the consultations with MHCUs . One participant stated;

“...normally rushing to go out, I find myself hurrying so as to go out with the mobile clinics to various points...”

One of the participants was concerned about the lack of support in rendering care to the MHCUs, explaining that nurses could benefit from further training, since they last practiced mental health during their training.

“Authorities in the clinic do not give us the good support; because some nurses were trained long time ago during their student days and they hadn't practiced mental health”.

The majority of participants voiced concerns about the once-off training which has never been repeated since the training they received at integration. They suggest that it indicates lack of support from the authorities, which makes it hard for them to institute the necessary level of care within the PHC setting. This is encapsulated in the following comment;

“you see, this integration came with once off short training which has never been repeated, hmmm meaning, the patients do not get the care they need timeously because not all of us are trained”.

Participants explained that training seemed to be a concern for MHCUs as well, saying that MHCUs were inclined to search out staff with recognisable qualifications. Participants were concerned that lack of training will have an effect on the way they are perceived by the MHCUs. This is highlighted in the following excerpt;

“...at first it was difficult for MHCU to be attended to by a person who did not have a black bar... (Smiling). They only understood that a nurse with the black bar is the only person who is trained to deal with their problems”.

One participant expressed concern that the funding of mental health training was insufficient, saying that, given a chance, he would like to be trained in advanced psychiatry, suggesting that it would help him in terms of managing the aggressive, violent and psychotic behaviours adequately.

“... I am seeing the need for advanced psychiatry in this clinic I have asked, but you know they talk about funding all the time which is deflating”.

4.3.2 Theme 2: Preparation for integration

The second theme that emerged was preparation and support during and after integration. The category for this theme was poor preparation of nurses for integration with sub-categories, integration was sudden and induction inadequate; integration was frightening; no (OSD) for highly skilled staff; and no one trained as an advanced practitioner in mental health.

Table 4.2 : Theme 2 – Preparation and support during and after integration

THEME 2	CATEGORY	SUB-CATEGORY
2. Preparation and support during and after integration	2.1: Poor preparation of nurses for integration	2.1.1: Integration was sudden, induction was inadequate. 2.1.2: Integration was frightening 2.1.3: No occupational specific dispensation (OSD) for highly skilled staff. 2.1.4: No one trained as an advanced practitioner in mental health

Various researchers have suggested that lack of consultation with the PHC nurses has had a negative impact on the smooth integration of other services into PHC (Lund et al., 2007; Petersen, Ssebunnya, Bhana, & Bailie, 2011; Saracerno et al., 2007; WHO, 2009). Although

PHC now offers an increased number of services, the nurses remain short staffed, which hampers the care of MHCUs within the PHC setting. Researchers concur that it is imperative that PHC nurses receive support from the authorities so as to ensure the provision of “Health for All”, as outlined in the Alma Ata declaration of 1978, which has been supported by various organisations aimed at adopting the concept of providing health services (Burns, 2008; Omar, et al ., 2010; The World Bank Report, 2003; Uys & Middleton, 2004; WHO and UNICEF, 1978).

Participants were concerned that they had not been adequately prepared for integration. The general feeling was that they had had a short course of 3-5 days when the changes were introduced and were then expected to start the process of integration as there was no going back. This raised concerns about coping with the integration after such a short period of time. Participants felt that transformation had taken place swiftly and that they had been given no time to internalise the whole process or work on their preconceived fears. Their perceived lack of support was further confirmed by one participant stating;

“I honestly think that if they had prepared us better than this.... {Quivering her shoulders}... it would have been different”.

Participant reported lack of support from the sister-in-charge for taking time with consultations. The findings revealed that lack of preparation resulted in limited understanding of holistic care, specifically with regard to MHCUs, and the amount of time required to achieve this.

“I was personally reprimanded for rendering holistic care in the psychiatric unit and reminded that am delaying the queue”.

“...the authorities did not prepare us enough and the support is really lacking honestly”.

The limited period of training for the integration was also of concern to one participant, who said that a lot had needed to be covered in a short period of time after which nurses were expected to be able to render integrated care to the patients who visited the clinics.

“I think that was very short period to master everything in few days”.

Additionally, participants indicated that there had been no support from the authorities in getting post-integration feedback. They felt that the sudden introduction of integration impacted negatively on preparing the nurses. Some had found the lack of preparation frightening.

“We were terrified of the inevitable we did not know what was going to happen to us. We had our own fears that we are going to be swallowed by the PHC clinic”.

“We had an idea that MHCUs were dangerous”.

Some participants explained that because the integration had taken place so quickly, they felt overwhelmed, unprepared and unsure as to whether they would be able to cope with mentally ill patients, which seemed linked to their stereotypes associated with mental illness labels.

“...we had had the feeling of insecurity if we could cope with them knowing very well that they had those months when they were psychotic can be harmful to the community, the clinic, the staff and to themselves...”.

This statement confirms lack of support pre and post integration as the participant expressed concerns about being left to manage with no mentors or support.

“I feel that this integration could have been introduced slowly rather than bombarding us with the changes and still not give us enough resources”.

The integration of PHC nurses at district level proved to be the single most important challenge for the attainment of service integration amongst others. A major barrier to nurses' motivation and commitment was expressed as related to the lack of occupational specific dispensation. This was iterated clearly by one participant.

“A critical challenge in the clinics is that when the other specialities in clinics were awarded the Occupational Specific Dispensation, mental health was not considered a speciality”.

4.3.3 Theme 3: Challenges in rendering care to MHCUs in PHC

The third theme that became apparent was related to challenges in rendering care to MHCUs in PHC. There were four categories to this theme, each with a sub-category. The first category was clinical skill in managing patients' behaviour, with its sub-category, violent, psychotic and aggressive behaviour; the second category was delays in acquiring medication, with its sub-

category, lack of stock; the third category was incomplete multidisciplinary team in the PHC, with its sub-category, no social worker or doctor on site; and the fourth and last category was staff frustration and anxiety, with its sub-category, fear of demotion and nurses resigning for greener pastures.

Table 4.3 : Theme 3 – Challenges in providing care for MHCUs in PHC

Theme 3	Category	Sub-category
Challenges in providing care for MHCUs in PHC	3.1: Clinical skill in managing patients' behaviour	3.1.1: Violence, psychosis and aggressive behaviours
	3.2: Delays in acquiring medication	3.2.1: Lack of stock
	3.3: Incomplete multidisciplinary team at PHC	3.3.1: No social worker and doctor on site
	3.4: Staff frustration and anxiety	3.4.1: Fear of demotion and nurses resigning for greener pastures.

The Mental Health Care Act (no 17 of 2002) stipulates that PHC facilities provide a high standard of mental health care. PHC nurses are expected to ensure that medicines are available, as well as deal with assessment and on-going referral for more specialist treatment in a district hospital. The Mental Health Care Act caters for the 72-hour emergency treatment of MHCUs who are in an acute state and need to be admitted for observation at the district hospital (WHO, 2008a). The facilitation of the referral process, based on accurate timeous assessment, is largely the responsibility of the nurse.

However, participants' comments offered striking confirmation that the lack of psychiatrists, nurses' legal inability to prescribe and a poorly coordinated system has not facilitated these expectations of integration of mental health into PHC (Lund, Breen, Flisher, Kakuma, Corrigan, Joska et al., 2010; WHO, 2007). Participants expressed that there were some challenges with regards to rendering care to the mental health care users within the PHC setting, particularly with

respect to, delays in acquiring medication for acutely psychotic patients. These were expressed as follows;

“...there are shortages all over the pharmacy department doesn't prepare these early and there are not enough drivers from our clinic to fetch the medication for our patients and it becomes a vicious circle really...”

The majority of participants referred to lack of resources, particularly the availability of pharmaceutical stock. They explained that the services are not fully integrated into the PHC as nurses cannot initiate treatment and the medication comes from the specialist clinic. This was affirmed by two participants.

“We send the pink card outside to the specialist clinic for patients' medication , so that does come late sometimes... and the patient has to go home without medication for a week till it arrives from the clinic”

“We as PHC nurses are not authorized to initiate treatment to those patients who are coming for the first time, all the treatment is doctor initiated”

References to limited human resources tended to focus on the need for more nurses to facilitate all the programmes offered at PHC. Comments specifically related to acutely psychotic persons were commonly related to lack of resources.

“We need more staff to be able to spend time with the MHCUs and other patients. There have been additional programmes like HIV/AIDS, TB, IMICI, obstetrics, however we are short staffed”

Participants' responses indicated that there were vital members missing from the multidisciplinary teams, which compromised effective management of the patients. They elaborated by saying there were no doctors or social workers stationed at the clinics. They therefore had difficulty in attending to patients who needed the expertise of a doctor and those coming in with social problems.

“...there is no psychiatric doctor on site it is only the Medical Officer who has come to review the patients”

“We call the doctor on call, who will order sedation telephonically who will authorise for us to sedate the patient before being transferred to the sister hospital.”

“There are times when you need a multidisciplinary team to address issues but this is not happening because it’s only the nurses that are on site”.

The findings revealed that nurses’ lack of skill in mental health nursing resulted in less effective nursing interventions for MHCU. Participants reported that the majority of the PHC nurses had not been adequately trained to offer all the services that should be provided in the clinics once mental health care had been incorporated into the PHCs. This is reflected in the following excerpt:

“.....there are few people that are trained in mental health as I mentioned before. If I am not available they just dish out medication and give the return date that’s all”.(Participant 2).

4.3.4 Theme 4: Advantages of Integration

The fourth theme that was identified from participants’ responses was the advantages of integration. There were five categories attached to this theme, each with a relevant sub-category: holistic treatment, with sub-category, one-stop-shop supermarket approach; multidisciplinary team involvement, with sub-category, involvement of the South African Police Department, CCGS and the community; education on mental health illness, with sub-category identification of mental conditions and initiation of ARVs to MHCUs; family involvement, with its sub-category decrease in the relapse rate; and lastly, MHCUs’ changes in self-worth, with its sub-category improvement in the personal hygiene of the MHCU.

Table 4.4 : Theme 4 – Advantages of integration

Theme 4	Categories	Sub-categories
Advantages of Integration	4.1: Holistic treatment	4.1.1: One stop shop, supermarket approach
	4.2: Multidisciplinary team involvement and other stake holders	4.2.1: Involvement of the South African Police Department, CCGS and community.
	4.3: Education on mental health illness	4.3.1: Identification of medical conditions and initiation of ARVs to MHCU
	4.4: Family involvement	4.4.1: Decrease in the relapse rate

	4.5: MHCUs' changes in self-worth	4.5.1: Improvement in personal hygiene of the MHCU
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Recommendations by the WHO argued that the reformed health care systems will address the mental health needs of the entire populace, while bringing the opportunity to redirect available resources towards mental health, even in circumstances where total health resources are constant (Patel, et al., 2007; WHO, 2007). They maintain that interventions can be made accessible through changes in policy and legislation, service development, adequate financing and the training of appropriate personnel (Petersen, et al., 2009; WHO, 2008).

Participants reported that the PHCs which have provided a ‘one- stop- shop’ have benefited the MHCUs in the sense that services are provided holistically within the clinic, under one roof. The participants recognized that the ‘supermarket approach’ is an excellent approach to cover the needs of the clients. Participants pointed out some of the underlying medical benefits of integrating mental health care into the PHC clinics. Some of their comments are as follows:

“It is good that there is now integration; we have an opportunity to provide a holistic approach to MHCU”.

“...before the integration these users would have to wait for the special unit to attend to their mental status then refer them for medical illness to the clinic that is not happening now, PHC is a true one stop shop”.

The PHC clinics are now offering voluntary HIV/AIDS testing and counselling to MHCUs visiting the clinics and this has assisted in early detection of HIV/AIDS and commencement of Highly Active Antiretroviral Therapy (HAART) by the PHC nurses. Some participants verbalised feelings of satisfaction that MHCUs with HIV/AIDS can now be treated.

“... we need to be able to identify MHCU who are HIV positive because these are unattended, you see ... Remember HIV is a chronic illness so as the mental illness”.

“We are allowed to initiate HAART now from the psychiatric, clinic”.

Participants felt that integration had brought the MHCUs closer to their relatives and that this prevented isolation, since they receive care near where they work, reside and socialise.

“I think integration is a good thing, because all the patients get the care they need next to their relatives”.

“Firstly, I must say it is convenient for the patient because the service is brought closer to their homes”.

They also felt that integration decreased the relapse rate and increased compliancy. The participants gave credit to the Community Care Givers for identifying and bringing defaulters to the clinic:

“The Community Care Givers do these visits and they come back to the clinic to give you reports and you have to take it from there... it would be ideal if we could do these ourselves”.

“Again we have Community Care Givers (onompilo) they are employed by the Department of Health (DoH) as an outreach team”.

“Another thing is that we do get help from the community care givers that help us in tracing the relapses within the area where they are located”.

One of the participants pointed out the importance of working collaboratively with other services within the community and the positive impact this has had on public insight.

“...integration is a good thing because in case where the patient is actively psychotic we inform the nearest police station and they...”.

Participants expressed observing changes in the relapse rate of MHCUs, as well as their self-worth and care for self. Some participants indicated that integration of mental health care into PHC seems to have had a positive impact on stigmatization. The following are some of their comments:

“My experiences now are that there have been improvements with regards to the patient coming into the clinic with their relatives. There is less relapse”.

“I must say that MHCUs seem to be presently looking cleaner and the hair their clothes; they are well groomed since the integration”.

“They feel good coming to the clinic and mix with all other patients, their personal appearance has improved”.

“Ok, what I can say is that integration is a good thing because people with mental illness have been removed from a psychiatric institution back into the community”.

4.3.5 Theme 5: Resource constraints

Resource constraints was the fifth and last theme that was identified. This theme had three categories, each having at least one sub-category. The first category was infrastructural deficits, with two sub-categories of location of treatment room at the PHCs and inadequate bed allocation for in-patients, as well as lack of stimulation for MHCUs. The second category was staff shortages, with its sub-category increased work load; and the third category was lack of continuity and breaking of therapeutic alliance, with its sub-category of inconsistency of staffing and frequent rotation.

Table 4.5 : Theme 5 – Resource constraints

Theme	Category	Sub-category
Resource constraints	5.1: Infrastructural deficits	5.1.1: Location of treatment rooms at PHC 5.1.2: Inadequate bed allocation for in-patient care, lack of stimulation MHCUs
	5.2: Staff shortage	5.2.1: Increased work load
	5.3: Lack of continuity and breaking of therapeutic alliance	5.3.1: Inconsistency of staffing and frequent rotation

Integration of mental health into the PHC setting has created problems in relation to the infrastructure as it has resulted in a shortage of beds, within district and specialist hospitals, for acutely ill MHCUs. Problems of infrastructure in this province have left the MHCUs predominantly being cared for within district hospitals that are suggested to have a sub-standard clinical environment (Ramlall, 2012). Although the introduction of mental health care into PHC aimed at identifying and addressing inadequacies in training needs and structural defects, the participants reported that this approach has resulted in a shortage of staff and space. Participants

said that the lack of space impacted negatively on the patients' privacy. This is illustrated in the following excerpt:

"... there is not enough space, there are not enough rooms to conduct the interviews. As a result there is lack of privacy when conducting the one and one interview with the patient".

Participants pointed out obstacles that are related to structural problems. They said that the lack of consultation rooms in their clinics has resulted in lack of privacy as they are forced to discuss private issues with the MHCUs in the presence of other patients visiting the clinic.

"There is not enough staff to conduct the groups and there is no privacy to conduct interviews and even other programmes. The psychiatric consultation is just done in a small room, and that creates a lot of tension from the MHCU and the relatives who are bringing them".

Participants expressed distress at the shortage of space and lack of privacy. They said that this caused them to become distracted during consultations. One of the participants stated:

"Our clinic is small and is not enough privacy you get distracted in the middle of the interviews, and hardly any time to talk to the MHCU as you would like to because of the long queues that is a huge problem".

It became evident that the unavailability of space hampers the consultation process between the PHC nurses and the MHCUs. It seems that even although the changes had been imminent, clinics did not seem to have been adequately prepared for the integration. Comments were raised about the shortage of rooms, inadequate bed allocation for in-patient care and lack of stimulation for MHCUs, as well as the increased work load, inconsistency of staffing and frequent rotation of nurses.

"There is not enough staff to conduct the groups and there is no privacy to conduct interviews and even other programmes. The psychiatric consultation is just done in a small room".

"It is a way this clinic is structured, it is very fragmented. Even though we try to provide a supermarket approach to the patients, it is not 100% practical due to structural problems in this clinic".

Participants expressed that the fragmented structure of the clinic was of prime concern to effective management within the clinic. They commented that the environments of some of the PHC clinics are not user friendly to the sick and irritated patients who visit them.

“...so we felt that we needed a conducive environment in managing these patients. Our own clinic is very small and was not designed to accommodate violent mental health care patients”.

Participants also verbalised that they sometimes meet with resistance when referring MHCUs who need urgent attention to the district hospitals because of the limited available beds. This was reinforced by one the participants who said:

“You know beds are a problem in the hospital, it’s like the beds are reserved for the medically ill patient. No one tells you that, but you get the feeling when you present the case to the doctor”.

On another note, participants expressed concern over the shortage of human resources, explaining that there were not enough nurses to cover the additional programmes that had been incorporated into PHC. They said that this had led to a serious increase in the work load. This was voiced as:

“...what makes it terrible is that since the integration, there is no additional staff, more, more programmes, no staff that is what happens in this place”.

“The nurses have so much work it looks like they have been given the bulk of work and left to perform miracles. In the present set up though, assessment of MHCU is compromised”.

“There has been an additional programme like HIV/AIDS, TB, IMICI, obstetrics, however we are short staffed. We need time to do all these programmes because you cannot rush patients through and you cannot push other patients to the side”.

Human resource constraints were visible during the data collection process. PHC clinics were observed to have fewer male nurses, which poses a problem in the management of aggressive behaviour, and this was verbalised by two participants who stated:

“There is a problem when the patient comes into the clinic with aggressive behaviour because we do not have enough male nurses”.

“We are very few male nurses in this clinic, would have been better if we were more, because patients here are psychotic and female nurses are usually fearful especially when they are not used to looking after the MHCU”.

The findings revealed that nurses are allocated according to the needs of the clinic and are rotated to any department to cover shortages. Participants indicated that this gave them the impression that mental health is perceived as being less important. Participants expressed these concerns:

“What I sometimes find is that you get to be removed from your department to cover in the other departments, but when it is your turn to be covered, suddenly your department is not heavy”.

“We all rotate, just when you adjust, you move, there is no continuity of care when that happens”.

“The nurses have so much work it looks like they have been given the bulk of work and left to perform miracles. In the present set up the assessment of MHCU is compromised”.

Additionally, there seem to be issues regarding communication between members of staff, which breaks the therapeutic alliance and affects mental health care outcomes. Participants reported that once the patient is admitted into hospital, there is no feedback about the patient and the clinic staff lose track with the management of the MHCU, leading to relapse. This was expressed as:

“We lose track when the patient has been in the hospital. It would be good benefit to the clients if we had communication and feedback ...This will prevent break in communication which leads to relapse”.

“Another problem is that once the MHCU get admission to the hospital we never get feedback from the nurses and doctors in the hospital as to what transpired in the hospital and what was done”.

4.4 Summary of the chapter

The researcher clearly demonstrated how each stage within the chosen framework described by Braun & Clarke (2006) was undertaken and has presented the findings from this study. Five major categories emerged from the data analysis process and these and their relevant categories

and sub-categories were illustrated in the tables provided for each theme. These included training and support; preparation for integration; challenges in caring for MHCUs in PHC; advantages of integration; and resource constraints. From the sample of fourteen PHC nurses in the study, the overall integration of mental health care into PHC was perceived as beneficial, despite continuing problems, as it has not only improved the quality of the health care system, but has also improved the utilization of PHC setting. It is clear from the analysis above that integration would have been smoother and less painful if the integration process been done more slowly, with nurses receiving proper basic psychiatric training and retraining, enabling them to be more proficient in mental health assessments.

CHAPTER FIVE

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

5.1 Introduction

This study had only one objective, which was to explore and describe PHC nurses' experiences as they related to the initial implementation of integrated mental health care within PHC clinics, and the ongoing provision of mental health care services within these settings. Two research questions answered this inquiry. These were; what experiences do PHCN's describe regarding the initial integration of mental health care services into the PHC clinic where they work? What experiences do PHCN's describe related to their ongoing provision of mental health care at the PHC clinics where they work? The findings of the study provided a description of the views of the PHCNs about the process of integration and their experiences in rendering care to the MHCU within PHC clinics.

The findings of the study are presented according to the research questions; discussions paying specific attention to unique findings indicated by the study results. The chapter concludes with the limitations of the study, the recommendations, the summary and the conclusions.

5.2 Discussion

5.2.1 Inadequate preparation for initial integration

The distinguishing factor of this study is that integration was valued by all the fourteen participants that took part in this study. The results of this study are similar to findings of other local studies describing various advantages and barriers of the integration of mental health care into the PHC setting (Lund et al., 2010; Mkhize & Kometsi, 2008; Petersen, 2009; Uys & Middleton, 2004). This study revealed the participants' feelings about the reality of the initial integration of MHCU to the PHC setting. Findings indicate that participants believed in the integration process and viewed it as a positive approach in the care of the MHCUs. However participants felt there was inadequate preparation for the initial integration of MHCUs within the clinics. The participants echoed that when the psychotic patient visit the clinic for the first time there are delays in the care because there is no doctor on site .The transfer of the MHCU to the transfer district hospital is a long process, the ambulance takes longer to arrive and this cause

delays in the care of the MHCUs. The participants recognised that the care of the MHCUs within the care necessitate the presence of the multidisciplinary team to prevent delays in immediate care. The participants answered the first research question by sharing their views on how they felt about the reality of the initial integration process and acknowledged it as having happened too fast.

5.2.2 Inadequate preparation for the on-going provision of mental health care

PHC was acknowledged as being effective in serving all the needs of the individual patients under one roof. This is supported by the WHO when describing the process of integration as bringing the care of the patients together under one roof and bringing various stakeholders to deal with community problems and to share a common goal (WHO, 1996: in Sibiya, 2009). It is also supported by local researchers stating that the advantages of the of integration brought optimistic results (Mkhize & Kometsi, 2008; Petersen et al., 2009; Zeiss & Karlin, 2008). PHC ensures that the needs of the individuals are met effectively under one roof and this safeguards continuity of care in the environment where people reside (Funk & Ivbijiro, 2008; Mkhize & Kometsi, in Ameerma, 2009, pg. 2; Mohan & Cleveland, 2005:314, as cited by Sibiya, 2009).

However, the preparation for ongoing integration process and support of the PHC nurses to render ongoing provision of care to the MHCUs was reported as inadequate. Findings revealed that as much as the PHC nurses viewed the integration as a vehicle to drive the PHC approach, they felt ill equipped to manage MHCUs. This was attributed to inadequate skills and support to manage patients with challenging mental problems. It became evident that PHC nurses in this study lacked the training and support which was crucial in supporting the implementation of ongoing provision of mental health care integration process. Essential concerns from their perspectives were that there was no going back with the changes, but as there had been no supervision prior to the integration and no subsequent feedback, the nurses were still following the biomedical approach, a different finding from other local studies (Petersen, 2000; Walley, Lawn, Tinker, Francisco, Chopra, Rudan, Bhutta, & Black, 2008). These researchers point out that reorientation and in-service education programmes for PHCNs is an important aspect of the transformation process. Giving PHCNs the needed support is in keeping with the re-engineering of the PHC services.

5.2.3. Voluntary counselling and initiation of HAART to MHCUs

Two unique results emerged from this study; support for integration and recognition that MHCUs benefit from the HIV/AIDS screening and counselling that is offered to all patients attending and there is a possibility that they need counselling and screening PHC clinics.

Results indicate that MHCUs were recognised by the participating PHCNs as a population at risk of developing HIV/AIDS. Local research suggests that the PHC setting has been recognised as an environment for voluntary counselling and treatment (VCT) of HIV/AIDS (Jarvis & Smith, 2014 in print). These authors indicated that within specialist psychiatric clinics, PHCNs should have a strong therapeutic relationship with the MHCUs, as this is noted to increase the probability of the MHCU being tested, the benefit of which would be to guarantee continuity of care and further identification of risk behaviour. Within this study, participating PHC nurses fully supported the integration of mental health care, saying that they were pleased that, MHCUs with HIV/AIDS could be cared for within their clinics. Participants shared the information on voluntary counselling and initiation of the Anti-Retro Viral (ARV) medications to the MHCUs, which suggests a different attitude and practice than reported in Jarvis and Smith (2014, in print). PHC nurses, however, acknowledged the need for further training, supervision from the medical practitioner and support from the management so as to be cognisance of the drug interaction.

5.3 Limitations the study

A limitation of the study was that the findings represent the views of a relatively small sample of nurses practicing in the PHC clinics following the integration of mental health care within the PHC setting. The researcher would recommend quantitative studies in this area to develop further knowledge for nursing practice. Additionally, this study focused on the views of the PHC nurses only and did not explore the views of other members of the multi-disciplinary team practicing within the PHC setting.

5.4 Recommendations

The following recommendations are based on the findings of this study.

5.4.1 Development and support

Data from the study suggested that integration was seen as a positive process in delivering PHC. On the other hand, however, nurses indicated that they needed sufficient knowledge and skills to deal with challenging behaviours such as violence, aggression and severe psychosis within the PHC environment. It appeared that professional practice could benefit by on-going training, education and support as a means of development. This would address the issue of PHC nurses being viewed as requiring improvement and would assist in closing the gap between physical and mental illness.

In response to the increased burden of disease and the growing population in SA, promotion of the multi-pronged approach to care in partnership with PHC is an advantage. As PHC is nurse driven, it is of prime importance that an adequate number of nurses are trained in mental. They should have appropriate skills to meet the needs of the whole population at present, this is not attainable with the current shortage of nurses. This study, therefore, recommends that schools, colleges and universities develop continuing programmes of nursing education to further the knowledge of nurses. This will reduce insecurities and fear in the treatment of the MHCUs, while at the same time giving the PHCNs confidence to identify those in need the treatment. To support the initiation of ARVs, the PHC nurses ought to have the multi-disciplinary team on site so that necessary arrangements are in place to support the MHCUs who need initiation while receiving psychotropic treatment. The rights of the people with mental illness are protected by the Mental Health Act no 17 of 2002 and it is important to note that in the quest for curbing the scourge of HIV/AIDS, the rights of the MHCUs should be respected in that they need to give their consent for blood tests. When the appropriate steps for Voluntary Counselling and Treatment (VCT) be followed. Furthermore the PHC nurses need training and supervision when dealing with such treatment in the PHC environment to prevent drug interaction which might be detrimental to the patient. MHCUs might need the support of the family members to promote compliance.

The PHCNs in this study mentioned the importance of using a comprehensive approach to provide holistic care to individual patients. This is in keeping with the principles of PHC which involve treating the individual's physical, psychological, social and spiritual well-being (WHO/UNICEF, 1978). According to the discussions in the SA AIDS Conference held at the

Durban ICC, it was stated that the government is presently looking positively on mental health issues and intervention. The managers at all levels are supporting the initiatives stipulated by the government policy. National Core Standards for Quality Improvement of mental health, questions on screening and care have been included in all provinces. These are the indications that the government is trying to address the discrepancies especially for the foreseeing future . Participants did point out that, even though integration process was introduced fast there are some improvements in the care of the MHCUs. Voluntary screening and testing for HIV/AIDS assist in the early diagnosis and treatment of all the patients coming into the clinics including the MHCs coming for the first time and those coming on subsequent visit.

5.4.2 Participation in planning

The government is in the process of re-engineering PHC and it is therefore important that all stakeholders at the PHC level get an opportunity to give input as this will contribute to effective management of the patients within the PHC setting. The involvement of a multi-disciplinary team benefits both the PHC nurses and patients and the patients visiting the clinic will receive holistic care. The PHC nurses should be involved in decision making and be given support post integration so as to prevent the tendency to follow the biomedical approach in the caring for the MHCUs. Future research could benefit from further studies in this area by exploring patients' views about the integration process.

5.5 Summary of the chapter

Participants viewed the integration of mental health within the PHC as helpful in providing care closer to the clients and their families at a cost they can afford. However, the findings revealed that the staff needed to attain more knowledge and skills to render sufficient integrated care. PHC nurses acknowledged the lack of adequate preparation for initial integration of MHCUs process in that they had not received sufficient training to equip them with the skills they needed to assist in identifying and managing mental illness within the PHC on the ongoing process. They believed that the manner in which integration was initially introduced resulted in areas of uncertainty regarding their roles in the integration process.

5.6 Conclusion

Policies are in place to institute changes within the health care system. However, despite the principles and interest after Alma Ata, the delivery of PHC services continues to face challenges. Contributing to these challenges, amongst other things, is lack of support from the government agenda, absence of common goals among the authorities and PHC nurses at different levels, which resulted in inadequate preparation for the integration of the health system (Walley, et al., 2008). Participants acknowledged that integrating services under one umbrella provided a better health service, but they also highlighted some of the challenge associated with the process. These included the lack of adequate preparation for integration and the paucity of resources that came with the transformation process. To ensure efficiency in integrated care, there should have been adequate preparation, accompanied by feedback after the integration process. This would have assisted in identifying the strengths and flaws of the process to augment its authenticity. The PHC nurses are the backbone of the integration process and their input is vital to its success.

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LIST OF ANNEXURES AND TRANSCRIPTS

Annexures

Annexure A: Interview Schedule

Demographic information of the participants used in collection of data included: age, gender, qualifications, years of experience in PHC and years of experience working with mental health care users (MHCUs).

The following questions were used to generate communication and access to participant's experiences. The researcher used communication skills to probe, reflect and to clarify, during the interviews.

Open-ended questions

What has been your experience of the integration of mental health care into this clinic?

What are your experiences in providing mental health care to people who attend your clinic?

What resources do the PHCNs regard as lacking since the integration of mental health care within the PHC clinics?

Annexure B: Letter requested permission to conduct study to the Provincial office



To whom it may concern

Health research and knowledge management
hrkm@kznhealth.gov.za

Date:

RE: request for permission to complete a Masters Research project

My name is Cynthia Glover; I am currently employed as a lecturer in Addington College, a campus of KwaZulu-Natal College of Nursing. In addition I am a MN (mental health) student at the University of KwaZulu-Natal (Student No: 971206764).

My proposed study focuses on the experiences of the PHCN regarding the mental health care services they are rendering at PHC clinic. The study title is: *Exploration of primary health care nurses experiences of mental health services provided at their primary health care worksites in EThekwini Sub-South district KwaZulu-Natal.*

I have obtained ethical approval from UKZN (HSS/036/012M) and support from the clinic managers of the proposed research sights.

Please find attached

- Ethical approval from UKZN ethics committee
- The research study proposal
- Support letters from the nursing managers

In addition to requesting permission from Provincial health research and knowledge management I have also submitted a request for permission to the eThekwini district office.

Should you have any questions or concerns please contact me or my research supervisor.

Regards

Cynthia Glover

Mrs C. Glover

Email: Cynthia.glover@kznhealth.gov.za

Mobile contact No: 0826617418

Research Supervisor: Ms M. Smith

Email: smitha1@ukzn.ac.za

Annexure C: Permission request to the Clinic manager

My name is Cynthia Glover; I am currently employed as a lecturer in Addington College. In addition I am a MN (mental health) student at the University of KwaZulu-Natal. I am writing to request permission to interview PHCN's working at your clinic.

My proposed study focuses on the experiences of the PHCNs regarding the mental health care services they are rendering. The study title is: Experiences of primary health care nurses providing primary health care services at primary health care clinics in eThekweni South- Sub district KwaZulu-Natal. I have obtained ethical approval from UKZN, and permission from the eThekweni district office and KwaZulu-Natal provincial health office. Proof of each was attached.

Proposed data collection will be facilitated through individual interviews. I therefore request to schedule a meeting with you, at your clinic, for me to introduce the study, decide on potential participants amongst the PHCN, and negotiate a day and time, that suit you, when interviews could be done. The participants will not be travelling away from their place of work and I will come during the times we will all agree upon. The information will be treated confidentially and will not be used for anything else except for the reason it is intended for. Each interview should not last more than 45-60minutes per participant. In Addition, once I have analyzed the data I will need to return to the clinic to confirm with participants the veracity of the analysis. This should take approximately 30 minutes and will occur approximately three weeks after the initial interviews.

Please note that the identity of the participants and information that will be obtained will be treated with respect, as will the name of the clinic. Neither will be revealed in any report or publication.

Kindly feel free to ask if there is anything that you are not sure of, and need clarification. The findings of the study will be available to you from UKZN School of Nursing and Public Health. Should you have any complaints or concerns you may also contact my supervisor, contact information below.

Regards

Cynthia Glover (Student No: 971206764) :

Contact No:082661741

Research Supervisor: Ms. Smith

Email address:smitha1@ukzn.ac.za

Phone 0839289296

Annexure D: Information and consent sheet (Participants)

Dear Participant

My name is Cynthia Glover, I am currently employed as a lecturer in Addington College. In addition I am a MN (mental health) student at the University of KwaZulu-Natal.

I am requesting that you participate in a research study that aims to explore your experiences of the mental health care services that you are rendering at the PHC clinic. This information is aimed at gaining an in-depth understanding of your experience. The title of the study is:

‘Experiences of primary health care nurses experiences providing mental health care services at primary health care clinics in EThekweni South Sub- district KwaZulu-Natal’.

If you agree to participate you will remain completely anonymous. No personally identified information will be included in these forms. Although you will be asked questions that relate to your age, gender, and experience your name is not required. In addition your participation takes the form of an individual interview, your names, nor is the name of your clinic attached to the interview notes. In order that I do not miss or misinterpret what you say I will be recording the interviews. However these audio recordings will be transcribed by me and a code (such as P1) will be used to identify your content. In this way I am ensuring that you remain anonymous.

Your participation will require initially 45 - 60 minutes of your time for the initial interview. In addition I will be returning to discuss, as a group, with you and other participants, the analyzed data to provide an opportunity for you to confirm or dispute analyzed results.

Your clinic manager has suggested the following dates and times for potential bookings:

Please note that there is no payment for participation however your willingness to share your experiences could be used to inform further integration mechanism.

I want to stress that your participation in this study is entirely voluntary, and you may withdraw from it at any time. If you decide to discontinue your participation you will continue to be treated in the usual customary fashion as at present. There will be no negative consequences.

You can access the results of the study through UKZN School of Nursing and Public Health.

Should you have any questions or concerns please feel free to contact myself, Cynthia Glover or my research supervisor, contact details below.

Should you agree to participate in the study. Please complete the attached consent form and hand to me on the day of data collection. There will be an opportunity for questions before we commence the interview.

Regards

Cynthia Glover (Student No: 971206764)

Contact No: 0826617418

Research Supervisor:

Ms. Smith Email address:smitha1@ukzn.ac.za

Phone 0839289296

Consent from :

The study entitled ‘Experiences of primary health care nurses providing mental health care services at primary health care clinics in EThekweni South- Sub district KwaZulu-Natal’.

I have read and understood the information sheet. All of my questions regarding this study have been answered to my satisfaction.

I _____ agree to participate in the above mentioned study. I understand that this participation is voluntary, that I may withdraw at any time and that any information I share will be kept separate from personal identification information.

Signed _____ this day _____ of _____ at _____

Signature of the Witness:

Date:

Date

Annexure E: Raw data/ Transcript example

Interviews conducted in two primary health care clinics between 22/12/12 – 8/01/13

All interviews began with an invitation to ‘tell more about who you are’ to break the ice and to develop rapport. The was then followed by the first main question “*Just tell me a little bit more about your experiences with regards to the integration of mental health care into this clinic where you are working?*” and then the second main question “*What are your experiences in providing care to the mentally ill patients coming for the first time or subsequently to this clinic?*” Probing questions where used to facilitate information sharing and focus on participant’s comments. The transcripts include the two main questions and probing questions.

I-Interviewer

P-Participant

Clinic A, P1 (22nd/12/2012)

P: I am 58yrs, a female and I am widowed and I have one son who is married and he has two kids and he is working in Cape Town. As you can see {Laughing},I am long in the nursing profession and I am aging.

I: {Smiling} maintaining an open posture.Thank you so much for sharing the information with me. Before we go any further, let me find out from you how long have you worked in this clinic?

P: I began working here in 1998, and It has been 15years now working in this as a professional nurse, I was a staff-nurse before I did bridging course, then midwifery, community health nursing then, last year in June I did the primary healthcare. I did other short course like HIV, IMCI, TB training. I am not trained in mental health but I have been working with MHCU for 4years

I: Let me just take you back on what you have said, you’ve done PHC besides being a general nurse but no training in mental health did I understand you well ?

P: You are correct, unfortunately I am not trained in mental health, but I am still seeing patients with the psychiatric conditions. There are very few people trained in mental health in this clinic, you know... Even though this training is desperately needed very few people wants to do it because it is not recognised as a speciality, unless you did advanced mental health, meaning you do not get occupational specific dispensation for working here.

I: Tell me how does that make you feel?

P: It is a terrible feeling though... because I am not trained in mental health, and I sometimes feel that my hands are tied up really. You can do so much if you are not trained. Besides I do not feel that we were well prepared with this integration.

I:Tell me why do you think so?

P: In the clinic you are supposed to see all the patients since the integration was commenced with no training in mental health it makes it hard to get by. You do get support from your colleagues but you cannot consult every minute. It would be great if we were all trained.

It is hard you know... because, every nurse regardless of whether you are trained or not you still have to see MHCU coming to the consultation room . You still see all the clients visiting the clinic regardless of your lack of mental health training you see {shrugging the shoulders}. When this integration was introduced we received training that took 5days only depending on whether you are trained or not if you were trained it took 3days.

I: Tell me more about the training that?

P: The training we got was to tell us about the changes and what we were now going to receive mentally ill patients together with the medically unwell clients (sighing) ...Training us about caring for mentally ill person didn't happen all. We did it on our own we taught one another until we had gotten used.

I: I understand: Let us continue. Just tell me a little bit more about your experiences with regards to the integration of mental health care into this clinic where you are working?

P: Integration was a frightening experience. We were fearful because it was the first time that we would be seeing these patients in this clinic within such short notice. It was a terrible feeling really... to have your hands tied because of lack of training. They should have prepared us before this integration, that didn't happen it was a fast change (sighing).

We did it on our own.... taught one another until we had gotten used. Our training.... I, mean those who are not psychiatric trained like me, took five days and those who were trained took three days. Like I mean even if you were trained that was still not enough because, we were not used of treating MHCU within the clinic... you know.... Prior to the integration these patients had their own psychiatric clinics and their own nurses who were only looking after their mental well-being nothing else in their stand-alone clinics.

I: I understand you personally felt that training was not enough, how do you feel about it now that it has started?

P: I would say that eeee....., personally integration was a very good stance because when we talk of integration we talk of one stop shop. It is easier because the clients are not sent from pillar to post now that there is integration of services. The client goes to one department and everything is being attended to, whatever problem she or he will be attended to in one interview. And when everything has been done the patient just goes home.

I: O....kay... {Nodding and listening attentive}

P : There comes a point though, where there is more work you know.... Because with integration it means everybody who is sick comes into the PHC clinic and as a result there is more strain to staff ... because as you

know... we do not only see the MHCU , we see all the patients coming to the clinic, you see {emphasizing} that is when we feel we need more staff.

You know one stop shop means the patient get all the care he or she needs within the same clinic which sometimes is hard to achieve this {"Breathing"}.It becomes a bit hectic because with this integration you see all type of patients coming to the clinic, you have to see them and their problems..... you have to send the patient to that place for bloods. It is a way this clinic is structured, it is very fragmented. Even though we try to provide a supermarket approach to the patients it is not 100% practical due to structural problems in this clinic. One nurse does not do the patient from head to toe you refer to other departments, mentally ill patients get fed up at this time and start screaming {smiling}.

Another thing is that you cannot predict how long you going to take with each client in the consulting room .You can't say you'll take 2 or 5 minute it depends on what the problem of the client is. You find that some patients will continuously be knocking at the door disturbing the other patient inside as if you are wasting time when you take longer.

Another thing is that there are numerous programmes added by the department but the number of nurses is the same and we must still look after the patients with both physical and mental conditions. We are seeing post-natal patients, those mothers who have brought their children who are medically unwell, those who have come for immunisations as well as those who have come for family planning including the MHCU, in that case the load becomes too much.

I: I see, You are saying there are a lot of programmes and there are no nurses to perform the duties:

P: Hmmmm {shaking the head} to add on that PHC nurses are not all qualified for mental health care training. So... even though iam not psychiatric trained, I do attend to those patients that come in the primary health care setting then depending on their problems then we do refer them across to mental health department because there is one within the clinic. I would say though that integration has helped but there is not much support we are getting from the matrons.

I: Tell me more about the support that you think is needed in order to facilitate this change?

P: I honestly think that if they had prepared us better than this.... {Quivering her shoulders}... it would have been different, like I said If we were to be trained in psychiatry and told be of the expectations about the integration process, you know... things would have been different.

I:Tell me more about what could have made a difference?

P: I mean if only we could be given more staff we would be able to see the patients within the reasonable time than now patients would not spend whole day in the clinic. We are very short staffed and expected to perform miracles.

I: I see... {Listening ...} is there anything you would like to add?

P: To add on the integration, I would say it has helped the mentally ill clients especially those that come early to the clinic they get to be seen promptly without following the queue and they love this attention. It helps because MHCU tend to be impatient, they are easily distracted, so seeing them first helps. Another thing is that.... {Pausing}the integration has assisted in identifying those mental conditions that are not easily understood by the community.

I: Tell me more about that? What do you mean when you say those that are not understood by the community?

P: Let me share with you what I experienced in this clinic. I was working in the clinic one day the family brought an old lady they said it was their mother. They said she was found by the neighbours wandering aimlessly naked at night and they nearly killed her You know in the areas where people still believe in Zulu medicine they always think of the Zulu medicine like witchcraft. They suspected that she was performing Zulu rituals in the neighbourhood because she was wondering naked they did not associate this nakedness with mental illness you know or any form of illness for that matter.....

Again when this old lady arrived in the clinic she was very tired and ill looking, and looked dehydrated, there was no doctor on site that day. This woman was transferred by the nurses to the nearest hospital where she was diagnosed with Alzheimer's disease.

The people in the community do not know about these things and they thought this person was using traditional medicine to poison their families but in the meantime this person has got this condition.

I: Hhhmmm... I see, so tell me why are you relating this story?

P: Okay I am relating this because like this woman, hmmm if there was no clinic nearby the old lady wouldn't have gotten the help she got from the clinic. I am saying this because I think integration helps in identifying both medical and psychiatric condition within the clients' geographical area they do not go too far to obtain medical help. Bringing this lady has taught the relatives about Alzheimer's which has enlightened the public and misconceptions about her nakedness will be cleared, her family members were worried about the reputation of the family, but they got all the information from the clinic. I would think the hospital would have brought clarity to this condition as well.

I: Okay, you mean integration has helped because other medical conditions will be detected from the clinic closer to where people reside?

P: Absolutely; the relatives will bring the client to the clinic and this is where the person's problems will be diagnosed, treated or transferred to the nearby hospitals without delays. Moreover the community will be able to understand through knowing from other clients in the community like this woman.

Again integration will assist in tolerating the behaviour of mentally ill patients better because they are coming in like any other patient. The MHCU themselves feel welcomed by everybody, nobody is laughing at them even if they talking too much.

They like attention you know... and they feel accepted I have seen them interacting well with other patients in their own way.

I: Okay, I see, thank you let us then move on to the second question unless there is something else that you still want to add about integration.

P: Right now I'm going to tell you about the incident that happened when I was working in the HIV/AIDS department. A client was commenced on Anti Retro Viral (ARV's) treatment about a year ago. She then started seeing things and was hearing voices that were threatening to kill her if she continued to take the ARV's. She stopped the treatment as a result she collapsed due to opportunistic infection.

She was brought into the clinic by people from the place of work because they could something was strange. So she was seen by our doctor who had to ask her to bring one of his relatives to the clinic that is when the doctor got all history and started her on anti-psychotic for 3 months of which she improved. Before the integration they would have sent him straight to a mental health institution, but now with this integration she was stabilised in this clinic and is receiving medication monthly. I suppose she wouldn't have survived in the institution I tell you..... Hmmmm at least the clinic doctor did something.

I: Let us continue: What are your experiences when rendering care to the MHCU in this clinic?

P: What I've gathered through the years... {Breathing} is that mentally ill patients are very irritable and impatient, so one needs to take great care when dealing with these patients and if you are not skilled enough like being trained, you are not going to be able to understand their behaviour and you mismanage them and miss important aspect of health care.

I: So what you saying it would be beneficial to be trained in mental health when you are working in the PHC setting?

P: It would have been so good... but... I still feel the management should send us for training so as to decrease the work load from the nurses who are trained in mental health , we actually need to be trained in PHC as well all of the nurses working here.

I: What are your experiences in providing care to the mentally ill patients coming for the first time or subsequently to this clinic, what do you do?

P: Usually the relative will bring the patient and say that the patient is acting funny so they think she has got mental sickness. Then in that case we will interview the client in the meantime trying to get whether her mind is in good order then...refer to the psychiatric nurse after opening a folder if not suitable we refer to the patient to the nearest community health clinic for further management.

I: Tell me a bit more about how you try to get whether the clients mind is in good order or not?

P: Hmmm we ask ordinary questions...simple questions hmmm ... then we see if she or he will divert to your question and give you a wrong answer, if they divert we will see that there could be something funny in the brain.... In which case we will write a letter write down all that we have concluded during the interview. Then send the patient to the nearest hospital where they will further examine the patient.

They might keep the patient for 72hours and then discharge with treatment or could be observed more than 72hrs and be reviewed.

Sometimes we miss these patients because you know..... the hospital does not give us the feedback once the patient is discharged back to the community. But the patient will receive treatment from the clinic as usual if not lost. I am saying this because some of them do not come back to the clinic for follow up treatment and they relapse.

I: What happens then under those circumstances tell me more about that?

P: You know... you will find that the MHCU will come to the clinic after months psychotic, when he gets to the clinic you know ...he/she would need to be seen by the doctor who might not even be there, and that's a problem... now we have to involve the police and so forthSometimes the MHCU might be picked up by the Community health workers in the community and be brought to the clinic psychotically ill. We calm them down by giving them valium, the sisters are allowed to give that in the clinic, and we sedate the patient and let the doctor on call know.

I: Hmmm? So you saying they will be brought to the clinic with relapsed symptoms, tell me more about the role you play as a PHC nurse when that happens?

P : Yes we start all over again and that is a problem you know sometimes the patients comes back really sick mentally It is getting better though now because there is a team that goes out to the outreach clinics and they identify the defaulters for us and are then referred back to the mobile clinic to see the nurses or call the ambulance to the hospital.

If they need review from the clinic we refer them for when the doctor is available in the clinic that is if the family can still cope with the patient at home.

The doctor comes weekly to check whether there are scripts that need to be renewed and check if there are any blood results and the patient's response to treatment this is when he will see relapsed cases.

I: Is there anything else you'd like to share?

P: Well. we have problems when the patient comes in violent or probably those who are said to have defaulted because the nurses do not prescribe and there is no doctor on site, what we do they are stabilised with valium and transferred to the nearest hospital. We do experience problems with the issuing of the medication you now, because we send the pink cards outside, to the specialist clinic for patients medication , so that does come late sometimes... and the patient has to go home without medication for a week till it arrives from the clinic .

I: Thank you very much for the time, Tell me more about what do you think can be done to prevent this these problems and the delay to getting medication?

P: You know if there could be feedback for when the patient has been discharged from the hospital and giving us a report in writing that can be much better.

I: Thank you very much for the time that concludes the end of our interview.

-End of Interview-

ANNEXURE F : Comprehensive Table with the List of Themes, categories and sub-categories

THEMES	CATEGORIES	SUB-CATEGORIES
4.1: Training and support	4.1.1. 4.4.1. Poor clinical assessments and treatment 4.4.2. Lack of mental health training	4.4.1.1. Lack of mental health training. 4.4.2.1. Other programmes given priorities more than advanced psychiatry.
4.2: Preparation and support during and after integration	4.2.1: Poor preparation of nurses for integration	4.2.1.1: Integration was sudden, induction was inadequate. 4.2.1.2: Integration was frightening 4.2.1.3. No (OSD) for Highly skilled staff. 4.2.1.4: No one trained as an advanced practitioner in mental health
4.3> Challenges in the care of MHCUs	4.3.1. Clinical skill in managing patients behaviour 4.3.2: Delays in acquiring medication 4.3.3: Incomplete multidisciplinary team at PHC 4.3.4: Staff frustration and anxiety	4.3.1.1. Violent , psychosis and aggressive behaviour 4.3.2.1. Lack of stock 4.3.3.1: No social worker and doctor on site 4.3.4.1. Fear of demotion to junior nurses staff resigning for greener pastures
4.4. Advantages of Integration	4.4.1: Holistic treatment 4.4.2: Multidisciplinary team involvement and other stake holders 4.4.3. Education on mental health illness 4.4.4: Family involvement 4.4.5: MHCUs change in self-worth	4.4.1.1. One stop shop, supermarket approach 4.4.2.1. Involvement of the South A African Police Department, CCGS and community. 4.4.3.1. Identification of medical conditions and initiation of ARVS to MHCU 4.4.4.1. Decrease in the relapse rate 4.4.5.1: Improvements in personal hygiene of the MHCU
4.5. Resource constraints	4.5.: Infrastructural deficits 4.5.2. Staff shortage 4.5.3. Inconsistency of staffing and frequent rotation	4.5.1.1: Location of treatment rooms at PHC 4.5.1.2: Inadequate bed allocation for in-patient care 4.5.2.1: Increased work load 4.5.3.3: Lack of continuity and breaking of therapeutic alliance

Annexure G

Letter from clinic A to conduct the study

Matron in charge
[Redacted]

Date: 2012

Dear Mrs C. Glover

Support is given for the collection of data at [Redacted] for the study titled
*Exploration of primary health care nurses experiences of mental health services provided at
their primary health care worksites in EThekweni Sub-South district KwaZulu-Natal.*

I understand that the data involves individual interviews with PHCN working at this clinic.
That their participation is voluntary and that the research will provide information and obtain
consent from potential participants.

I have been provided with a copy of ethical approval from UKZN (reference:
HSS/0936/012M). in addition to the researchers contact details and those of the researchers
supervisor.

Regards
[Signature]



Annexure H

Letter of approval from clinic B

Matron in charge
[REDACTED]

Date: 24.10.2012

Dear Mrs C. Glover [REDACTED]

Support is given for the collection of data at [REDACTED] for the study titled *Exploration of primary health care nurses experiences of mental health services provided at their primary health care worksites in EThekweni Sub-South district KwaZulu-Natal.*

I understand that the data involves individual interviews with PHCN working at this clinic. That their participation is voluntary and that the research will provide information and obtain consent from potential participants.

I have been provided with a copy of ethical approval from UKZN (reference: HISS/0936/012M). In addition to the researchers contact details and those of the researchers supervisor.

Regards

Keethu W. K. K. K.
24/10/12



Annexure I

Letter of Ethical approval from UKZN



18 September 2012

Mrs Cynthia Nomthandazo Glover 971206764
School of Nursing and Public Health

Dear Mrs Glover

Protocol reference number: HSS/0936/012M

Project title: Exploration of the experiences of Primary health care nurses providing mental health care services at primary health care clinic worksites in EThekweni Sub-South district KwaZulu-Natal.

Provisional approval - Expedited

This letter serves to notify you that your application in connection with the above has been approved, subject to necessary gatekeeper permissions being obtained.

This approval is granted provisionally and the final approval for this project will be given once the above condition has been met. Please quote the above reference number for all queries/correspondence relating to this study.

Kindly submit your response to the Chair: Prof. S Collings % Ms. P Ximba, Research Office as soon as possible

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

/px

cc Supervisor Ms A Smith
cc Academic leader Professor Mars
cc School Admin. Mrs C Dhanraj

Professor S Collings (Chair)
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Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS



ANNEXURE J

Letter of approval from Provincial Office



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg, 3200
Tel.: 033 – 3953 189
Fax.: 033 – 394 3782
Email: hkrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 177/12
Enquiries : Mr X Xaba
Tel : 033 – 395 2805

Dear Ms C. Glover

Subject: Approval of a Research Proposal

1. The research proposal titled 'Exploration of the experiences of primary health care nurses in providing mental health care services at primary health care clinic worksites in the eThekweni sub-south district' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at Pinetown and Botha's Hill clinics. Data collection will take four weeks.

Please note: KwaDabeka clinic can be included once this office has received a letter of support from the clinic.

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 hkrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely


Dr E Lutge

Chairperson, Health Research Committee

Date: 29/11/2012

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope