

**PERCEPTIONS OF PROFESSIONAL NURSES REGARDING FACTORS THAT
INFLUENCE THE INTEGRATION OF PSYCHIATRIC SERVICES INTO
PRIMARY HEALTH CARE IN BUFFALO CITY CLINICS
IN THE EASTERN CAPE PROVINCE**

by

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DECLARATION

I, NONTIBEKO BEATRICE MHLAHLA, declare that "Perceptions of Professional Nurses Regarding Factors that Influence the Integration of Psychiatric Services into Primary Health Care in Buffalo City Clinics in the Eastern Cape, is my own original work, and that I have not previously, as a whole or in part, submitted it for obtaining any qualification. Moreover, all the sources that I have used have been acknowledged.


SIGNATURE



22.04.2014
DATE

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ABSTRACT

The purpose of this study was to explore the perceptions of the professional nurses regarding the factors that influence integration of psychiatric services into Primary Health Care (PHC) in Buffalo City clinics In the Eastern Cape.

A qualitative research design was seen as the most suitable in this study. This method was chosen because the researcher was committed to explore the perceptions of the participants in the study. A purposive sampling method was used to select participants for the study, who were selected on the basis of their knowledge of the phenomenon. The participants were professional nurses who were involved in providing mental health care services at the primary health care settings. A pilot study was conducted in a primary health care setting involving participants with similar characteristics to the study population.

Data were collected by means of individual interviews during which participants were able to relate their perceptions with regard to factors influencing integration of psychiatric services into primary health care. One broad, open-ended question was used to gather information from the participants. Data were collected until saturation point was reached.

Transcriptions were made within three days of the interview. Data were analyzed manually. The researcher used the process of bracketing during data analysis and remained neutral, setting aside previous knowledge and beliefs about the phenomenon under study. The researcher repeatedly listened to audio tapes used for data collection until completely satisfied with the interpretation of verbatim data. The research study was conducted in an ethically reflective manner, and trustworthiness was ensured at all times. The researcher allowed the participants freedom to conduct their lives as autonomous agents, without control, coercion or exploitation.

The following findings were evident:

In spite of a policy dictating the integration of services, it is apparently not done. The findings revealed that participants experienced barriers with regard to implementation of integrated mental health services due to lack of supervision, unavailability of protocols and policies, as well as inadequate trained staff to provide mental health services in PHC. There is either complete absence of or only fragmented mental health services at some clinics. The participants understood that integration of mental health services into primary health care would contribute to the reduction of stigma and the promotion of human rights for psychiatric patients. Shortage of resources, both human and material, imposed a great challenge with regard to provision of quality mental health services. The participants strongly recommended that basic training should be provided to improve their knowledge and skills to enable them to integrate psychiatric services into primary health care .

The results also revealed that at specific times, primary health nurses provide psychiatric services for patients who have already been seen in a hospital and in some clinics such services do not exist. In clinics where the nurses are not psychiatric trained, there is no case finding, rehabilitation or prevention strategies taking place. Incorporation of comprehensive mental health services into primary health care is far from ideal, as professional nurses focus on issuing medication as a method of providing mental health services.

DEDICATION

This dissertation is dedicated to my children, Nwabisa, Amphiwe and Abongile, who always believe in me.

I would like to express my gratitude to my supervisors for support and understanding.

This work is further dedicated to all learner nurses, professional nurses, nursing educators, clinical supervisors and all nurses in the Eastern Cape Province.

I also wish to dedicate this work to my grandson, Akhanani.



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Participants in the study: The professional nurses, the managers and the supervisors of Buffalo city clinics and District community psychiatric services.

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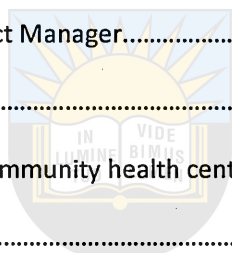


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CHAPTER 1

ORIENTATION TO THE STUDY

1. INTRODUCTION:

This study was conducted to address the lack of integration of mental health care services into general Primary Health Care services at Buffalo City clinics in the Eastern Cape Province.

1.1 BACKGROUND

According to the Department of health policy mental health services delivered in the community to mentally ill individuals should be integrated into primary health care services. The candidate noticed that in spite of the policy psychiatric services are not being integrated and tried to solicit the views of primary health care nurses on this topic.

The researcher noticed that patients suffering from mental illness were not being accommodated at the Buffalo City clinics. The mental health care services were not integrated into the general mainstream health care services. The researcher also noticed that, mental health care services did not form part of the mainstream services at the three Community Health Centres; patients were attended to by separate psychiatric nurses who visit these clinics once a week.

This is contrary to the integration of services policy, which was established in 1996, in South Africa. This policy is aimed at increasing health service utilisation by promoting accessibility and availability of health care services at primary health care level as stipulated in the Republic of South Africa Mental Health Care Act (MHCA), (Act No. 17 of 2002),. This Act emphasises the holistic integration at health services at primary, secondary and tertiary levels of care. This serves as a component of the comprehensive Health Care Approach.

The Eastern Cape Dept of Health expects all the clinics at Buffalo City to render comprehensive health services to the patients. The World Health Organization (WHO) defines health as a complete state of physical, mental and social wellbeing and not merely the absence of disease and infirmity. Health care services in South Africa are expected to adopt a holistic approach, which includes treating the individual in totality.

Primary Health Care (PHC) is defined as the first level of contact of the clients, family and the community. This service enables the consumers of health care to access health care services as close as possible to where they live. This is the priority of the National Health System (Dennil, King, & Swanepoel 2010:2).

According to Drew, Saraceno, Funk & Faydi (2008), primary health services should not be associated with any health condition. The fear by mental health care users of being stigmatised as mad and dangerous is reduced. Marginalisation from the community and discrimination is also avoided. Mental health care users are likely to benefit from such a system of health care services.

The National Health Plan identifies strategies to join divided health care services into a comprehensive health care service (Government Gazette, April 1997). Comprehensive Mental Health Care is defined as services that should address all health problems of persons from before birth until after death (Uys & Middleton, 2007:48).

The WHO and WONGA (2008) mention the following benefits from a Comprehensive Health Care Approach, namely:

- Reduced stigma
- Improved access to care
- Reduced chronicity and improved social integration
- Human rights protection
- Better health outcomes in Primary Health Care, and
- Improving Human Resource capacity for Mental Health Care.

The Eastern Cape Department of Health issued a memorandum to District Health Services stating that separate community psychiatric services/clinics should be

phased out and the service should become part of integrated mental health care services with a clear referral system (Government Memorandum, 1999).

The education of nurses is based on a comprehensive holistic approach with a focus on correlation of theory and practice. Students gain competency in nursing skills through simulations and clinical placement in wards and clinics. The researcher, who is a nurse educator involved in the placement and accompaniment of students for clinical practice, noticed that the Comprehensive Health Care Approach has not been adopted at the Buffalo City Clinics. Such an approach disadvantages the Psychiatric Nursing Students with regard to acquiring practical skills, with a detrimental effect on quality patient care.

According to the South African Nursing Council (SANC) (2005) safe and effective nursing refers to nursing practice rendered within the Scope of Practice. The safety and effectiveness of nursing care depends on the quality of clinical teaching and education which leads to the quality of practice in the clinical nursing environment. Penman and Olivier (2004) state that the clinical placement areas should be supportive and encourage meaningful education, resulting in optimal performance by students. The Primary Health Care Services remain fragmented at the Buffalo City Clinics. This requires scientific research to investigate reasons for the lack of integration of mental health care services with general health care services.

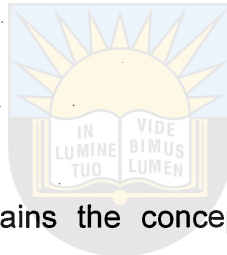
1.2 PROBLEM STATEMENT

Mental health care seem to be neglected at Buffalo City Clinics, despite the availability of the integration policy which was enacted in 1996. There is stigma attached to mental health users. The users are discriminated against, their rights violated, and the provision of mental health care services remains fragmented. The Government has committed itself to transforming the fragmented health services at Primary, Secondary, Tertiary and Rehabilitation levels of care into a comprehensive health care system by means of the Mental Health Care Act (Act No. 17. of 2002).

The Eastern Cape Department of Health issued a memorandum to District Health Services stating that separate community psychiatric services should be phased out

and be made part of integrated mental health care services with a clear referral system; this seems to have been ignored, as community psychiatric services are still offered on certain days at some of these clinics, and remain rendered in isolation from the general mainstream of health care services at community health centres in Buffalo City. The reason for the lack of integration of mental health care services into the general mainstream of primary health care services is unknown. This kind of health care approach does not only affect patients, but student nurses on training as well. This is likely to have a detrimental effect on quality patient care, and the competencies of student nurses. No research seemed to have ever been conducted to investigate the reasons for the lack of integration of these services.

1.3 DEFINITION OF CONCEPTS



1.3.1 INTEGRATION

The Oxford Dictionary (1996) explains the concept integration as a means to combine as a whole or to end segregation. In this study integration means collaboration of mental health care services into the general mainstream health care services at the primary health care settings.

1.3.2 PRIMARY HEALTH CARE (PHC)

The primary health care concept includes a political belief that demands radical improvement in both the planning and content of customary health care services. It supports an approach to healthcare based on the principles that allow people to obtain the care that enables them to conduct their lives productively, socially and economically (Dennil *et al.* 2010:2). In the study PHC means an institution that provides integrated mental health services with general mainstream, and enables mental health users to access health care services where and when they are needed every day.

1.3.3 COMPREHENSIVE PRIMARY HEALTH CARE

According to Uys and Middleton (2007:44), comprehensive primary health care is described as the services that address all health problems of clients before birth and until after death. It consists of three levels of prevention. These levels are Primary, Secondary, and Tertiary. This comprehensive approach to mental health is supported

by the Mental Health Care (Act No. 17 of 2002). Comprehensiveness involves intersectoral working together, promotive, preventative, rehabilitative and multidisciplinary health, at all levels of care, which are primary, secondary and tertiary levels (Dennil *et al.* 2010). In this study levels of care can be utilised to prevent mental disorders in the general public. These levels of prevention of mental disorders can be achieved if there are adequate human and material resources to carry out these activities (Kachingwe 2011:16).

1.3.4 MENTAL HEALTH CARE SERVICES

Mental health care services, refers to any one of a group of government, professional, or lay organisations operating at community, state, national, or international level to aid in the prevention and treatment of mental disorders (Mosby's Medical Dictionary, 2010:832). In this study, Mental Health Care Service (MHCS) refers to health care services provided to psychiatric patients at the clinics.

1.3.5 CLINIC /CLINICAL PLACEMENT AREA

A clinic is the health establishment allocated to a community to provide a comprehensive service MHCA (Act No. 17. of 2002), while Clinical Placement Area refers to the area in a health establishment to which student nurses are allocated according to their learning needs. This is done to expose them in a real practical area to enable them to acquire knowledge and skills needed to practice nursing, Nursing Act (Act No. 33. of 2005).

1.3.6 PROFESSIONAL NURSE

A Professional Nurse is defined as an individual who is qualified and competent to independently practise comprehensive nursing in a prescribed manner, one who is capable of assuming responsibility and accountability for her/his actions as well as registered as a registered nurse with South African Nursing Council, Nursing Act (Act No. 33. of 2005). In this study a professional nurse is a competent psychiatric trained professional who is capable of assessing and identifying mental disorders.

1.3.7 THE SCOPE OF PRACTICE FOR NURSES

This is defined as the condition under which nurses may practise their profession in a safe and effective way and remain competent in the manner that is prescribed

Nursing Act (Act No. 33. of 2005).Through lack of integration of mental health care services with general health care services, students are often allocated tasks which are inconsistent with their scope of practice and may not be adequately equipped with the appropriate skills and knowledge.

1.4 SIGNIFICANCE OF THE STUDY

The study aimed to identify gaps and address reasons for lack of integration. It will be beneficial to the clients as fragmented mental health services are likely to result in stigmatisation of clients and noncompliance with treatment. Hidden psychiatric problems will be identified more readily if services are integrated. No similar study has been conducted at the chosen clinics.

1.5 AIM OF THE RESEARCH

The aim of the study was to explore the perceptions of professional nurses regarding factors influencing integration of psychiatric services into Primary health care in Buffalo City Clinics, and to develop suggestions to promote the integration of the services.

1.6 RESEARCH QUESTIONS

Tell me about factors that influence lack of integration of psychiatric services into Primary health care?

What hinders integration of psychiatric services into Primary health care in Buffalo City Clinics?

What should be done to promote the integration of such services?

1.7 THE RESEARCH OBJECTIVES:

- To investigate factors influencing lack of integration of mental health care services with general health care services by professional nurses at the Buffalo City Clinics.
- To develop suggestions for integration.

1.8 THEORETICAL/SCIENTIFIC JUSTIFICATION FOR RESEARCH

The researcher utilised the Florence Nightingale's theory to guide the study. According to Lancaster & Stanhope (2006), a theory, "provides a starting point to collect facts in a systematic way so that phenomena can be described, explained and predicted". The systematic approach of finding out the phenomena by means of research process was used by the researcher. Florence Nightingale's conceptual model and theory identified the concepts that are essential for nursing and guides actions that nurses should apply in their practice. According to this theory, nursing practice is regarded as holistic. This is in line with the definition of health, which states that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity (WHO 2008). The physical aspect of a person was a priority, which was addressed by both medicine and nursing care in the attempt to alleviate disease; Nightingale saw the need for the comprehensive approach which include integrating other components such as thought processes (Selanders 2010:84). This view is related to the integration of service policy which was enacted in South Africa in 1996, to achieve a comprehensive and seamless PHC delivery system Mental Health Care Act (Act No.17. of 2002).

1.9 RESEARCH DESIGN AND METHODOLOGY

Burns and Grove (2007:553), define a design of the project as a general detailed plan for conducting a study where in it enhances the control over various factors which may influence the validity of the findings. It guides the planning and implementation of the study in the manner that is most likely to achieve the intended goal.

A research method is defined as a technique used to structure a study, and to gather and analyse information in a systematic way (Polit & Beck 2004:731). LoBiondo-Wood and Haber (2006), further describe methodological research as the search and the measurement of the means of gathering and analysing data. This study adopted a qualitative research method as the researcher conducted a systematic inquiry concerned with understanding human beings and the nature of their connections with themselves and their environment by describing life experiences of nurses giving

them meaning (Burns & Grove 2007:51). A qualitative research paradigm which was explorative, descriptive and contextual was used to explore the factors influencing the lack of integration of psychiatric services with general Health care services by professional nurses at Buffalo City Clinics and Community Health Centres in East London. In this study, the researcher used a qualitative approach as it would give the participants an opportunity to express their views. Sullivan (2001) defines descriptive research as an attempt to find out facts or describe the truth. For the above-mentioned reason, the researcher adopted a qualitative research method.

1.9.1 THE STUDY POPULATION

The research population is described as a set of entities in which all the measurements of interest to the research meet the sample criteria for inclusion in the research study. This criterion is set out by the researcher before the research starts (Burns & Grove 2007:549). Polit and Beck (2004) further define population as the entire set of individuals that have the same characteristics. The population in research is referred to as the entire group of persons or objects that are of interest to the researcher and meet the criteria for participating in the research study (Brink 2009:123). Burns and Grove (2009:714) explain that a population represents all elements, individuals, objects, events or substances that meet the sample criteria for inclusion in a study

The population for the study was the professional nurses with four to six years of experience in the field of rendering primary health care service at Buffalo City Clinics and Community Health Centres in East London. Their age range was between 30 and 60 years. According to the Nursing Act (Act No. 33. of 2005) a professional nurse is defined as an individual who is qualified and competent as well as registered with the South African Nursing Council to independently practise comprehensive nursing in a prescribed manner; one who is capable of assuming responsibility and accountability for his/her actions.

1.9.2 THE SAMPLE AND SAMPLING METHOD

Babbie and Mouton (2009:180) state that sampling is the process of selecting the sample from the population so as to obtain the information regarding a phenomenon in a way that represents the population of interest. Burns and Grove (2007:554) further state that a sample is a portion or a fraction of a whole, or a subset of a large set, chosen by the researcher to join in a research project. A sample for this enquiry was drawn from the professional nurses who were involved in rendering mental health services at primary health care settings and those rendering separate community psychiatric services.

Purposive sampling method was used to select participants for the study. Purposive sampling is a method of sampling which selects individuals for participation in the study based on their knowledge of the phenomena for the purpose of sharing that knowledge (Speziale & Carpenter 2007:94). The logic and power of purposive sampling lies in selecting information-rich participants for the study. In-depth information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of research. This sampling method was suitable for the qualitative research because the researcher intends to gain insight and an in-depth understanding of factors influencing lack of integration of mental health services into primary health care (PHC).

The sample size stipulates the number of elements from whom the required information is obtained (Kumar 2005:65). In qualitative research, the focus is on the quality of information obtained from the participants rather than the size of the sample (Burns & Grove 2009:361). The researcher visited the clinics and community health centres, since the population was very huge; the sample size was determined by whether any new ideas emerged from data. That was when saturation point was reached. Fourteen professional nurses who met the inclusion criteria were interviewed.

The availability of professional nurses was determined by whether they were allocated to work day shift. The reason for this was that there were professional

nurses on night duty, especially at the community health centres, and those who were on sick; study and maternity leave who were excluded from this study.

All participants were professional nurses employed in Buffalo City Municipality Clinics, and the Psychiatric Professional Nurses from district services. Each participant was expected to be part of the study until the researcher had done a very thorough investigation of the situation that was being studied. The researcher collected data until the same information was provided on repeated inquiry or until the participants had nothing more to share.

1.9.3 PILOT STUDY

A pilot study is a smaller version or trial-run of an actual research study and it allows the researcher to identify problems early. A pilot study therefore is defined as a smaller edition of a proposed study. It is conducted under similar situations as the actual study. The aim is to refine the methodology, as well as to identify potential problems in the data collection and to show that the study design is both appropriate and feasible (Burns & Grove, 2007:549). The pilot study was conducted to check for any vagueness and inaccuracies. The interviews were piloted on five professional nurses who were not part of the main study. The researcher collected data personally. The researcher noticed that in spite of the integration policy being available, psychiatric services are not being integrated into Primary Health care.

1.9.4 INCLUSION CRITERIA

The population for the study included the professional nurses in their fourth to sixth year of experience in the field of rendering primary health care services at Buffalo City Clinics and Community Health Centres in East London. The availability of these nurses was determined by the shifts they had been allocated.

1.9.5 EXCLUSION CRITERIA

The professional nurses working at the community health centres, clinics, and district community psychiatric services who were on sick, study and maternity leave were excluded in this study.

1.10 DATA COLLECTION

According to Burns and Grove (2009b:695), data collection, "is the detection of the subjects and the precise, orderly gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study". The researcher utilised an unstructured interview guide in individual sessions on a one-to-one basis as the method of gathering information. Data were collected by means of listening and asking questions as they arose in order to gain insight into what had happened.

The Interview guide was used, as well as document analysis. To back up the notes compiled during interview session, an audio-recorder was used. Data were collected until saturation point was reached. The data were transcribed word for word from statements by the participants. All responses were read over and over to gain a sense of their meaning. The interviews were conducted in English. The written copies were coded manually.

1.11 DATA ANALYSIS

Polit and Beck (2004) define data analysis as the systematic organisation and synthesis of research data and testing of research hypotheses using those data. Data analysis starts during interviews (Speziale & Carpenter 2007:96). The purpose of data analysis is to preserve the uniqueness of each participant's lived experiences while permitting an understanding of the phenomena under study. These authors mention that there are three major analysis styles, namely editing; immersion and crystallisation. Researchers whose research tradition is phenomenology use procedures that fall within the editing style (Polit & Beck 2004: 508).

Researchers using the editing style act as interpreters who read through the data in search of meaningful segments and units. Once segments and units are identified, they develop categories, schemes and corresponding codes that can be used to sort and organise the data. Researchers then search for patterns and structures that connect categories. In this phenomenological design, the editing style of data analysis was used.

Transcription of the interviews was done by the researcher and data were read over and over, word for word, sentence by sentence until the researcher was convinced that the data was interpreted correctly. This activity in phenomenological study is termed “dwelling” with the data (Burns & Grove 2007:519). The search for themes was done manually with the assistance of a qualitative research specialist.

1.11.1 RIGOUR AND TRUSTWORTHINESS

Struebert-Speziale and Carpenter (2007:49) mention that, “the issue of rigour in qualitative research is important to the practice of good science”. The trustworthiness of the questions put to study participants depends on the extent to which they tap the participants’ experiences, apart from the participants’ theoretical knowledge of the subject.

Consistent use of the method of bracketing of prior knowledge assists to ensure pure description of data. To ensure trustworthiness of research analysis, each and every step of the research process was supervised by two supervisors, and the researcher presented the proposal at the seminar at the University of Fort Hare, Department of Nursing Science for quality control.

The four criteria that were used to determine the trustworthiness of qualitative research are as follows:-

- Credibility, described as the truth, value or believability that is derived from prolonged observations or involvement of the researcher with the participants or the situation. Participants’ cumulative knowing is regarded as authentic when they relate their lived experiences of the topic that is under question (Streubert-Speziale & Carpenter 2007:49).

- Dependability follows immediately on completion of credibility criteria. The researcher had to find out how dependable the results were. Division of methods is likely to contribute to dependability of the outcomes. Similar to quantitative research, in which there can be no validity without reliability, the same holds for dependability: there can be no dependability without credibility. (Streubert-Speziale & Carpenter 2007:49).
- Confirmability is described as repeating and direct information observed or obtained from the primary source or participants. It is further described as directly obtaining repeated, mentioned facts of what the researcher has heard or observed. The researcher requested the participants to repeat the ideas or instances to those who shared their ideas. These were confirmed throughout the study by the researcher (Streubert-Speziale & Carpenter 2007:49).
- Transferability refers to, “general similarities of outcomes under similar environmental conditions”. It is labelled as suitability. The probability for determining whether the findings fit or are transferable depends upon the potential users of the outcomes and not on the researcher (Streubert-Speziale & Carpenter. 2007:49).

1.12 ETHICAL CONSIDERATIONS

A research project is, “ethical to the extent that its design and execution conforms to set of standards or conventions guiding research” (Polgar & Thomas 2008:70-72). The researcher considered the three ethical principles of beneficence, autonomy and justice in order to protect participants in the study. Participants were assured that participation in the study would not in any way affect their lives in the working environment.

The participants were not harmed, as understood by the ethical principle of beneficence. At the beginning of the interview each participant was given a participant information sheet concerning the study and they were required to sign consent to ensure willingness to participate in the study. Written consent to

participate in the study was obtained. Consent was also obtained for the use of audio-tape as well as for written recording of the interview.

Anonymity was assured. For the purpose of anonymity, participants' names were omitted from the questionnaire. The researcher has an obligation to maintain confidentiality; this was ensured by not divulging data gathered during the study to other persons. The data was locked away and stored in a safe place and accessible to the researcher only. Participants were informed that, they were free to withdraw from the study at any time, with no penalty. Participants were provided with feedback during the period of research, in the form of research reports.

Letters for requesting permission to conduct the research study were submitted to various departments. These departments included the Department of Health, Eastern Cape Province, the Ethics Committee for Human Research at the University of Fort Hare, the Manager of Municipality/District Services; and Managers of the clinics and Community Health Centres.

The logo of the University of Fort Hare, featuring a sunburst design with the motto 'IN VIDE LUMINE BIMUS' and the text 'UNIVERSITY OF FORT HARE' and 'Together in Excellence' below it.
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1.13 DISSEMINATION OF FINDINGS

The findings of the research will be distributed to the University of Fort Hare library; the Department of Health, Research Directorate and the Director of the Amatole District Health services. The information of this study furthermore will be shared with colleagues in clinical forums held at the clinics and community centres of Buffalo City. The results will be published in an accredited nursing journal such as *Curationis* and may be presented at conferences of organisations such as the Nursing Education Association (NEA).

1.14 STRUCTURE OF THE REPORT

This section of the research describes the layout of the chapters in the dissertation. Chapter 1 contains the introduction to the study with emphasis on the orientation to the study, the identified problem, background and significance of the study, and the aims of the study.

Chapter 2 includes all theory and models that were chosen to guide this research. It provides a limited literature review of the experiences of professional nurses regarding integration of mental health services into Primary Health Care.

Chapter 3 describes the research design and methodology used by the researcher. It involves a discussion of the data collection, data analysis and trustworthiness of the study.

Chapter 4 includes the research presentation, research results and the findings.

Chapter 5 is the final chapter. It deals with the conclusion, discussion, limitations of the research and recommendations derived from the research. The results according to the study's objectives are concluded and recommendations are made on the basis of scientific evidence obtained in the study.

Annexures and all other supporting information are added to the document.

1.15 CONCLUSION

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In this study the researcher explored the views of professional nurses regarding factors influencing lack of integration of psychiatric services into PHC. The orientation and background of this study is presented. An outline of the research method and design were presented in order to give the reader a clear understanding of the study processes.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In Chapter 1 an outline of the research study was presented. The research problem was explained and objectives were highlighted. This chapter presents the limited scope of literature reviewed about what other authors have written, the appropriate research paradigm for this study as well as gaps on the problem investigated (*De Vos, Strydom, Fouché & Delport 2007:83*). The extensive literature review was used for discussing the results of the study

Burns and Grove (2009b:38 & 707) define a literature review, “as an organised written work on what has been published by other scholars”. The same authors further state that a literature review “is conducted to generate an understanding of the phenomenon of the study”. In this study, the literature reviewed comprised the work of the other scholars in books, theories, government information and journals.

The purpose of a literature review is, “to express what is currently known about the subject to obtain a broad background and understanding of what is already known about a particular problem and the knowledge gaps that exist in the field” (Burns & Grove 2009b: 91). This account of the theoretical and empirical sources indicates whether enough knowledge exists to make changes in practice or whether supplementary research is required (Burns & Grove 2009b: 37; Becker & Bryman 2009:69; Parahoo 2006:25). The researcher will explore literature related to integration of mental health services into primary health care.

Polit and Beck (2004) define the literature review as, “the summary of the research topic of interest which is criticised and prepared to place a research problem in context”. This is evidence for the current study. In this chapter, the literature study was conducted to obtain scientific information about factors influencing lack of integration of mental health services into primary health care at Buffalo City clinics in

the Eastern Cape. An in-depth literature review will be conducted to substantiate and discuss the results of this study.

It is crucial to conduct a literature review before embarking on a research project, "because this facilitates identification of relevant sources and information on which to develop one's study" (Terre Blanche & Durrheim 2004:19). Through a literature search, "researchers can establish what is already known regarding their research topics" (Whittaker & Williamson 2011:25). Fox and Bayat (2011:35) support this view and assert that a literature review, "gives researchers insight into the context within which the previously investigated phenomena had been dealt with, with regard to the specific research topic".

The mental health care services are not integrated into the general mainstream health care services. At the primary health care level, there is either absence of or fragmented health services (*Mwape, Sikwese, Kapungwe, Mwanza, Fisher, Lund & Cooper. 2010:1*). This is contrary to the integration of services policy that was established in South Africa in 1996 (*Sibiya & Gwele 2009:31*).

To be successful in conducting the present study, the researcher deemed it essential to have a sound knowledge of what is available in the literature, and what has been done so far in the area of interest (Hofstee 2006:91) This stimulated the thinking of the researcher around deriving ideas and perspectives so as to contextualise the present study within what is already known about the topic under investigation (*Parahoo 2006:127; Terre Blanche et al. 2004:19*).The researcher was thus enabled to understand the concepts of interest pertaining the phenomenon under study. This enabled the researcher to be open-minded with regard to exploring, and discussing the essential issues of the views of the professional nurses (Silverman 2011:319).

2.2 CONDUCTING THE LITERATURE SEARCH

The researcher conducted a literature search using Google Scholar, EBCO host, Science Direct, journals, books, studies by other researchers and information from experienced people in the field in the attempt to find literature to guide the present study. It became clear that no study investigating integration of mental health

services into primary health care had been conducted at Buffalo City clinics in the Eastern Cape. This information therefore assured the researcher of the need and significance of conducting the present study.

2.3 THEORETICAL/SCIENTIFIC JUSTIFICATION FOR THE RESEARCH

A theory is defined as, “a set of ideas which are interrelated and bring about a systematic view of an event. It serves to uncover relationships that may not be overtly clear to the casual observer. The ultimate result of a theory is to search for truth, resulting in formation of a predictable nature of law” (Selanders 2010:82).

The current study was guided by Florence Nightingale’s Theory of Nursing. According to this theory, nursing practice is regarded as holistic. The main concepts that have been utilised are person, environment, health and nursing (Selanders 2010:82). This study will share the concepts that are mentioned in the theory.

According to Nightingales’ theory of nursing, an environment is the umbrella concept. In this theory an environment is, “anything that, if manipulated, can enable the individual to be in the best possible condition for nature to act”. Caring is the main focus in nursing while curing of disease is the focus in medicine.

Collaborating the nursing and medicine is necessary for quality patient care. One of the responsibilities of the nurse is to ensure that the environment is conducive for effective patient care (Selanders 2010:84). The theory states that an individual receiving nursing care is a holistic person who is multidimensional with biological, psychological, social and spiritual components. (Selanders 2010:84). According to Nightingale, health is “not only to be well, but to be able to use well every power we have” (Selanders 2010:85). This is in line with the WHO definition of health, which states that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity. In Nightingale’s theory it is stated that symptoms alert the nurses to the presence of illness, which allows for appropriate intervention to be effected (Selanders 2010:85). In adhering to the principles of PHC, the clinics should render comprehensive, integrated services, (Dennil *et al.* 2010:2). Functional integration of the services that meet the patients’ needs is necessary to

ensure that the patient receives a comprehensive package of primary health services in one place, at one visit (Toomey 2000:14).

Nightingale identified nursing as the activities that promote health and nursing. This requires educated individuals in the art and science of nursing so that the nurse will be able to implement problem-solving skills in a logical manner, as the nursing process is known in modern terminology and emphasised the need to include theoretical and clinical experiences as part of the educational package (Selanders 2010:84).

Nursing is a profession where practical and theoretical knowledge need to be highly integrated for the professional development of the undergraduate nursing students (Burns, Beauchesne & Ryan-Krause 2006). Nursing students are allocated to clinical placement area in order to correlate theory and practice. The nursing process which is the guiding principle and approach for rendering nursing care, consists of seven sequential steps namely, assessment, interpretation, planning, implementation, evaluation and documentation (Fitzpatrick & Whall 2005:165-169).

2.4 THEORETICAL LITERATURE

The literature reviewed focused mainly on integration of mental health services into Primary Health Care, as discussed further in this chapter.

2.4.1 INTEGRATION OF MENTAL HEALTH CARE SERVICES INTO PRIMARY HEALTH CARE (PHC)

According to Gask (2005), integrated care is defined as care ensuring the rendering of a combination of health services and information that is of benefit to the needs of the clients and involving the link between these services. With reference to integration in mental health services, Toomey (2000:14) refers to functional integration of mental health services as the provision of services to the patient by one nurse, meeting the needs of the client and those of the organisation by rendering the comprehensive package of primary health services in one location in one visit.

In this study, integration refers to collaboration between mental health care services and the general mainstream health care services at primary health care settings.

Primary care professionals need to assume the key significant role of gate keepers to specialist referral or primary care physicians for integration, to be effective. Gask (2005) refers to two dimensional representations of integration, namely horizontal and vertical integration. Horizontal integration is defined as, "the collaborating of professionals, services and organisations that operate at similar levels of care in the hierarchy" and vertical integration is defined as, "the bringing together of various levels in the hierarchy of care". (Gask 2005:1785-1794).

Integrated services are comprehensive in nature as there is intersectoral working together for promotive, preventive, rehabilitative and multidisciplinary health care, at primary, secondary and tertiary levels of care (Dennil, King & Swanepoel 2010: 2). Petersen & Swartz (2002:55), state that Primary health care nurses understand the holistic concept of illness, collaborating physical, spiritual, and social wellbeing. The authors are of the view that, this knowledge is not translated into practice because nurses feel inadequately empowered to deal with problems of a psychological nature. This study might also seek to understand if nurses are inadequately empowered to implement integrated services at the Buffalo City clinics.

In Tint, Fonn, Khuzwayo & Robertson (2000:15), it is stated that integrated primary health care (PHC) implies that services will be offered by the same providers in the same consultation in one visit. At Buffalo City Clinics mental health services are provided in isolation from the general mainstream. Moreover, these services do not exist at other clinics, instead they are offered by comprehensively trained nurses, in separate consulting rooms. The aim of the integration of services is to increase health service utilisation by increasing accessibility and availability of all health care services at (PHC) level (*Tint et al. 2000: 15*).

Integration of mental health services into Primary Health Care is expected to contribute to potential reduction of stigma and is likely to promote human rights for people with mental health problems (Mental Health Care Act (Act No. 17.of 2002). The World Health Organization (WHO) has been motivating the various nations to develop a policy to integrate mental health services into primary health care. This first

took place in 1978 at the Alma Ata International Conference on Primary Health Care (Mwape et al.2010:4-21). The researcher noticed that there is a gap between what is prescribed by the WHO and the current provision of mental health care services at the Buffalo city clinics.

WHO & WONGA (2008) refer to the following ten principles for the integration of mental health into primary health care, namely:-

- Pre-service/ in-service training of primary care workers on mental health issues is an essential pre-requisite for mental health integration and that
- Health care workers must practice skills under the supervision of a specialist over a period of time, and that ongoing training and support is crucial.
- Patients may have access to essential psychotropic drugs/ medication at PHC as this integration promotes accessibility of psychotropic drugs/medication at PHC. The availability of psychotropic treatment at primary health care institution is essential for the success of integration, and to be distributed to PHC facilities rather than through psychiatric hospitals.
- Training could equip PHC workers with skills and knowledge to prescribe and dispense psychotropic medication, especially where mental health specialists and physicians are scarce. Mental health clients are benefiting from this principle as medication is stored within the primary health care setting.
- Collaboration with other government, non-health sector non-governmental organisations.
- Village and community health workers and volunteers are required. These play a major role in supporting PHC for mental health.
- Village workers can be taught to identify and refer people with mental disorders to PHC institutions.
- Community-based non-governmental organisations can assist patients become more active, and
- To decrease their need for hospitalisation.

Strategies for integration of mental health services at Buffalo City clinics are far from benefiting clients suffering from mental illness, as some of the above-mentioned structures are available but under-utilised by the community.

The researcher has observed that most of the clinics do not have a specialist professional trained in mental health on site for the purpose of supervision which is likely to pose a challenge with regard to service delivery.

In South Africa, the integration of service policy was enacted in 1996 with the aim of increasing health service utilisation by increasing accessibility and availability of all health services at Primary Health Care (PHC) level (Sibiya & Gwele 2009:31-37). The implementation of this policy in the Buffalo City is still a challenge as confirmed by the availability of separate community psychiatric professional nurses who render mental health services at some of the clinics of Buffalo City.

2.4.2 BENEFITS OF INTEGRATION OF MENTAL HEALTH SERVICES

The Mental Health Care Act (Act No. 17. of 2002) alludes to the holistic integration and comprehensive approach at Primary, Secondary and Tertiary levels of Health Care as benefiting the users of the services. All health problems of the users from before birth until after death, are attended to comprehensively. Such services adopt a holistic approach wherein the user is treated in totality as an individual. The Eastern Cape Department of Health expects all the clinics at Buffalo City to render comprehensive health services to the patients.

Some of the benefits accruing from integration of mental health services are related to the potential reduction of stigma attached to patients suffering from mental illness; protection of human rights; improving access to care; and improving human resource capacity for mental health care (WHO 2008; *Funk et al.2008:5-8*).

2.4.3 MODELS OF INTEGRATION OF MENTAL HEALTH SERVICES

Several studies were conducted in South Africa regarding the integration of mental health services into primary health care. At Ehlanzeni District in Mpumalanga Province, the institution utilised two different service models, one involving a skilled professional nurse to see all patients suffering with mental illness at the clinic.

The second model entails that the institution manages mental conditions in the same way as other health problems and all care practitioners are involved in treating patients. The clinics chose the model that best accommodates their available resources and local needs. The method that was found most acceptable in that district shows that, patients and nurses are satisfied with the integrated approach. This was confirmed by 80% of clinics providing mental health services in the Province (WHO & WONGA 2008:5).

The supermarket approach service care models seem to be adopted by some of the clinics at Buffalo City clinics. The supermarket approach was initiated in Tanzania and has been successfully adopted by most East African countries (Sibiya & Gwele 2009). These authors mention that managers depict the supermarket approach as the daily rendering of all services to the community, with no reference on how these services are offered (Sibiya & Gwele 2009).

Studies conducted abroad, like in the United Kingdom and Northern Ireland, reveal that primary care practice has established innovative methods to include and mainstream disadvantaged populations like immigrants and homeless people. The primary health care setting provides improved holistic mental and physical health needs, early diagnosing of illness and co-morbidity, resulting in reduction of stigma and social inclusion.

In the Moorreesburg District, Western Cape Province, mental health services are provided by general primary care practitioners at the clinics. The psychiatrist and specialist mental health nurses visit the clinic occasionally to manage complex cases and for supervision purposes. Patients are seen at the clinics. Access to care is improved, thereby reducing potential stigma related to mental illness. Primary care practitioners are satisfied with the model. They are grateful for the regular visits by mental health nurse specialists and the psychiatrists who provide ongoing in-service training as well as support for complex cases (WHO & WONGA 2008:5).

In Uganda, in the Sembabule District, mental health services are available in the primary health care setting. Those services are provided by primary care workers who identify mental health problems, treat clients with minor common mental

disorders, as well as chronic psychiatric problems. They take care of emergencies and refer clients who need changes in medication or require hospitalisation. Ongoing training and mentoring of primary health care workers is provided by specialised outreach services from hospital level. The village health teams consisting of volunteers who assist in diagnosing and referring patients collaborate. Mental health care services have improved, compared to the previous institutional care model (WHO & WONGA 2008: 5).

In the Southern Cape, Karoo and West Coast Winelands regions, mental health services are provided by mental health practitioners or psychiatric nurses. Psychiatric cases are referred by the health care worker to the psychiatric nurse at the clinic. The psychiatric nurse specialist visits many clinics per week. The psychiatric nurse provides the services through treatment including medication, short-term individual or group counselling and support. When additional expertise is needed, the psychiatric nurse in turn refers clients to the regional Psychologist/psychiatrist (WONGA & WHO 2008).

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Mental health care services in the Boland/Overberg region are available at the clinics. A Psychiatrist/psychiatric nurse is available as support system to the nurses (WONGA & WHO 2008).

Significant progress has been observed in assisting clients with psychosocial rehabilitation. A collaborative link has been developed with secondary-level health and community services, together with organisations and services dealing with employment, housing and legal issues (WONGA & WHO 2008).

2.5 CONCEPTUAL FRAMEWORK

Polit and Beck (2004) define a conceptual framework as interrelated ideas gathered together in a rational scheme by virtue of their relevance to a common theme. Furthermore, a conceptual theoretical framework as explained either in the form of a diagram, or in narrative form, presents the main aspects to be studied, the key factors, constructs, or variables and the relationships among them (Miles & Huberman 2003: 45).

Mouton (2008) states that scientific statements do not occur in isolation. When statements are structured according to certain interests or objectives and become integrated into conceptual frameworks, familiar structures of science are found, meaning typologies, models and theories. Rossouw (2003:100) mentions that a theoretical or conceptual framework means that the concepts of the research are identified and linked to each other by means of a literature study of existing conceptual frameworks. The conceptual framework for this study was developed by making use of related concepts, discussions and theories applicable to the study. The researcher used information from an extensive literature review to create a conceptual framework in order to connect or link the work of other researchers, as also stated in Polit and Beck (2004:490), for interrelated ideas to be gathered together in a rational scheme by virtue of their relevance to a common theme.

2.5.1 CONCEPTS

Concepts that commonly pertain to health services are presented below:-

2.5.1.1 Integration of Mental Health Services into PHC

The Oxford Dictionary (1996) explains the concept integration as a means to combine as the whole or to end segregation. In this study integration means collaboration/synergy of mental health care services with the general mainstream health care services at primary health care settings.

2.5.1.2 Primary Health Care

Primary Health Care (PHC) is defined as the first level of contact of the clients, family and the community with health services. This service enables the consumers of health care to access services as close as possible to where they live. This is the priority of the National Health System (Dennil, King & Swanepoel 2010:2).

The PHC concept includes a political belief that demands radical improvement in both the planning and content of customary health care services. It supports an

approach to health care based on the principles that allow people to obtain the care that enables them to conduct their lives productively, socially and economically, (Dennil, King & Swanepoel 2010: 2).

PHC, is an approach which has the capability of achieving both the millennium development goals and the wider goals of universal access to health through acceptable, accessible, appropriate and affordable health care (Walley, Lawn, Tinker, Francisco, Chopra, Ruda, Bhutta & Black 2008).

The primary health care package for South Africa mentions that the clinic should render comprehensive integrated primary health services, and this requires that clinics find suitable strategies that would make attainment of comprehensive health service standards feasible for their own particular context (Department of Health 2001a).

Strategies adopted for provision of mental health services at Buffalo City clinics seem to be disadvantaging clients suffering from mental illness. The services are offered on special days, at different consulting rooms, thereby promoting stigma attached to people with mental illness. The facility is expected to provide comprehensive integrated services for a minimum of eight hours a day, five days a week (Department of Health (2001b). Some of the clinics at Buffalo City adhere to this requirement. According to the researcher's observations, the practice adopted by mental health care professionals is that the availability of mental health care services at each clinic and each institution is restricted to either once a month or when emergency cases arise.

The PHC health workers have a vital role in managing patients with co-morbid physical and mental disorders; subsequent to assessing and diagnosing the patients. Professional nurses should be able to provide patients with honest and realistic information about the nature of their illness and give emotional support (WHO & WONCA 2008). Some of the professional nurses seem to be able to identify hidden psychiatric conditions and when the need arises they refer these cases to mental health care providers at the clinics.

Nurses at primary care level focus on clinical examination of the body and do not take into consideration the illness description which is the subjective feeling of distress for the patient, Moreover, where there are no physiological causes, they fail to account for somatic complaints (Petersen & Swartz 2002: 55).

The reorganisation of the health care system to care for mental disorders most likely is the duty of psychiatric nurses and trained PHC personnel (managing chronic cases or stabilising psychiatric patients). Health care providers at the basic level of care should be able to attend to every patient's psychological needs besides the physical ailment that has directed the patient who seek professional help (Petersen & Swartz 2002: 55).

Health care providers who do not have the skill to attend to people with mental health problems should at least have the skill to identify the problem and refer to colleagues who are competent to provide mental health interventions. Such an approach would be embracing the holistic concept and person-centred approach to care suggested by World Health Organisation for its mental health programmes (*Mwape et al. 2010: 4-21*). The researcher has observed that there is no specially trained mental health provider who is allocated to each clinic to provide ongoing training related to current mental health issues.

2.5.1.3 Comprehensive Primary Health Care

A comprehensive health care should include mental health care (Petersen 2000:321). Primary prevention of mental disorders is aimed at promoting mental health in individuals who are mentally well and prevention of mental illness at those groups who are at risk in the community. This is achieved through mental health education programmes to those who are at risk, such as adolescents, street children, antenatal mothers, but undertaking such programmes require enough time and human resources (Thorncroft & Szmukler 2001:492-493).

Secondary prevention of mental disorders is defined as the early identification and prompt treatment of an illness or disorder. The goal of secondary prevention is reducing the prevalence of the conditions by shortening the duration. Communities

need to be educated on early detection of signs and symptoms of mental disorders and the importance of seeking treatment (Thorncroft & Szmukler 2001:487).

Tertiary prevention is defined as minimisation of the disabilities and impairment which are the result of illness and disorder. The goal of tertiary prevention is to reduce defects and disability caused by the disorder. These authors further mention that tertiary prevention enables those affected to reach the highest feasible level of functioning (Thorncroft & Szmukler 2001:509).

In this study, a successful integration of mental health care services into PHC should incorporate all the preventive levels of care and collaborative network should be developed. The collaborative network requires that psychiatric nurses to be equipped with mental health skills to promote a more holistic approach to mental health users (WONGA & WHO 2008).

2.5.1.4 Mental Health Care Services

These include any one of a group of government, professional, or lay organisations operating at a community, state, national, or international level to aid in the prevention and treatment of mental disorders (Mosby's Pocket Dictionary 2010:832). According to this study, Mental Health Care Service (MHCS) concerns mental health service delivery provided to psychiatric patients at the clinics.

2.5.1.5 Community Mental Health Services

Community mental health services are defined as services that treat and help people with mental disorders in proportion to their suffering or distress (Thorncroft & Szmukler 2001:20). These services are rendered in association with voluntary agencies. Community mental health services are provided in various communities to promote health, prevent mental illness and facilitate rehabilitation of those suffering from effects of mental disorders (Kaplan & Sadock 2003:1374). The goal of prevention of mental disorders is to reduce the onset (incidence), duration (prevalence) and residual disability of mental disorders. Prevention of mental disorders is divided into primary, secondary and tertiary levels. These levels of

prevention of mental disorders can only be achieved if there are enough human and material resources to carry out these activities.

2.5.1.6 Accessibility

Accessibility is defined as services which can be entered or reached at the Primary health Care Institutions. (Thorncroft & Szmukler 2001:160). These authors further state that community psychiatric services should be able to reach and provide services where and when they are needed. In this study accessibility means mental health services be made available at all the clinics and community health centres and be offered on a daily basis by any available psychiatric trained nurse.

2.5.1.7 Clinical Placement Area

The clinical placement area is the area in a health establishment to which student nurses are allocated according to their learning needs. According to the Nursing Act (Act No. 33. of 2005), this is done to expose them to a real practical area to enable them to acquire knowledge and skills needed to practice nursing. According to this study the clinic is referred as the health establishment allocated to a community to provide a comprehensive service MHCA (Act No.17.of 2002).

2.5.1.8 Professional Nurse

A professional nurse is an individual who is qualified and competent to independently practice comprehensive nursing, that is, general nursing, community nursing, midwifery and psychiatric nursing, in a prescribed manner. Such a nurse is regarded as capable of assuming responsibility and accountability for his/her actions Nursing Act (Act No. 33. of 2005).

2.5.1.9 The Scope of Practice for Nurses

This is defined as the condition under which nurses may practise their profession in a safe and effective way and remain competent in the manner that is prescribed by the Nursing Act (Act No. 33. of 2005). Lack of integration of mental health care services

into general health care services, lead to students being allocated tasks which are not at the level of their competence as they still need to be equipped with the relevant skills and knowledge.

2.6 CONCLUSION

In this chapter the researcher has presented a brief literature review regarding the definition of the concepts integration, benefits of integration, models of integration, comprehensive primary health care, conceptual framework as provided in the literature as well as the theoretical justification that guided the study.

In reviewing literature that has addressed the integration of mental health services into primary health care. Challenges that occur globally and are similar to those experienced locally with regard to integration of mental health services into primary health care have been identified. An in-depth literature will be conducted to support discussion of findings of the study.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The literature review was highlighted in the previous chapter. This chapter focuses on the research design and the method used to obtain insight into the phenomena under study, and includes the population, sampling technique, data collection and analysis, as well as ethical considerations.

3.2 RESEARCH METHODOLOGY

This method was used to discover the participants' interest and understanding of a natural fact, uncovering the most important experiences with regard to integration of mental health services into primary health care by gathering stories; translating them and offering implications for practice (Streubert-Speziale & Carpenter 2007:76).

The study was qualitative in nature as the participants were enabled to express their opinions or concerns about integration of psychiatric services into primary health care at Buffalo City clinics and health care centres. The participants were allowed to share their experiences in a manner which would reveal the actual situation. The researcher attempted to interpret and to expand awareness of participants' experiences and practices and tried to uncover what it means for them to be a person in the world (Draurker 2001: 360-370).

This approach assisted the researcher to generate an in-depth description of experiences of the professional nurses with regard to the factors influencing lack of integration of mental health services into primary health care and also enabled them to gain understanding of how the process is to be carried out so that psychiatric patients can benefit from it (Holloway & Wheeler 2010:213). The participants were encouraged to express their thoughts about their own world.

The participants' experiences provided valuable information in understanding what was really happening in a real-world situation, namely the clinic setting and it enabled the researcher to observe the situation first-hand and from the perspective of others. It was thus possible to identify gaps and to test whether data collected was relevant (Burns & Grove, 2007:51).

3.3 RESEARCH SETTINGS

This study was conducted in East London, at Buffalo City PHC Urban clinics and community health centres. This research setting played an important role with regard to collection of data from the participants, as they did not feel threatened or intimidated because they were familiar with the environment and were allowed to express their views freely (Greeff 2005: 34).

Ethical considerations were observed. To gain access to the institution, the researcher had prepared a written statement in the form of letters to the Buffalo City District Management as well as from the Nursing Management in charge of the settings, (sees Annexure, C and D).

3.3.1 PREPARATION FOR THE INTERVIEWS

In order to ensure effectiveness and efficiency of the interviews, the researcher made proper arrangements for participants to feel comfortable during the interview. Participants were contacted telephonically to arrange a day and time in preparation for the interview.

In preparation for the interviews, the researcher ensured that the venue that was chosen was exposed to minimal distraction; was quiet and private to enable the participants to focus on the interview throughout the whole process. The purpose of the interview and the study was explained; and each participant was informed of what was expected of him or her.

Terms of confidentiality were addressed so that the participants could feel protected. They were assured, once again, of the ethical issues and their rights during the

interview. The format of the interview was discussed; the interviewer made it clear to the participant that they were free to ask questions.

The researcher obtained permission from the participants to tape record the interview and also explained about note taking. The participants were informed that the interviews would take approximately thirty minutes, and were encouraged to adhere to the time frames to avoid losing interest.

Contact information of the interviewer was provided so that the participants were able to build a trusting relationship with the researcher. It was advisable to provide contact details in case the need arose for them to communicate for specific reasons. Interviewees were allowed to clarify any doubts about the interview so as to minimise threats and were allowed to communicate freely.

A method for recording data was prepared, for example notes were taken and information was recorded on audio-tape to be transcribed verbatim for data analysis at a later stage. The interviewer entered the interview setting well prepared to avoid fumbling around during the interview (Valenzuela & Shrivastava 2008:10).

3.4 POPULATION

The population for this study was all professional nurses allocated at Buffalo City clinics for the purpose of rendering mental health services in PHC clinics.

3.4.1 TARGET POPULATION

The target population for this study included only the professional nurses with four to six years of experience in the field of rendering mental health services in the primary health care (PHC) setting at Buffalo City clinics and community health centres in East London (Parahoo 2006: 257).

3.5 SAMPLE AND SAMPLING METHOD

A purposive sampling method was utilised to select individuals for the study. The researcher made use of purposive sampling whereby the researcher selected the sample on the basis of own knowledge of the population, its elements and the nature of the research aims (Babbie & Mouton 2009:166).

The researcher focused on particular criteria for the selection of the sample. The participants were professional nurses involved in rendering mental health services at the clinics. The sample had to meet characteristics that the researcher had planned for inclusion in the study. The following selection criteria were used:-

- Participants with four to six years' experience in rendering mental health care services;
- Who were well-versed in English;
- Represented different racial and gender groups (that is, black, white, indians and coloured; male/female); and
- Were of 30-65 years of age.

3.5.1 THE SAMPLE SIZE

The researcher aimed at a sample size of 20 professional nurses involved in rendering mental health care services at the PHC setting at the District community psychiatric services and community health centres. The actual size was to be determined by saturation of data. In qualitative research data collection continues until the researcher believes saturation has been achieved, that is, when no new themes have emerged from the participants and the data are repeating (Speziale & Carpenter 2007:460). In this study, the researcher considered the purpose of the study as well as the depth of the information generated. The researcher identified the professional nurses by communicating with the unit manager of each clinic or community centre. Who further referred the researcher to the relevant professional nurses. The researcher made arrangements with professional nurses about the day and time for conducting interviews and their contact details were requested to confirm the appointments.

The clinics were visited once every two months. The researcher therefore visited various clinics and community centres and interviewed as many participants as possible until saturation took place. Individual interview session took approximately thirty to forty five minutes. The saturation took place when the researcher had interviewed 14 professional nurses.

3.5.2 RESEARCH INSTRUMENT

The instrument developed for the purpose of this study was the semi-structured interview guide which was designed and submitted to the supervisor for approval (Bless, Higson-Smith & Kagee 2006:43-52). The researcher was the primary instrument for data collection and analysis.

The semi-structured interview guide consisted of questions related to the investigation of the integration of mental health services into primary health care, as follows:

Tell me about the factors that influence the integration of mental health services into primary health care?

What hinders integration of psychiatric services into Primary Health Care?

What can be done to promote integration of psychiatric services into Primary health Care?

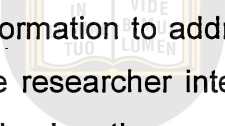
3.6 PILOT STUDY

A pilot study was conducted to identify potential problems in the collection of data and to accustom the researcher with the difficult issues that needed to be corrected in preparation for the larger project (Drummond 2003:156). Thus the pilot study enabled the researcher to practice interviewing in order to gain skills and refine the instrument. Pilot study was conducted with three (3) professional nurses who were not involved with the main study. This took place at the health centres and clinics. The purpose was to evaluate the interview guide and to identify ambiguities.

The semi-structured interview guide was able to elicit the necessary responses from the participants before the actual data were collected. No problems were identified, apart from the lack of privacy because other staff members moved in and out to utilise the telephone, because the interviews were conducted in the duty room due to the challenge of space. This was corrected by locking the duty room and a sign reading "Interviews in progress; don't disturb" was placed at the doorpost.

Data were analysed manually and sent to the supervisor and to a specialist in qualitative research in East London. Following this, the researcher was recommended to proceed with the actual data collection for the main study.

3.7 DATA COLLECTION



Data collection is the gathering of information to address a research problem (Polit & Beck 2008:716); which is what the researcher intended to do during this study. Individual interviews were used predominantly as a means of data collection (*de Vos et al. 2005:287*). The researcher arranged appointments with the participants in order to access the information. Individual interviews were conducted with the participants. Participants were allowed to share their experiences on an individual basis in an environment that was quiet, private and comfortable for data to be collected without any interruptions.

This is one of the most widely used methods of data collection in qualitative research. The interview guide used in this study was developed from the main research questions (Zorn 2008:1). An audiotape recorder, of which the participants were informed and which they agreed to, was used during the interviews (Polgar & Thomas 2003:78). Information was captured on tape in order to prepare the transcripts which later were transcribed verbatim. Names of participants were not linked to any information gathered, as it was coded and destroyed after the research.

Field notes were taken and information about the participants' reactions and non-verbal cues were recorded in writing. The field notes made by the researcher

concerned the interview situation and what the researcher's impression was. Participants were allowed to talk freely during the interview.

It was important that the questions were meaningful to the interviewee. The researchers asked open-ended questions and probing strategies were used in order to allow for sufficient information to be collected. Interviews were conducted with professional nurses so that their views of implementing integration of mental health service into primary health care and their recommendations could be utilised to improve the situation. No assumptions were made by the interviewer. The process of this research was inductive in that the researcher built up concepts, hypotheses and theories from data. Thus the interview ended when the same information was heard over and over again (Streubert & Carpenter 1995: 24).

3.8 ETHICAL CONSIDERATIONS

Research is an ethically significant activity and the research must be done in an ethically reflective manner to prevent problems around ethical issues. According to Van der Wal, cited in Pera and van Tonder (2005:147), "the researcher should at all times consider the institution, the participants and the scientific integrity of the researcher".

The researcher considered the three ethical principles of autonomy, beneficence, and justice in order to protect participants in the study. Polgar and Thomas (2008 70-73) state that, "a project is ethical to the extent that its design and execution conforms to a set of standards or conventions". Ethical considerations highlighted for the participants were as follows:

3.8.1 VOLUNTARY PARTICIPATION

Voluntary consent was obtained after the prospective participants had been given essential information about the study and had shown comprehension of the information. The researcher explained the purpose of the study to individual participants. Each participant was informed of the risks and the benefits of the study.

The participants were informed about the scope of the study and the type of questions to be asked. The participants were given sufficient information to help them decide whether they wanted to be research participants or not. Apart from explaining the study to the participants, the researcher gave each participant a copy of the information sheet (see Annexure F).

The contents of the information sheet were: An introduction of who the researcher was, the purpose of the research, and the participants in the study, the duration of the interview and the assurance of anonymity and confidentiality. It was stated that participation was voluntary and refusal to participate would not involve any penalty or loss of benefits to which the participants were entitled, such as not to be given a salary increment. The information also indicated that participants were free to withdraw at any stage of the interview.

After going through the information sheets, each participant was given a written consent form to read and sign if they were in agreement with the contents of both the information sheet and the consent form. All the participants signed the consent forms, which indicated that they were ready to participate in the study (see Annexure C, D and E). The researcher requested permission to record the interviews on audio tapes.

3.8.2 NO HARM OR DISCOMFORT TO PARTICIPANTS

No injury to the participants was foreseen by the research regardless of their voluntary participation (Polit & Beck 2008:170). The participants in this study had the right to self-determination and freedom to participate or not to participate in the study. The ethical principle of beneficence required the researcher to do good and, above all, not to harm participants physically, psychologically, socially or economically. The researcher ensured participants that they were not to be kept for more than one hour while interviews were conducted to prevent fatigue and headaches. The researcher avoided interviews that might cause sensitive issues to surface, which could result in emotional trauma to the participants. To prevent harming the participants economically, the researcher held interviews at the clinics

and community health centres where the participants worked, to protect them from incurring travelling expenses.

The researcher developed one-to-one relationships to establish rapport and not to harm the participants socially, as well as to allay anxiety. The participants were told in advance not to answer questions which made them feel uncomfortable. Participants who were included in the study were the ones who were in a position to comprehend what was happening.

3.8.4 CONFIDENTIALITY AND ANONYMITY

The researcher assured participants that confidentiality and anonymity would be upheld and that participants would be treated with respect and dignity. In a qualitative study, the researcher can identify a given person's responses but essentially promises not to disclose it publicly (Newman 2000:99). According to Burns and Grove (2009a:18), "anonymity exists if the participant's identity cannot be linked, even by the researcher, with his or her individual responses".

A breach of confidentiality can occur when a researcher, by accident or direct action, allows an unauthorised person to gain access to the raw data. Confidentiality can also be breached in the reporting or publication of a study, when a participant's identity is accidentally revealed, thus violating the participant's right to anonymity. Breach of confidentiality can harm participants psychologically, and socially, as well as destroy the trust they had in a researcher (Burns & Grove 2009:21).

The researcher ensured that the names and addresses of participants did not appear anywhere because they were not necessary. The researcher was only interested in finding out participants' views and experiences concerning the phenomena.

The interviews were carried out in a quiet and closed room away from people, for confidentiality and privacy. The researcher ensured that the information gathered from the interviews was not reported in a manner that identified the participants. The information (transcripts and the tapes) were only accessible to the researcher, the

specialists of qualitative research and the supervisors. The transcripts were kept in a safe place and nobody gained access to them and they will be destroyed two years after the publication of the research.

The researcher obtained permission to conduct the study from the University of Fort Hare Ethical Committee who granted an ethical clearance certificate to the researcher. Letters for requesting permission to conduct the research were submitted to the Department of Health Eastern Cape Province, the Manager of the Buffalo City Municipality/ District Services, the Nursing Service Managers of the community health centres and the clinics (see Annexure A, B, C, D, E, H and I). This was done because research is an ethically significant activity and any research must be done in an ethically reflective manner to prevent violation of the rights of the participants, protect human life and privacy.

The researcher subsequently obtained consent from the following role-players:

- Research Ethics Committee of the University of Fort Hare (refer to Annexure A)
- Permission to conduct research, from Eastern Cape Department of Health (refer to Annexure B)
- The Director of Amatole District health services (refer to Annexure C)
- The Nursing Service Manager of the clinics and community health centres (refer to Annexure D)
- Information given to participants (refer to Annexure E)
- Participant consent form (refer to annexure F)
- Interview guide (refer to Annexure G)
- Letter from the professional Editor (refer to Annexure H)

3.8.7 RISK ASSESSMENT AND PROMISES

All potential risks were considered and included in the consent process and the issue was what the participant would receive in return for sharing their time and insights with the researcher (Sewell 2008:3). The researcher did not make

promises, such as giving copies of reports to the participants; if those were made, those promises were to be kept.

3.9 DATA ANALYSIS

Polit and Beck (2008:716) define data analysis as, “a systematic organisation and synthesis of research data”. Data analysis involves categorising, ordering, manipulating and summarising the information and describing it in meaningful terms (Brink 2009:170). Data were categorised and reduced in order to give meaning to it. Data analysis was done at the same time as data collection.

The audiotape interviews were listened to repeatedly to give backing to hand-written notes. The data were transcribed word for word from the audiotape. All responses were read over and over again to gain a sense of their meaning. The interviews were conducted in English. During this process, key phrases were pointed out and communication and feelings expressed by the respondents were observed.

The researcher used the process of bracketing and remained neutral by setting aside previous knowledge and beliefs about the phenomenon under investigation (Speziale & Carpenter 2007:80). Bracketing assisted the researcher not making judgements about what one has heard or observed; and remaining open to data as they are revealed. The transcripts were proof read and the information was sorted into categories to form a story (Creswell 1994:153). The interviews were analysed and themes were established. The transcribed interviews were handed to an expert in the field of qualitative research for further encoding. Themes were then discussed with the private encoder in order to reach consensus. The data analysis process was guided by Tesh's steps (1990).

Cresswell (1994:155) outlines the steps as follows:-

- Getting a sense of the whole by reading through all the transcriptions carefully and jotting down ideas.
- Picking the most interesting interview and considering its content.
- Categorising topics as major, unique and “leftovers” abbreviating the topics as codes next to the appropriate segments of the text, and then trying out this

preliminary organising schemes to see whether new categories and codes emerge.

- Finding the most descriptive wording for the topics and turning them into categories and grouping topics that relate to each other in order to reduce the total list of categories.
- Make a final decision on the abbreviation of each category and placing codes in alphabetic manner.
- Assembling the data belonging to each category in one place and performing preliminary analysis.

Field notes were developed by transforming shorthand into narrative and elaborating on non-verbal observations made during the interviews.

3.9.1 TRUSTWORTHINESS

In qualitative research, trustworthiness is the measure that is applied in the place of validity and reliability (Denzin & Lincoln 2000:84). Another approach to clarify the idea of objectivity as it is manifested in qualitative research is found in the significant work of Guba (cited in Krefting 1991:215). Rigor in qualitative research is demonstrated through the researcher's attention to and confirmation of information discovered. The goal of rigor in qualitative research is to accurately represent the experiences of participants in a study.

There are different terms to describe the process that contribute to rigor in qualitative research. Speziale & Carpenter (2007:48-52) and Lincoln & Guba (1985) identified the following terms that describe operational techniques supporting the rigor of work: credibility; dependability; confirmability and transferability. For the purpose of this study, the researcher applied the criteria as described by Lincoln and Guba (1995).

3.9.2 CREDIBILITY/ TRUTH VALUE

Credibility refers to whether the research was conducted in such a manner so as to ensure that data gathered and emerging themes were accurately identified and described (Speziale & Carpenter 2007). To achieve credibility of the data, the interviewer verified the collected data, as well as the conclusions drawn from the information collected during interviews with the participants to ensure that the interpretations were correct. Member checking with the participants can be carried out in an ongoing way as data are being collected (Polit & Beck 2008). This was done through deliberate probing to ensure that interviewers understood participants' meanings. The interviews were audio taped to capture the accurate responses of the participants. The transcribed data were checked against the audio tapes from time to time for accuracy.

Findings derived from the living experiences of human beings and how participants perceive it, give rise to truth value. The strategy to ensure truth value is credibility (Krefting, 1991:215). De Vos et al. (2005) state that, "credibility is the alternative to internal validity, in which the goal is to demonstrate that the inquiry is conducted in such a manner as to ensure that the subject was accurately identified and described".

According to Babbie and Mouton (2009:277), credibility is achieved by prolonged engagement, persistent observation, referential adequacy, peer debriefing as well as member checks. This is described as a criterion referring to confidence in the truth of the data. In this study findings were mutually established between the researcher and the participants.

Accuracy was maintained throughout the study by making use of member checks and allowing the participants who provided the information to check both the data and the interpretation (Babbie & Mouton 2009: 277). The supervisor was contacted from time to time as the study progressed to facilitate the process and the results of the study. The participants were also given in-depth explanations regarding the study in question so as to enable them to answer appropriately when responding to the questions that were asked.

3.9.3 CONSISTENCY/DEPENDABILITY

According to Polit and Beck (2008), dependability is referred to as the stability (reliability) of the data overtime and over conditions. The dependability question is, "Would the findings of an inquiry be repeated if it were replicated with the same participants in the same context?" Credibility cannot be achieved in the absence of dependability, just as validity in quantitative research cannot be attained in the absence of reliability. In this study, the transcribed data recorded during interviews were verified by the participants themselves. The data were verified for authenticity and accuracy by recording the actual data during interviews. The analysis of the data was further verified by two supervisors of the research project and an expert in qualitative research.

Babbie and Mouton (2009:277) describe dependability, "as the extent to which the findings of the study would be consistent if the enquiry were replicated with the same subjects in a similar context". Prolonged engagement with the participants would increase the dependability of the results. The researcher conducted a pilot study and interviewed several participants until saturation was reached and the same themes started to appear in the data.

3.9.4 CONFIRMABILITY/ NEUTRALITY

Confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator's interpretation and the actual evidence (Brink 2009:119). Babbie & Mouton (2009:277), further outline it as, "the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher". The researcher sought confirmability by giving an accurate interpretation of data which reflected that the data had been obtained from the respondents during data collection (Polit & Hungler 1997).

According to Guba and Lincoln (1995), confirmability describes the objectivity of the process of research and the findings which are supported by the data that are collected. In this study confirmability was promoted by using a tape recorder to

record the interviews and transcribing the information provided by the participants. The initial coding of the data was done by the researcher. Collected data were shared with the supervisor, as well as the co-supervisor. The researcher remained neutral; her perspectives and motivations did not have an impact on the study. A meeting was held with the independent coder to compare and verify findings. The supervisor went through transcriptions to verify the conclusions; interpretations and recommendations.

3.9.5 TRANSFERABILITY

Transferability refers to the probability that the study is applicable to others in similar situations, and has also been labelled “fittingness” (Speziale & Carpenter 2007:98). These authors describe it as essential to the generalisability of the data, that is, the extent to which the findings can be transferred to or be applicable to other contexts. A qualitative study does not strive for generalisability.

Babbie and Mouton (2009:277) refer to transferability as, “the extent to which the findings can be applied in other contexts or with other respondents”. The researcher provided an in-depth description of the purpose of qualitative research as used. This allowed the researcher to present and describe data in such a manner that another person could compare the data to the findings of other students and enable the person to transfer the results to other settings. Detailed descriptions of the setting and the context of research have been provided to enhance transferability.

3.10 CONCLUSION

In Chapter 3, the focus has been on the research design which guided the collection and analysis of data, on trustworthiness, and on ethical issues in research. How the data were categorised for analysis, is highlighted. Chapter 4 is focused on data analysis and a discussion of the findings

CHAPTER 4

DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The research design and method of data collection were described in Chapter 3. The present chapter presents the findings of the research which were obtained through content analysis of the data that were collected. This also includes the demographic data of the participants and the themes that emerged.

The analysis of data followed Tesch's eight steps of data analysis as discussed in Chapter 3. The analysis process was further guided by the responses to the two objectives of the study, which were (1) to explore the professional nurse's perceptions regarding integration of mental health services into primary health services at Buffalo City clinics in East London; and (2) to develop suggestions that could be adopted to improve the integration of mental health services into primary health care.

The themes, categories and subcategories presented in this chapter emerged from the phrases with the "units of meaning" obtained from the statements in the description of the experiences of the participants. The themes that were identified were derived from the data that were collected. It included relevant quotations from the participants.

4.2 DEMOGRAPHIC DATA

The study included a total of fourteen (14) participants. These were both females and males who worked at Buffalo City clinics. Their ages ranged between 30 and 60 years old. The researcher conducted several interviews with different professional nurses allocated to different clinics.

4.3 THEMES THAT EMERGED

Three main themes emerged from data analysis: (1) Barriers to integration of mental health services into Primary Health Care; (2) Failure to implement integration of mental health services into Primary Health Care; (3) Mechanisms to facilitate integration of mental health services into Primary Health Care.

The themes were further classified into categories and subcategories as indicated in Table 4.1.



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Table 4.1. Themes, categories and subcategories regarding investigation of integration of mental health services into Primary Health Care

MAIN THEMES	CATEGORIES	SUB-CATEGORIES
1. Barriers to integration of mental health services into Primary Health Care	Lack of mainstreaming of health care services	<ul style="list-style-type: none"> • Separate queues • Separate days • Different cards • Separate room due to lack of space
	Inaccessibility	<ul style="list-style-type: none"> • No transport • No home visits conducted
	Lack of confidentiality	<ul style="list-style-type: none"> • Lack of privacy • Lack of dignity • Disrespect
2. Failure to implement integration of mental health services into Primary health care	Patient's preferences	<ul style="list-style-type: none"> • To come once a month • Fear to walk alone
	Lack of resources	<ul style="list-style-type: none"> • Human, Material • Poor infrastructure • Lack of facilities • No transport to conduct home visits
	Lack of supervision and guidance	<ul style="list-style-type: none"> • Incompetence • Less number of psychiatric trained nurses • No protocols • No policies
3. Mechanisms in place to facilitate integration of Mental health services into Primary Health Care	No discrimination	<ul style="list-style-type: none"> • Same queue and join mainstream of care
	Accessibility	<ul style="list-style-type: none"> • Transport to conduct home visits
	Competence	<ul style="list-style-type: none"> • Provision of training and of skills.
	Supermarket approach	<ul style="list-style-type: none"> • Services offered on a daily basis • Protocols and guidelines be supplied to the clinics

4.4 DISCUSSION AND PRESENTATION OF THEMES

The main themes, categories and subcategories are discussed in this chapter. The following discussion of results is supported by direct quotes from the participants, as well as the literature control. Although the professional nurses had different experiences, they reported some commonalities which formed the main themes for the study. These are discussed in detail.

4.4.1 BARRIERS TO INTEGRATION OF MENTAL HEALTH SERVICES INTO PRIMARY HEALTH CARE

This is one of the main themes identified during data analysis. This theme is supported by the identified categories and sub-categories discussed below.

Barriers to integration are related to lack of mainstreaming of health care services, inaccessibility of services as well as lack of confidentiality. Lack of mainstream of services is characterised by separate queues, separate days for services to psychiatric patients as well as lack of space. Inaccessibility of services is characterised by no transport available to conduct home visits. Lack of confidentiality is characterised by lack of privacy, lack of dignity as well as disrespect. A barrier is referred as an obstacle that can restrain or block something (Mosby's Pocket Dictionary 2010:145). A hindrance to perform health service activities, for example integration of mental health services into Primary Health Care, is regarded as a barrier (Uys & Middleton 2007:45).

According to the study, a barrier is regarded as resistance shown by professional nurses to carry out activities of integrating mental health services into PHC, as required by the integration policy of (1997). Professional nurses experienced challenges with regard to integration of mental health services into Primary Health Care, such as lack of space, shortage of transport, lack of supervision and guidance and unavailability of protocols and policies, hence they displayed resistance.

Lack of mainstream health care services

Mental health services are provided in isolation from the general mainstream of health care at the clinics, patients are attended by separate psychiatric nurses who visit these clinics once a week and at other clinics these services do not exist.

It emerged from the findings of this study that the personnel working at the primary health care settings were supposed to integrate mental health services into primary health care. PHC is an approach which has the capability of achieving both the millennium development goals and the wider goals of universal access to health through acceptable, accessible, appropriate and affordable health care (Walley, Lawn, Tinker, Francisco, Chopra, Ruda, Bhutta & Black 2008).

The primary health care package for South Africa mentions that the clinic should render comprehensive integrated primary health services, and this requires that clinics find suitable strategies that would make attainment of comprehensive health service standards feasible for their own particular context (Department of Health, 2001a).

The Eastern Cape Department of Health (1997) issued a memorandum to District Health Services stating that separate community psychiatric services should be phased out and psychiatric services had to become part of integrated mental health care services with a clear referral system. This seems to have been ignored, as community psychiatric services were still offered on certain days at some of the clinics, and continued to be rendered in isolation from the general main stream of health care services at community health centres in Buffalo City.

At some clinics, one or two professional nurses are allocated to attend to psychiatric patients. The clients there are provided with different seats and do not follow the same queue or join the mainstream of general patients. At some clinics they are allowed to join the queue, but are directed to a mental health unit on completion of the observations, and are not allowed to wait for any available professional nurse.

Participants:

“On arrival at the clinic, psychiatric patients do not queue with other patients; they have their own seats so that they cannot be disturbed and we attend to them immediately because they panic when they wait for a long time”.

“At the clinic I am the one who is allocated to take care of mental health services and if I’m not here my colleagues that is other professional nurses do assist with providing services for psychiatric patients, even the clients themselves when they come here they ask where is my nurse” [referring to the participant].

Lack of space for providing mental health services

It emerged from the findings of this study that the participants experienced lack of space at the clinics and inability to provide mental health services on a daily basis. Participants find it difficult to render counselling services due to limited space at the clinics. Lack of a separate room may inhibit some patients from asking questions. Privacy is the key in counselling and therefore a separate room is recommended (WHO 2002:52-54). With this view in mind, more infrastructures are needed to ensure privacy when providing mental health services.

Data revealed that providing mental health services together with all other programmes every day poses a challenge as the clinics are small. The participants would rather these services are offered once a month. There is no suitable space for counselling in some clinics as there are many health care programmes offered at the clinics. At some clinics clients are given different clinic cards as a means of identifying them from general health clients.

Participants:

“We are sharing consultation room at this clinic and it is difficult to offer all the programmes every day at this clinic, this clinic is small and is always full, there is a big shortage of staff”.

“The structure of the clinic is small. No safety for infection control due to patients suffering from MDR; there are no fern extractors. So ...Pregnant women can get infection. Attending to minor ailments, children for immunisation, they can get cross infection”.

Inaccessibility of mental health services

Inaccessibility emerged as a sub-theme, as data revealed that some clinics lack separate rooms for conducting counselling and assessing a patient in privacy. Accessibility is defined as the ease in which services which can be entered or reached (Thorncroft & Szmukler 2001:160). Psychiatric patients should be able to reach services where and when they are needed.

The argument in favour of integration was that mental health care would be more accessible and available if integrated into primary health care (Mwape et al. 2011:5). The same authors indicate that psychiatric patients would be able to receive care within easy reach and the cost of transport to mental institutions would then be reduced.

Participants:

“This clinic is very busy and always full and sometimes we use tearoom, duty room and labour ward for consultation when it is full and there is a shortage of vehicles to conduct home visits.”

In Mkize and Moketsi (2011:108), it is stated that a shortage of vehicles means that mental health workers are experiencing difficulty in visiting patients at home and are unable to transfer patients between the clinics and the hospital. When mental health services become more accessible and available, stigmatisation at the primary health care level is reduced. The opportunities for prevention, both primary and secondary, would thus be greater with integration.

Lack of confidentiality against psychiatric patients

Lack of confidentiality emerged as a sub-theme, as psychiatric clients are treated in the same room and in the presence of other patients. They have no option but to reveal their private information in front of other patients. Professional nurses have to share consultation rooms due to lack of space.

Confidentiality means keeping information secret. Pera and Van Tonder (2002:50) mention that the patient has the right to believe that confidential information will not be conveyed to others without the patient's permission.

Participants:

"We are sharing consultation rooms, and we are forced to say things in front of other patients as there is no privacy and no confidentiality".

Psychiatric patients are given a certain day for collection of their medication at almost all the clinics, including community health centres. This is perceived as a human rights violation and is reinforcing the stigma on mental illness. The stigma attached to mental illness is another barrier in the attempt to shift the burden of care for mental illness (McCabe & Macnee 2002:263-278).

According to Pogoloff (2004:116-119), nursing personnel should respect and guard confidentiality at all times. They should not discuss any information in front of others as this may open the door to mistrust.

Participants:

"We are sharing one consultation room amongst the 3 of us, and it is difficult to ensure privacy. We depend on clients' request when they say they want to talk to one of us, it is then that we look for a provisional space to work; as we have mention[ed]... there are lots of programmes taking place here space is limited."

According to the Mental Health Care Act (Act No.17.of 2002), psychiatric patients have a right not to be discriminated against due to their disability. Nursing in South Africa is largely governed by the South African Nursing Council (SANC). As a

professional legal body that ensures quality standards with regard to the rendering of health care services by all (Act No. 33. of 2005), the SANC could set out regulations pertaining to the conduct and scope of practice of professional nurses. Professional confidentiality is an important aspect of professional conduct and is supported by the Patient's Rights Charter as well (Department of Health 1999:3).

Lack of privacy

Pera and Van Tonder (2002:37) stress that patients have a right to their private affairs, and privacy is the healthcare professionals' obligation to protect the patients from undesirable interaction. It emerged from the findings that patient's rights were violated when they were forced to share their private information in the presence of other patients and other professionals. Psychiatric patients moreover have a right to respect and to be treated like anyone else.

With the above-mentioned view in mind, the principle of ethical consideration regarding maintaining privacy and confidentiality has been ignored by the system prevailing at the clinics and community health centres. Privacy and confidentiality are not guaranteed for victims of trauma, rape, alcoholism, and abuse and the result is that it is a challenge for any counselling or psychotherapy to take place (Mkize & Moketsi 2011:108).

Participants:

"When dealing with psychiatric patients, you need 30-45 minutes for a client to open up to you and moreover privacy is important, but some of the clinics are built of prefab which you can easily hear what is being said on the other side that poses a challenge when dealing with psychiatric patients."

"You know ma'am (referring to researcher) at first it was quite embarrassing when one is busy counselling a psychiatric patient on this side and the other is counselling and testing for HIV/AIDS on the other side".

"We are forced to say things in front of the other. It is a disgrace ma'am. There is no privacy and no confidentiality, there is no partition and you have to give results in

front of other patients in the same room. It is no longer embarrassing anymore because there is nothing we can do about it.”

It has been shown that integration has the potential to minimise stigma attached to mental illness and promote human rights for people suffering from mental illness if mental health services are rendered at primary health institutions (Funk et al. 2008: 5-8). Mwape et al. (2011:5) reiterates that people would start to regard mental illness as a disease like any other because clients would be treated at the same facility as any other patients.

4.4.2 FAILURE TO IMPLEMENT INTEGRATION OF MENTAL HEALTH SERVICES INTO PRIMARY HEALTH CARE

Failure to implement integration of mental health services into Primary Health Care are related to patient's preferences, lack of resources and lack of supervision and guidance. Patients' preferences are characterised by, clients wishing to come to the clinics once a month as they prefer to wait for an escort because they fear to walk alone. Lack of resources are characterised by shortage of human and material resources, poor infrastructure, lack of facilities and no transport to conduct home visits. Lack of supervision and guidance is characterised by incompetence of staff, less number of psychiatric trained nurses, no protocols nor policies.

Failure to implement integration of mental health services into primary health care emerged as a theme from the data. Professional nurses experience difficulty in rendering integrated mental health services due to the patient's preferences, lack of resources and lack of supervision and guidance.

Merriam-Webster (2013) defines failure as, “lack of success”. In this study failure means inability to implement integration of mental health services into Primary Health Care as required by integration policy. White Paper for the transformation of the Health System in South Africa makes reference to a comprehensive service which includes the integration of mental health care into the primary health care system (Petersen 2000:321). Data revealed that provision of mental health services is regarded as supplying repeats of chronic medication for psychiatric patients at the

Primary Health Care settings, a situation misinterpreted as integration of mental health services into PHC.

Patients' preferences

It emerged from the data that psychiatric patients prefer to come to the clinic once a week or once a month because they fear walking alone; some of them walk long distances to reach the clinics so they prefer to wait for relatives to escort them. *Mwape et al. (2010:6)* state that many people travel long distances, and incur great costs to seek care at a mental hospital, therefore mental health services would be more accessible and available if integrated into primary health care.

Participants:

...“we divided the patients to come on Monday, Tuesday, Wednesday, Thursday to remove stigma, but patients complained that they are scared to walk alone because they walk instead of driv[e]”.

“When psychiatric patients come to the clinic they register at same are[a] as other patients and they normally ask where my nurse is; we give them priority when they are there - we start with them because they are very impatient.”

Lack of resources

Resources play a major role in the implementation of integrated mental health services. Professional nurses indicated that they experience difficulties in rendering integrated mental health services because of the shortage of resources. The three subcategories that were identified, namely shortage of human resources, lack of material resources and inadequate training and skills are discussed below.

Shortage of human resources

The shortage of human resources is a subcategory that emerged from the participants. This was evidenced by the allocation of one professional nurse to render integrated mental health services per clinic and community health centre. The role of conducting home visits is reserved for health care givers due to a shortage of staff as

well as a shortage of cars. The shortage of staff results in professional nurses being overworked. This results in tiredness and job dissatisfaction. .

Participants:

"We cannot do home visits due to shortage of staff, moreover this clinic is always full."

"No home visits are being done to see what has happened to patients who no longer come to collect their medication from the clinic; as a result patients relapse"

One of the codes of ethics for nurses is that the nurse promotes, advocates for and strives for the health, safety and rights of the patients (Sullivan & Decker 2005:22-25). These authors further state that nurses can be held liable for acts and omissions. Inadequate staff is not an excuse for negligent acts (Sullivan & Decker 2005:24).

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As found in this study, the time spent on assessment and treatment, including health education and counselling, is more or less 45 minutes. There is not enough staff to implement this and it is evident in that only secondary-level care, which means issuing medication only during return visits of the clients, can be provided. This indicates that in as much as nurses are willing to render services as expected, they are limited by the shortage of staff. .

Lack of material resources

Lack of material resources are related to poor infrastructure. Poor infrastructure is an indicative of lack material resources. Sufficient resources are a prerequisite for effective mental health care (WHO and WONGA 2007:6). Suitable buildings for rendering integrated mental health services are needed at the clinics.

Participants:

"This clinic is very small and there is not enough space to accommodate the services rendered at the clinic, and the biggest challenge is transport; we are unable to

conduct home visits, we have only one car that we alternate using it that is why we offer these services once a month.”

Poor infrastructure

Poor infrastructure is related to the failure of organisations to assess local health care needs in order to clearly define new services (Bryant-Lukosius & DiCenso 2004). Professional nurses experienced an increase in the number of patients visiting the clinics after the introduction of free health services (WHO 2003-2007:14). Petersen (2000) further states that the free health system in South Africa has increased access, and as a result the capacity of the health care system to provide comprehensive primary health system has been compromised. Furthermore professional nurses are expected to provide comprehensive primary health care and face the increased patients' numbers.

Participants:

“The clinic is always full, and there are many other programmes that are taking place here on a daily basis, some they overlap each other, so if I'm busy with psychiatric services, others are busy with TB, mother and child, immunisations and chronics.”

Wand and White (2007) state that health care services are required to be increasingly flexible and open to new approaches to meet changing demands. The authors further mention that health care services must adjust and expand as new challenges are presented.

Participants:

“There I'm sharing with a consulting room with another professional nurse who is doing another programme, when they are called into the consulting room, we took their book and ask if they have problems, do observations and also check for side effects.”

Lack of supervision and guidance

Lack of supervision and guidance is also characteristic of failure to implement integration of mental health services into Primary health Care. Lack of supervision is due to incompetence, less number of psychiatric trained nurses, absence of protocols and policies.

Lack of supervision and support lowers productivity, staff morale and quality care and it contributes to the brain drain (Lehmann & Saunders 2002:133). Adali & Priami (2002:20) found that lack of support from a supervisor causes burnout. Burnout has become a serious problem, as supervisors rarely visit the clinics.

Nurses need adequate time to cater for people with mental disorders and they need support and supervision to enable them to undertake their tasks confidently.

The mental health professional should be available to discuss difficulties in management and to provide advice on interventions to be carried out by primary care staff, particularly with nurses (WHO & WONGA 2008). In some clinics there is neither supervision nor follow up.

Participants:

"There is difficulty in providing comprehensive health care approach due to unavailability of policies and guidelines and moreover there is no direction from the managers or supervisors about this integration".

The participants were keen to talk about their service delivery experiences and were appreciative of the fact that someone was listening to their concerns and comments.

Participants:

"... Ma'am (referring to the interviewer), I am so happy that I have the opportunity to participate in this interview; it has broaden out my mind. Some of the things you were talking about we didn't know as there is nobody who is listening or explaining things to us instead they are just concerned about collecting statistics and to present it to Bisho...."

Supervision of primary health care staff is an important issue for a sustainable integration (WHO & WONGA 2007:7). There was no assessment done by the managers amongst staff to see who is interested to render psychiatric services because people become productive when they like what they are doing and moreover they were not informed.

Participants:

"This integration of mental health services into primary health care is just been 'thrown into' primary health care services"

The challenge accompanying the integration of mental health services into the primary health care system is that integration is unlikely to be successful if it is characterised by an approach whereby services for serious mental disorders form part of the primary health care system without adequate foresight.

Inadequate training, incompetency and skills

Lack of supervision and guidance is characterised by incompetence which is revealed from data and evidence of inadequate training and skills. WHO & WONGA (2008) state that integration into PHC requires advancement in the training of staff to identify and manage mental disorders. Most of the psychiatric problems go unnoticed at the primary health care facility because professional nurses lack competence.

Participants:

Some professional nurses are not psychiatric trained; they are not even familiar with the new drugs and skills to provide these services and "Nurses at the clinics focus on the known; they are lacking skills for basic screening for hidden psychiatric illnesses." "No psychiatric nurse specialists are available at the clinics".

Dundon, Dollar, Schohn & Lantinga (2011) state that experts can be recruited to assist the local supervisors with hiring and interviewing new providers, training new staff, initiating programme implementation, continued monitoring of programmes and individual provider outcomes In this regard,

No guidelines, policies and protocols supplied at the clinics to guide implementation of integration of mental health services into PHC

Lack of supervision and guidance is characterised by lack of policies and protocols. There are no policies to guide the professional nurses on implementation of integrated mental health services. Professional nurses experience lack of guidance in that they are told to follow the supermarket approach related to implementing integrated mental health services without being shown how to do it; moreover, no protocols or procedures are available at the clinics.

Participants:

"We do not have anyone with advance psychiatry when we have a problem we consult CMH for advice and also no guidelines or protocol to guide our activities. We, as professional nurses experienced difficulty in providing comprehensive care approach due to unavailability of policies and guidelines."

"When a client comes to a clinic, do everything". ..."we are doing now is suitable for our clinic. "There is no actual guide as to how to go about implementing integrated mental health services into primary health care because this integration is new."

4.4.3 MECHANISMS IN PLACE TO FACILITATE INTEGRATION OF MENTAL HEALTH SERVICES INTO PRIMARY HEALTH CARE

Mechanisms in place to facilitate a successful integration of mental health services into PHC emerged as a theme. Implementation of integration of mental health services into PHC is characterised by lack of discrimination of clients, accessibility of services, competent professionals and adoption of the supermarket approach.

Managers give directions with regard to the supermarket approach to be used. Successful integration of mental health services into PHC; is used to treat patients for all the problems in one consultation at a primary care institution. In other words, a client receives care on visiting the clinic without specific days for a special clinic being specified (Vhuromu & Dhavana-Maselesele 2009:61). This is contrary to what is taking place at the Buffalo Urban clinics.

No discrimination in order to facilitate integration of mental health services into PHC

Clients are not discriminated against as they are made to join the same queue and mainstream of other patients. Integration of mental health services and substance abuse into the PHC system enables patients to receive physical and mental health care at the same time during a single visit (Mkize & Moketsi 2011:7).

Data reveal that psychiatric patients attend clinics or community centres on any day, resulting in nurses consulting 5 to 13 clients a day. Data further reveal that patients are allowed to join the same queue as other patients. Clients are also attended to by any available professional nurse. They join the mainstream of care to fetch their medication from the pharmacy. It is only in cases of emergency that professional nurses collect patient's medication from the dispensary.

Drew et al. (2011: 3) states that, "exclusion, marginalisation and discrimination of psychiatric patients in government and official services are regarded as human rights violation".

Participants:

"We don't see it that way – as imposing stigma to mental illness, we have many programmes here, and each one is allocated a day so as mental health services. It's their day and we don't want them to wait too long."

Accessibility to facilitate integration of mental health services into PHC

According to Wally et al. (2008) primary health care is the first level of contact, the closest and the easiest to access for individuals, the family and community within the national health system. Availability of mental health services at the clinics and community health centres is perceived as a mechanism to facilitate integration. Services are accessible as there is transport to conduct home visits.

Participants:

“At the clinic there are many programmes that are offered, like a day for chronics, either than mental health, a day for ante natal clinics and one for immunization, there is also a day for mental health which is once a month.”).

Psychiatric patients will benefit and save the transport costs of accessing mental health care services from the local hospital. If mental health services are integrated into primary health care, healthcare costs are greatly reduced and thus acceptability linked to reduced stigma and easier communication with health care providers (WHO & WONGA 2008).

Participants:

“At the clinic I am the one who is allocated to take care of mental health services and if I’m not here my colleagues, that is other professional nurses, do assist with providing services for psychiatric patients, even the clients themselves when they come here they ask where is my nurse?” (Referring to the participant).

According to Drew et al. (2011:3), denial or inability to access effective mental health services is regarded as human right violation; hence these services are made available at some clinics and community centres in spite of being inadequate.

Participants: *“The presences of a psychiatrist, psychologist and a social worker visits on site improve the accessibility of mental health services at Primary Health Care”.*

Competence, training and accessing psychiatric skill to facilitate integration of mental health services into Primary Health care.

Competence is characteristic of integrated services as professional nurses are trained and are skilled. Competence refers to the ability of a practitioner to integrate the professional attributes including, but not limited to, knowledge, skills, judgement, values and beliefs required to perform as a nurse in all situations and practice settings Nursing Act (Act No.33. of 2005). ”. Professional nurses who are exposed to psychiatry training in order to be able to diagnose hidden psychiatric morbidity.

In Jacoby (2004), training is defined as, “the acquisition of knowledge, skill and competencies as a result of the teaching and vocational practical skills and knowledge that relate to specific useful competency.

Participants:

“Training would assist general nurses to acquire skills to manage psychiatric problems effectively”.

In Mwape *et al.* (2010:8) it is stated that every health worker at the primary health setting or even in the wards should be provided with basic training to assist in exploring the mental health status of the clients who come to the clinic. The authors further state that knowledgeable and skilled staff would help people presenting with mental health problems to reduce the prevalence of mental health problems.

Participants:

“It is not easy to deal with psychiatric patients. One needs to have skills and training in order to deal with psychiatric patients. This integration is really a problem... (shaking the head). Managers need to assess people’s interests because people become productive when they like what they are doing”.

Despite the opinions voiced by Mkize & Moketsi (2011), even in instances where PHC nurses understand the holistic conception of illness, as incorporating physical, spiritual and psychosocial well-being, this understanding is not translated into practice because nurses do not feel empowered enough to deal with problems of a psychological nature.

Utilisation of the supermarket approach to facilitate integration of mental health services into PHC

Halper (2006) states that supermarket approach is client-oriented and is about provision of all services at the clinic during the time of visit. In Sibiya & Gwele (2009) supermarket approach is described as daily provision of all services to the community. The supermarket strategy combines the various special clinic visits into one (Vhuromu & Dhavana-Maselesele 2009: 64). This approach is regarded as daily provision of care during a single visit and in one room, and combining various special clinics into one visit.

The supermarket strategy of rendering mental health services emerged as a sub-category. Data revealed that managers instructed professional nurses to utilise the supermarket approach as a strategy to guide their activities, but were not shown how to implement it. In Sibiyá & Gwele (2009:31) it is recommended that daily provision of services should be offered in a supermarket approach manner, yet implementation of this approach is not described.

Data revealed that nurses explored ways of using the supermarket approach to improve their own productivity, even though mental health services are not offered on a daily basis. The supermarket approach promotes integration of mental health services into PHC as services are offered on a daily basis and guidelines are made available to the clinics. In relation to the aforementioned statement, treating patients as they consult is another supermarket strategy.

Participants:

"They say at the clinic we must be just like a cashier, when one comes to a consulting room offer services, but they don't stipulate how that is supposed to be done".

"When a client comes to a clinic, do everything. Nothing is said about the day and who must be one to be involved".

"Managers mention that patients should receive medication in one room and mental health services to be provided on a daily basis, but that is difficult here because medication is kept in one room under lock and key. There is no provision made for other rooms and patients still go and fetch their medication from dispensary either than psychiatric medication".

"We do not have a special day for them, they come on a daily basis and each is given a return date that is suitable for them if I'm not here some other professional nurses are helping".

4.4 SUMMARY

This chapter has presented the analysis and discussion of the study's findings. Results show that integration of mental health services into primary health care is far from ideal as professional nurses experience several problems. These problems are the following namely:

One or two professional nurse are allocated to take care of psychiatric patients; a consultation room without a partition is shared between two professional nurses, thus violating the human rights of psychiatric patients; overcrowding of the clinics so much so that several programmes are taking place at the same time every day and some are overlapping. Inadequate guidance and supervision experienced. Poor supervision in that there is no direction with regard to how to integrate mental health services into primary health care, inability to provide comprehensive care due to lack of skills and shortage of staff.

In this chapter, results have shown that positive integration is possible through the adoption of the supermarket approach with services being rendered any day by the available competent nurses. This involves fair and equal treatment of all patients despite the nature of their illnesses.

4.5 CONCLUSION

This chapter dealt with the interpretation of themes that were identified and included direct quotations from the interviews with the participants. Chapter 5 provides a discussion of the conclusions, limitations and recommendations pertaining to this study.

CHAPTER 5

DISCUSSION OF RESULTS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The analysis of the data, identification and discussion of themes related to the experiences of the mental health care professional nurses with regard to the integration of mental health care services into primary health care at the Buffalo city clinics were presented in Chapter 4. This chapter focuses on a discussion of results, conclusions and recommendations in response to the set objectives of this study, which were to:

- Explore factors influencing lack of integration of mental health care services with general health care services by Professional Nurses at the Buffalo City Clinics, and
- Develop suggestions for integration.

5.2 DISCUSSION OF FINDINGS

The findings arose from verbal comments made by professional nurses on their perceptions on factors influencing lack of integration of mental health services into primary health care and possible suggestions for integration of mental health services into primary health care, which was the focus of this study.

The results revealed that there are obstacles which results in failure to implement the integration of mental health services at the Buffalo City Clinics and the Health Centres. For purposes of this discussion, the obstacles to integration are grouped according to those which are service related, patient related and resource related. The services seem not to be mainstreamed, are inaccessible and are rendered in a manner that violate patient's rights as there is neither privacy nor confidentiality in the manner in which the services are rendered. The patient related obstacles seem to indicate patients themselves prefer to come to the clinic on specific days and prefer to be served by nurses of their own choice. There seem to be lack of material,

financial and human resources at the Buffalo City Clinics. Lack of human resource seem to be a factor associated with shortage of staff, lack of knowledge and skills of non psychiatrically trained staff, lack of specialist psychiatric nurses and lack of supervision and guidance of junior staff members by management..

The results also revealed that there are certain strategies that have a potential to promote integration of services, such as, putting mechanisms to make the services more accessible, empowering all the nurses with skills and knowledge in mental health/psychiatric nursing. Such initiatives would promote the adoption of the often recommended supermarket approach in rendering services to the patients. Of importance is that the recommended strategies as discussed below could form the basis of protocols for integration of services.

Lack of mainstreaming of services

Exclusion of mental health clients from the general mainstream seem not to be regarded as a violation of their rights as individuals or as causing stigmatisation to mental illness. It seems that lack of mainstreaming is not an intentional discrimination. The reason provided for lack of mainstreaming is that the clinics provide several programmes in a day. Setting aside a day for mentally ill patients is intended for them to get help quicker

The health care workers have a responsibility to fight stigma and discrimination against psychiatric patients; thus serving as advocates for them. At Buffalo City, a specialised psychiatric team from district services remains the sole agent visiting and providing mental health services to some of the clinics at certain intervals which is once a month to areas that do not have such services. This team entails a psychiatrist, psychiatric trained nurses and social workers. The team is based at a psychiatric hospital and psychiatric trained nurses are positioned at community district services but remain part of the Buffalo City primary health services. Consistent with the findings of this study, Sokhela (1998:230) states that, in some settings, psychiatric services are rendered by a specialised psychiatric team, which visits primary health care clinics at specific intervals.

Most of the clinics at Buffalo City mainly provide secondary-level care which involves supplying psychiatric medication, assessing the efficacy of medication and referring

clients to a hospital, should the need arise. The social worker may intervene by organising disability grants for the patients. No case finding, rehabilitation or primary prevention strategies are offered due to the shortage of staff, for example

Participants:

"We perform shortcuts in care as a result of the shortage of staff, because of being overworked as clinics are always full".

Inaccessibility of services

Inaccessibility of services happened because of unavailability of mental health services at some clinics at Buffalo City. Data revealed that professional nurses had transport problems, thus home visits cannot be conducted to trace defaulters of treatment.

Lack of confidentiality for psychiatric patients

In Monjok, Smesny and Essien (2009), discrimination is defined as an aspect of stigma and a form of exclusion, or restriction of expression, marginalisation, or prevention from access to something or services. In Birkman, Sperdip & Smith (2006:157-165) it is stated that patients who are stigmatised and discriminated against tend to relapse. The authors furthermore state that stigma contributes to isolation, loneliness and chronicity.

The World Health Organisation (WHO) (2002) states that all people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhuman treatment and discrimination. Stigma and discrimination are often linked to violations of human rights. WHO (2002) further affirms that it is a right of all people to be free from discrimination.

Goffmann (2009) refers to stigma as a process of devaluing and victimising someone because of an undesirable difference. It is further defined as a powerful means of social control applied by marginalising, excluding and exercising power over individuals who display certain traits. It also has important consequences for the way in which individuals come to see themselves. WONGA and WHO (2007:2) indicate that reduction of stigma is associated with receiving care in primary care

settings and that people with mental illness who are treated in these settings and their families are less probable to experience discrimination within the society.

This study has found that psychiatric patients are discriminated against as they are assigned their own waiting queue and have different colour cards to identify them from other patients, for example,

Participants:

“Ma’am,[referring to the researcher] “we never thought about stigma attached to mental illness when we ask them to form their own queue but we do feel sorry for those who have improved in their condition when they have to queue with those who have relapsed coming to the clinic dirty.”

Lack of supervision and guidance

Kilminster and Folly (2000) define clinical supervision as the provision of monitoring, guidance and feedback on matters of personal and professional development in the context of patient care. Clinical supervision ensures patient/client safety and promotes professional growth. Walsh, Nicholson, Keough, Pridham, Kramer and Jeffrey (2003:33-39) view clinical supervision as an important tool in the development of quality nursing care as it constitutes a process of reflection upon practice, The aim of which is to improve clinical practices and hence to improve patient outcomes. Jiang and Klein (2000) mention that nurse managers/ward sisters can empower the nurses they supervise to initiate changes that will improve patient care. Nurse managers/ward sisters can also improve the working conditions and thus increase the job satisfaction and retention of those they supervise.

Participants:

“This integration was thrown to some of the clinics, to us and the managers just say you have got psychiatry; you are supposed to see psychiatric patients. No assessment was done by the managers amongst the staff to see who is interested to render psychiatric services and we are not well informed about integration.”

The professional nurses experience stress and frustration due to insecurity and confusion caused by sudden changes taking place at the clinics. It seems as if the

integration policy was just announced to them as no one, for an example amongst the supervisors or managers came to discuss or demonstrate how integration was supposed to be handled. It was only presented on paper in the form of policy and verbally, that is not actually demonstrated the way it should be done.

Shortage of resources

Shortage of resources is explained as demand far exceeding the supply. It involves the rule of supply and demand where supplies are not enough (Moyo 2012). At the Buffalo City there seems to be a shortage of human as well as material resources, which includes shortage of staff as well as transport to conduct home visits. Ashton and Jarvis (2011) refer to shortages as both of supply and demand. Material resources such as buildings and infrastructure that are inadequate or not immediately available on commencement of each year affect the ability of professional nurses to perform well. There is not enough space available at the clinics to cater for extra programmes on a daily basis as the existing general health care programmes are evenly spread out to fit the weekdays. Nurses are sharing consultation rooms, which leads to lack of privacy, thus violating psychiatric patients' human rights. On busy clinic days, nurses go as far as utilising the tea room and duty room as consultation rooms. Besides the shortage of consultation rooms, there is also shortage of cars to enable them to conduct home visits.

The integrated mental health service is to be provided by the same provider in the same consulting room (*Tint et al. 2000:15*). The managers proposed the same, indicating that patients had to receive medication and mental health services in the same room and that this should to be available on a daily basis. This posed a very great challenge, as professional nurses emphasised the shortage of space at these clinics.

Participants:

"It is difficult here because medication is kept in one room under lock and key. There is no provision made for other rooms. The managers say patients must receive medication in one room and mental health services to be given on a daily basis, but that is difficult here because medication is kept in one room under lock and key.

There is no provision made for other rooms and patients still go and fetch their medication from dispensary either than psychiatric medication”.

Shortage of human resources

In this case shortage of nurses is not merely a shortage of individuals with nursing qualifications, but it is also shortage of nurses willing to work under the present conditions. In Buchanan and Aiken (2010:3262-3268) the main causes of nursing shortages are identified as inadequate workforce planning and allocation mechanisms; resource constraints; under supply of new staff; poor recruitment; return and retention policies; poor incentive structures; and inappropriate support of employees.

Shortage of human resources seems to be related to inadequate training and lack of skills. In this study, shortage of human resources means shortage of psychiatric trained personnel with advanced psychiatric nursing as a factor in lack of integration of mental health care services. Most of the mental health problems are likely to go unnoticed as a result of inadequate knowledge and skills in identifying and treating mental problems. This view is confirmed by Petersen and Swartz (2002) who found that some nurses at the primary health care level focus on the clinical examination of the body; they do not take into consideration the illness account, which is the patient's subjective experience of the distress.

Inadequate training and lack of competency and skills

Lack of supervision and guidance is characterised by incompetence which is evidence of inadequate training and skill. Competence refers to the ability of a practitioner to integrate the professional attributes including, but not limited to, knowledge, skills, judgement, values and beliefs required to perform as a nurse in all situations and practice settings (Nursing Act, 2005, (Act No.33 of 2005).

According to Jacoby (2004), training is defined as the acquisition of knowledge, skill and competencies as a result of the teaching and vocational practical skills and knowledge that relate to specific useful competency. The author further mentions that training has the specific goal of improving one's capability, capacity and performance and people within many professions and occupations refer to this kind of training as professional development.

There seems to be a shortfall in skills related to counselling and diagnosing of psychiatric conditions amongst other professional nurses at the primary health care clinics. Such nurses refer clients to psychiatric nurses whenever there is something related to mental illness. This behaviour can compromise the integration of services. Post-training mentorship and clinical support can improve generalists willingness to implement new skills therefore mental health service providers should avail themselves to provide this support and invest in capacity building (Kleintjies, Lund & Fisher 2010:138).

To promote the integration of services, professional nurses in primary health care settings need to be trained in basic assessment and screening of hidden psychiatric problems as well as counselling skills. Training would therefore equip general professional nurses with necessary skills to manage mental disorders appropriately.

Patel, Flisher and McGorry (2007) state that primary care workers, school counsellors, community social workers and juvenile police workers should be included in generalist training. These authors further mention that post training mentorship and clinical support can improve generalist willingness to implement new skills. This study revealed that some of the staff members at the primary health care setting have not received psychiatric training; hence post generalist training would be relevant to some professional nurses.

Professional nurses appeared to understand the importance of using a holistic framework to intervene in mental health problems. This is equivalent to comprehensive health care that includes all levels of care at primary health care clinics but they expressed a feeling of inadequacy and lack of skills to provide holistic care.

Participants:

"We just issue repeat medication for psychiatric patients and some of the professional nurses are not even familiar with the new medication".

Integration entails that both the specialist mental healthcare nurse and the generalist PHC nurse will be expected to undertake roles for which they have not been adequately trained, and hence they feel insecure. This may lead to a loss of professional identity and job insecurity. Further, despite the fact that one of the goals

of integrating mental health care into the PHC system was to reduce the stigma associated with mental illness, this ideal goal has not been achieved. It has been reported that, despite the integration, non-psychiatric nurses may opt to leave the tiring task of attending to mentally ill patients entirely to the psychiatric nurses, who, in turn, feel stigmatised by other staff due to the nature of their work.

This view is supported by Peterson (2000: 321-334), who states that, although primary health care nurses form the backbone of the primary health care settings, their training has not oriented them towards the provision of comprehensive health care. Their training in tertiary academic centres teaches them to take instructions from doctors; it does not empower the nurses with the necessary skills to work independently. Personnel only identify and treat the presenting physical complaints and the holistic belief of nursing care has, in South Africa, been subsumed by the biomedical model approach. The author recommends that reorientation programmes for nurses are necessary in facilitating comprehensive health care (Peterson 2000:321-334).

No policies and protocols available to guide implementation of integration of mental health care into PHC

In Buffalo City, lack of integration is associated with lack of guidance by supervisors as well as supervision of activities. Professional nurses revealed inability to implement the integration of mental health services into primary health care due to lack of guidance from the supervisors, as well as the non-availability of protocols to guide their activities. There seem to be a lack of policies, procedures and protocols to direct the professional nurse's activities. Lack of mental health policy and legislation to direct mental health programmes and services is of great concern in Africa and South East Asia, as it impedes direction of health workers as to how services should be organised (Mari, Screen lives & Saxena 2007:83-88).

Accessibility

Accessibility is defined as services which can be entered or reached (Thorncroft & Szmukler 2001:160). These authors further state that community psychiatric services should be able to reach and provide services where and when they are needed.

Moreover, in Petersen (2000: 321-324) it stated that free health services in South Africa had increased access and in acceleration to increase access to mental health care through integration into PHC professional nurses are faced with increased numbers and lack of support, this has led to a demoralised workforce.

Utilisation of the supermarket approach to facilitate integration of mental health services into PHC

The factors which seem to promote integration of mental health services are related to the adoption of the supermarket approach, is described as the daily rendering of all the services to the community. Although this approach is recommended, there are no clear guidelines for how these services should be offered.

Pillay and Asia (1999) state that managers describe the supermarket approach as the daily provision of all the services to the community, but not specify how these services can be obtained. The professional nurses therefore ensure that the services are available and they choose their own way of providing these services.

In Sibiya & Gwele (2009:31) recommend that daily provision of services should be done with a supermarket approach, yet implementation of this approach is not described. Availability of all the services under one roof seems to be conceptualised as integration by the participants, with patients being seen by one allocated professional for the programme and being referred to another professional if there is need for further specialised intervention. The policy of the Department of Health (2001) states that the facility is expected to provide comprehensive integrated services for a minimum of eight hours a day, five days a week.

Most of the clinics at Buffalo City adhere to this requirement, although mental health services are not available at some institutions and are provided once a week due to unavailability of space. It seems that some clinics provide mental health services on a daily basis with an average of clients seen ranging from five to six per day. At such clinics, professional nurses do not offer secondary-level care only, but also offer

counselling sessions and assess newly-diagnosed patients referred by their co-workers at the clinic.

According to *Mwape et al. (2011)*, integrated mental health care services could be promoted into primary health care services by removing the barriers preventing integration. In this study, some of these factors are discussed above. Integration could be promoted through the provision of clinical skills and education, as well as through changing attitudes and beliefs. With regard to policies, procedures and protocols to guide the integration of services, it is recommended that strategic plans and monitoring tools to evaluate the achievements of integrated mental health services, should be developed.

5.3 LIMITATIONS

This study had the following limitations, namely:

The sample size was limited to the voluntary respondents with an interest in participating in the study. The results may not be generalised to other clinics of Buffalo City as this is a qualitative study. The characteristics of those organisations that did not respond in the study cannot be known.

The voices of the supervisors or of psychiatric clients regarding implementation of mental health services at primary health care settings were not investigated. The researcher and the participants communicated in English, which is not their first language. The riches of expression of what professional nurses feel may have been held back by limits imposed on the expression of feelings by having to use a foreign language.

5.4 RECOMMENDED SUGGESTIONS TO IMPROVE INTEGRATION OF MENTAL HEALTH SERVICES INTO PRIMARY HEALTH CARE

These strategies will be brought to the attention of the Management of Buffalo City clinics as well as of Community health centres.

5.4.1 MAINSTREAMING OF SERVICES

There is a need for psychiatric patients to join the mainstream of care. In *Tint et al.* (2000:15) it states that services will be offered by the same providers in the same consultation in one visit. Mental health services to be available for a minimum of eight hours a day, five days a week (Department of Health 2001b).

5.4.2 ACCESSIBILITY OF SERVICES

Home visits by professionals were recommended as the strategy to trace defaulters. This can be possible when there is transport and more professional nurses. Volunteer community health workers do not have a clearly defined career path within the health system and, as such, they are likely to be disrespected by professional staff (*Funk et al.* 2008). These health care workers play a vital role in conducting home visits at Buffalo City clinics.

5.4.3 CONFIDENTIALITY, STIGMA AND HUMAN RIGHTS VIOLATION

Research and education of clinic staff in various aspects of mental illness towards reducing the stigma and protection of psychiatric clients towards human rights violation is needed. Each and every professional nurse should be capacitated in the provision of mental health services, thus preventing psychiatric patients being seen in a special consultation room which is known as a psychiatric unit. More consultation rooms should be erected to ensure privacy and thereby promote the dignity of psychiatric clients. Confidentiality should be maintained at all times with regard to psychiatric patients.

According to the Mental Health Care Act (Act No. 17. of 2002) service users have a right to communicate with service providers in confidence. Information gathered should be used to facilitate treatment and should remain confidential. Consent must be given by the service users if the information needs to be disclosed to another person. At Buffalo City Clinics, the above-mentioned act is ignored and the reason for that, according to professional nurses, is that there is lack of space.

5.4.4 ADEQUATE SUPERVISION AND GUIDANCE

Carroll (2007) defines supervisor as a person taking responsibility for the supervisee's job performance, and deciding what they should be doing, when and how. In clinical context this could mean a ward manager deciding how many cases professional nurses are working with, what they are expected to do in their sessions, how they record them, and how they share that information.

Support and supervision is needed to enable professional nurses to confidently perform their activities; even though they may understand the holistic concept of illness, incorporating physical, spiritual and psychological wellbeing require extensive training. Primary health care staff has to be adequately supervised, monitored and supported by mental health specialist professionals on secondary level if integration is to succeed.

A positive organisational culture and climate needs to be created, in which professional nurses can reach their full potential. Organisational culture is defined as ways of thinking, behaving, and behaviour that people have in common (Ingersoll, Kirsch, Merk & Lightfoot 2000:11).

This mutual understanding is obtained through group socialisation and learning. The desirable culture is seen as being one that is open and honest and that has a no-blame approach (Wilkinson, Rushmer & Davies 2004:110). Necessary training, support, supervision and follow-up in line with the Alma Ata Declaration which called for a primary health care system that is complete with referral systems, supervision and support, amongst others, is required.

5.4.5 ADEQUATE COMPETENCE, TRAINING AND SKILLS

To ensure that the professional nurses are knowledgeable and competent, they must be kept up to date with current knowledge and trends in their respective areas of care provision by means of staff development. This can be ensured by providing in-service training in skills. In-service training programmes should be organised, stating dates and topics in order to avoid time clashes and the staff should consolidate the

programme together. There is a need for a sufficient number of primary health care workers with essential skills and competencies to identify mental disorders, provide basic education and psycho interventions (WHO & WONGA 2008:7).

There is a need for training staff in basic assessment and screening of hidden psychiatric problems. Dundon et al. (2011) further mention that mental health education should be instituted in the curriculum during undergraduate medical and paramedical studies and should be actively strengthened in the form of on-the-job training and supervision (WHO and WONGA 2008:7). A mental health component should be included in the educational curriculum of all social and health workers and ongoing training and support should be provided on site (WHO and WONGA 2008).

Pre-service and/or in-service training of professional nurses on mental health issues is an essential prerequisite for mental health integration. Pre-service training should provide basic education on the epidemiology, identification, and treatment of major mental disorders. Relationships between mental and physical health and illness should also be highlighted (WHO & WONGA 2007).

The training programmes of staff should include diagnosing, management, and follow-up consultations, as well as human rights and family interventions. General health professional nurses must have the knowledge, skills and motivation to treat and manage patients suffering from mental illness.

Training workshops for professional nurses are needed on a regular basis. For training to take place, manuals need to be developed to guide the nurse's activities. On-the-job training is necessary for the professional nurses to be able to provide mental health services in the absence of a psychiatrist or mental health specialist.

Evaluation of the programme should take place to ensure effectiveness of the in-service training and to verify whether programme aims and objectives have been met. The content of training workshop should include the following, namely: How to identify hidden psychiatric morbidity; how to conduct counselling sessions; negotiating treatment plans; and how to maintain confidentiality and avoid human

rights violation. Motivating and preparing patients to self-manage and follow their treatment plans at home must also be taught.

Communication skills are indispensable for all primary health care workers, as health outcomes depend on a good patient–health worker relationship. As such, professional nurses should be taught how to listen actively, show empathy, use open and closed questioning techniques, and manage their nonverbal communication.

5.4.6 AVAILABILITY OF GUIDELINES AND PROTOCOLS.

Guidelines should be available in each department to clarify how the professional nurses should integrate mental health services into primary care. General health staff must have the knowledge, skills and motivation to treat and manage patients suffering from mental disorders.

5.4.7 SHORTAGE OF RESOURCES

Government needs to ensure that sufficient funds are available for the provision of cars/transport for each institution to enable participants to conduct home visits, as well as awareness campaigns. Improvement of infrastructure is urgently needed: renovating existing buildings; erecting new buildings to accommodate the shortage of consultation rooms; and utilisation of temporary structures like prefabricated accommodation are recommended so as to ensure privacy, thus protecting human rights and restoring the dignity of clients suffering from mental disorders.

This is in line with the requirements listed by WHO (2007) where it is stated that investment in facilities, transport or technologies for recurrent costs, staffing levels, skill needs and maintenance systems is required to enhance service delivery at primary health care settings.

Collaboration with non-health sectors such as education, social welfare, justice or labour is required because many mental disorders need psychosocial solutions. Links should be established to ensure that housing, income support, disability benefits, employment, and other social service supports are mobilised for psychiatric

patients. Such collaboration will facilitate the implementation of strategies for prevention and rehabilitation services. Close links with NGOs and religious leaders will enhance better outcomes of rehabilitation programmes for clients suffering from mental disorders (WHO 2008).

5.4.8 SHORTAGE OF STAFF

The government must pay attention to human resource management issues at primary health care level. Adequate working conditions, salaries, resources and support to carry out the demanding work at primary health care should be established. Lack of motivation leads to high staff turnover with major implications for patient care (Sullivan & Decker 2005:46).

There is a need to increase the number of professional nurses to relieve overburdened clinic staff. All the staff at the clinics should have good knowledge of psychotropic drugs. WHO (2007) mentions that the well-performing health workforce is one which is available, competent, responsive and productive, therefore actions are needed to manage dynamic labour markets by addressing entry and exits from the health work force and improving the distribution and performance of existing health workers.

5.5 IMPLICATIONS FOR FURTHER RESEARCH

The researcher noticed potential areas for further research which could have an impact on the employees improved work performance and high quality patient care. Since the findings of this study cannot be generalised to the other clinics of Buffalo City, and the voice of the psychiatric patients is silent in this study, further research is needed to assess the impact of such an approach on client satisfaction.

5.6 APPLICATION OF FLORENCE NIGHTINGALE'S THEORY TO THE STUDY.

The researcher used the holistic theory to guide the study. In Lancaster & Stanhope (2006) it states that the theory provides a starting point to collect facts in a systematic way. The researcher as well followed a systematic way of finding out the phenomena

by using the research process. The researcher followed a systematic approach when conducting this study. The researcher assessed the situation and came out with the research problem and the questions through research methodology.

Florence Nightingale's conceptual model and theory identified the concepts that are essential for nursing and guides the actions that nurse should implement in their daily activities. The researcher selected the holistic model theory because of its unique feature of the client-centered approach by searching for wisdom on perspectives on illness, the person, their environment and holistic nursing.

This study was done at the clinics and community health centers at Buffalo City in order to assist psychiatric patients to access integrated mental health services at the Primary health Care institutions. The researcher identified challenges with regard to integration of mental health services into PHC and was committed to finding out the cause of the phenomena. Furthermore, the researcher selected participants from the same clinics and community centers to describe their lived experiences about the reasons influencing the lack of integration of mental health services into PHC.

According to this theory, nursing practice is regarded as holistic. This is in line with the definition of health today, which states that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity (WHO 2008). The physical aspect of a person was a priority, which was addressed by both medicine and nursing care in the attempt to alleviate disease; Nightingale saw the need for the comprehensive approach based on integrating other components such as thought processes (Selanders 2010:84).

This view is related to the integration of service policy which was enacted in South Africa in 1996, to achieve a comprehensive and seamless PHC delivery system Mental Health Care Act (Act No.17. of 2002). Nightingale's theory emphasized the moral qualities of nursing and introduced humanitarian, patient-centred values that are still relevant today and the idea that nursing required specific education. Nightingale's nursing education emphasized the need to blend a mixture of theoretical and clinical experiences. In this study, the participants are expected to provide comprehensive primary health care which is equivalent to Nightingale's

holistic theoretical model, in order to achieve that nurses must achieve competence, training and acquire knowledge and skills on rendering care to psychiatric patients.

Data revealed failures related to the implementation of integration are related to specified patients preferences, lack of resources and lack of supervision. The failures identified have a potential barrier to the integration of services. Barriers identified are lack of mainstream of care, inaccessibility of services and lack of confidentiality. The researcher will disseminate the results of this study to the management of Buffalo City, at conferences and workshops and through publications in refereed journals.

5.7 SUMMARY

The study highlighted the challenges of professional nurses in the implementation of integration of mental health services into primary health care. As a point of departure, guidelines are to be developed for the support of professional nurses in order to provide effective mental health services. There is an essential need for professional nurses to have full understanding of aspects regarding integration of mental health services, therefore continuous professional development programmes should be instituted at the clinic settings.

It has been identified that primary health care nurses provide psychiatric services at specific times for patients who have already been seen in a hospital, while these services do not exist at all and at some clinics. Not all these nurses have psychiatric training. No case studying, rehabilitation or prevention strategies are taking place at these institutions. Incorporation of comprehensive mental health services into primary health care is far from ideal as professional nurses focus on issuing medication as a method of providing mental health services.

Comprehensive care should involve primary, secondary, tertiary and rehabilitation levels of care as described in the Alma Ata Declaration. A holistic approach to mental illness integration, incorporating the social, economical, psychological and physical and cultural aspects is necessary, rather than viewing integration as just insertion of mental health services into primary health care.

5.8 CONCLUSION

In this chapter, the researcher highlighted the conclusions, limitations and the recommendations derived from this study. Suggestions based on the findings, are also identified to promote integration of mental health services to primary health care services.



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LIST OF REFERENCES

Adali, E., & Priami, M., 2002: Burnout among nurses in intensive care Units, international medication and emergency departments in Greek hospitals. *Intensive Care Units and Nursing Journal*. 10 (11) 19-38.

Ashton, J & Jarvis, R. 2011. Shortage of Key Hospital Drugs: "A Major Crisis", <http://www.cbsnews.com>.

Babbie, E. & Mouton L. 2009. Research methods for social work. Belmont, California: Wadsworth.

Becker, B. & Bryman, A.B. 2009. Social research methods. 2nd edn. Sage Publications.

Bless, C., Higson-Smith, C. & Kagee, A. 2006. *Social research methods: An African perspective*. 4th edn. Cape Town, South Africa: Juta.

Birkmann, N., Spierdip, R. & Smith, S. 2006. A collaboration approach to the improvement of patient treatment for persons with psychiatric disability, *Journal of Psychiatric Rehabilitation*, 29(3), 157-165.

Buchanan, C. & Aiken, A. 2010. Sorting nursing strategies. *Journal of Clinical Nursing*, 17(24), 3262-3268.

Booyens, S.W. 2006. Introduction to health service management. Lansdowne: Juta.

Brink, H. 2009. Fundamentals of research methodology for health care professionals. Lansdowne, Cape Town: Juta.

Bryant-Lukosius, D. & DiCenso, A. 2004. Advanced practice nursing roles: Development, implementation and evaluation. *Journal of Advanced Nursing*, 48(5) 430-433. Wiley Online Library.

Burns, C., Beauchesne, M. & Ryan -Krause, P. 2006. Mastering the preceptor role: Challenges of clinical teaching: Reflections from nurses in a Canadian Hospital. *Journal of Clinical Teaching, Journal of Paediatric Health Care*, 20(3) 2006, pp 172-183. Article.

Burns, N. & Grove, S.K. 2007. Understanding nursing research. Building evidence-based practice. 4th edn. Philadelphia, PA: W. B. Saunders.

Burns, N. & Grove, S. 2009a. The practice of nursing research: Conduct, critique and utilization. 5thedn. St Louis, Missouri: Saunders.

Burns, N. & Grove, S.K. 2009b. The practice of nursing research: Appraisal, synthesis and generation of evidence. 6thedn. Philadelphia, PA: Saunders.

Carroll, M. 2007. Clinical psychology supervision. *Clinical Psychology Forum*, 174, 35-38.

Creswell, J.W. 1994. *Research designs: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage.

Dennil, K., King, L. & Swanepoel, T. 2010. *Aspects of primary health care. Community health care in Southern Africa*. Cape Town: Oxford University Press

Denzin, N.K & Lincoln, Y.S. 2000. *Handbook of qualitative research*. Thousand Oaks: Sage Publications.

Department of Health. 1997. Government Gazette No. 17910. White Paper for the Transformation of the Health System in South Africa. Pretoria: Government, Printer.

Department of Health. 1999. *Government Memorandum for Decentralization of Separate Community Psychiatric Services Department of Health: Eastern Cape Province*. Bisho.

Department of Health. 2001a. *The comprehensive primary health care service package for South Africa*. Pretoria: Formeset Printers Cape for the Government Printer.

Department of Health. 2001b. *The primary health care service package for South Africa. A set of norms and standards*. Pretoria: Formeset Printers Cape for the Government Printer.

De Vos, A., Strydom, H., Fouché, C. & Delport, S. (eds.). 2007. *Research at grass roots: For the social sciences and human service professions*. 3rdedn. Pretoria: Van Schaik.

Draurker, R. 2001. The critique of Heideggerian hermeneutical nursing research 2nd edn. *Journal of Advanced Nursing* > (30) issue 2. Digital Library: University of Adelaide.

Drew, N., Funk, M., Stephen, T., Jagannath, L., Elena, C., Kantotoka, S., Soumitra, P., Olivier, L., Lawrence, G., Saraceno, B. 2011. *Human rights violations of people*

with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet*, 378, issue9803, pp1664-1675, 5 November. doi: 10. 1016/so140-6736 (11)61458-x.

Drummond, A. 2003. *Research methods for Therapists*. Cheltenham: Stanley Thomas

Druss, B.G. 2007 improving medical care for persons with serious mental illness: Challenges and solutions. *Journal of Clinical Psychiatry*, 68(suppl. 4), 40-44.

Dundon, M., Dollar, K.M., Schon, M. & Lantinga, L.J. 2011. Primary care-mental health integration co-located, collaborative care: An operations manual. Wikipedia.

Fleming, I. & Steen, L. 2003. *Supervision and clinical psychology: Theory, practice and perspectives*. London: Brunner-Routledge.

Fitzpatrick, J. & Whall, A. 2005. *Conceptual models of nursing: Analysis and application*. 4thedn. Upper Saddle River, NJ: Pearson Education.

Fox, W., & Bayat, M. S. 2011. *A Guide to Managing Research*. Juta and Company Ltd.

Funk, M., Saraceno, B., Drew, N., & Faydi, M. 2008. Integrating mental health into Primary Health Care. *Mental Health in Family Medicine*, 5: 5-8.

Gask, L., 2005. Overt and covert barriers to the integration of primary and specialist mental health care. *Social science and medicine*. 61:1785-1794.

Goffmann, E., 2009. HIV/AIDS-Related Stigma and Discrimination: Review of Research Studies and future directions for Prevention Strategies. *Afr J Repro Health*. September, 13(3):21-35.PMCID: PM 2919838.

Greeff, M., 2005. *Qualitative health Research. HIV and Aids stigma Violated human rights in five African Countries*. Sage Publications.

Halper, E. B., 2006 Evolution and maturity of the American supermarket during World War II. *Real property, Probate and Trust Journal*, 41 (2): 253,104.

Hofstee, E.M. 2006. *Constructing a good dissertation*. Sandton. www: Exactica

Holloway, I. & Wheeler, S. 2010. *Qualitative research in nursing and healthcare*. 3rd edn. Chichester, West Sussex: Wiley-Blackwell.

Ingersoll, L.G, Kirsch, J.C Merk, S.E & Lightfoot, J.B.S. 2000. Relationship of Organisational culture and readiness for change to employee commitment to the organisation. *The journal of nursing Administration* 30 (1):11.

Jacob, J., 2004: Becoming a Competent clinician: Basic Competences in intervention. *Journal of Clinical Psychology*, 60: 741-754.

Jiang, J.J., & Klein, G. 2000. Supervisor support and career anchor impact on the career satisfaction of the entry. *Journal of Management Information Systems*, 16(3) Winter, 219-24 Article Stable URL:
<http://www.jstor.org/stable/4039845010.2307/40398450>.

Kachingwe, B.M. 2011. Experiences of community Psychiatric nurses and guardians of discharged psychiatric patients on the effectiveness of community Mental Health Services of the Zomba District in Malawi. University OF FORT HARE.

Kaplan, H., & Sadock, B.J. 2003. Synopsis of Psychiatry. California: Williams and Wilkins.

Kilminster, S. M., & Folly, B.C 2000. Effective Supervision in clinical Practice settings. Faculty Development: Academy of Medical Ed. London.

Kleintjies, S.R., Lund, C. & Fisher, A.J., and MHaPP Research programme Consortium.2010. *A Situational Analysis of child and adolescent mental health services in Ghana, Uganda, South Africa and Zambia. African Journal of Psychiatry*, 13:132-139.

Krefting, L. 1991. Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy*, 45(3): 214-222.

Kumar, R. 2005. Research methodology: A step by step guide for Beginners 2nd edn. Thousand Oaks, CA: Sage.

Lancaster, J., & Stanhope, M. 2006. Community and Public Health Nursing. St Louis: Mosby.

Lambert, M. & Leucht, S. 2008. Co morbid somatic illnesses in patients with severe mental disorders: clinical, policy and research challenges. *Journal of clinical psychiatry* 69:514-519.

.Leedy P.D. & Ormrod, J.E. 2005. Practical research planning and design. 8th edn. United States of America: Pearson. Merrill Prentice Hall.

Lehmann, U. & Sanders, D. 2002. Investigating the roles and functions of clinic supervisors in three districts in the Eastern Cape Province. Technical Report, Durban: Health Systems Trust.

Lincoln, Y.S. & Guba, E.G. 1995. *Naturalist Inquiry*. Newbury Park, CA: Sage.

LoBiondo-Wood, G. & Haber, J. 2006. Nursing research methods and critical appraisal for evidence based practice. (Eds.). St. Louis: Mosby.

Mari, J. J., Screenlives, V., & Saxena, S. 2007. Follow- Up Care of Discharged Psychiatric Patients. *The Lancet*. 410, pp. 83-88

McCabe, S. & Macnee, S. 2002. Weaving a new safety net of mental health care in rural America. *Issues in Mental Health Nursing*, 23(3), 263-278.

Merriam- Webster dictionary. 2013: Online: Dictionary and Thesaurus. 11th edn. Science Direct, Elsevier.

Miles, M.B. & Huberman, A. M. 2003. *Qualitative data analysis: A sourcebook of new methods*. Beverly Hills, CA: Sage.

Mkize, N & Moketsi, M. 2011. Community Access to mental health services: Lessons and Recommendations. School of Psychology, University of KwaZulu-Natal.

Monjok, E., Smesny, A., & Essien, E. 2009. HIV/AIDS-Related Stigma and Discrimination: Review of Research Studies and future directions for Prevention Strategies. *Afr J Repro Health*. September, 13(3):21-35.PMCID: PM 2919838.

Mouton, J. 2008. *How to succeed in your master's and doctoral studies*. Pretoria: Van Schalk

Mosbys' Pocket Dictionary of Medicine, Nursing and Health Professionals 2010: 6th Edition. London: Mosby.

Mwape, L., Sikwese, A., Kapungwe, A., Mwanza, J., Fisher, A., Lund, C. & Cooper, S. 2010. Integrating mental health into primary health in Zambia: A care provider's perspective. *International Journal of Mental Health Systems*, 4:21. [Online]. Available: document: 10.1186/1752-4458-

Moyo, D. (2009. p 129). Complex conflict in the Democratic Republic of Congo: Good governance a prerequisite of CRS (Corporate Social Responsibility) peace building. *African Journal of Conflict*. Zambia.

- Newman, W.L. 2000. *Social research methods: Qualitative and quantitative approaches*. 4th edn. Pearson Education Company.
- Oxford advance student's dictionary of current English. 1996. 8th edn. Cape Town. Oxford University Press.
- Parahoo, K. 2006. *Nursing research: Principals, process and issues*. 2ndedn. Basingstoke, Hampshire: Palgrave Macmillan.
- Patel, V., Fisher, A.J. & McGorry, P. 2007. The mental health of young people. A global public health challenge. *Lancet*, Apr 14. 369(9569):1302-13 [Online]. Available: [www the lancet.com](http://www.thelancet.com)
- Penman, J., & Olivier, M. 2004. Meeting the challenge of assessing clinical placement venues in a Bachelor of Nursing program. *Journal of University Teaching and Learning Practice*, 1(2): 59-73. <http://jutp.uow.edu.au>.
- Petersen I. 2000. *Comprehensive integrated primary mental health care for South Africa: Pipedream or possibility?* *Social Science Med.*, 51(3), 321-4.
- Petersen, I. Swartz, L. 2002. Primary health care in the era of HIV/AIDS: Some implications for health systems reform. *Social Science Medicine*, 51(6):1005-13.
- Pera, S.A. & Van Tonder, S. 2005. *Ethics in health care*. 2ndedn. Cape Town, South Africa: Juta.
- Pillay, Y. & Asia, B. 1999. *Handbook for clinic/CHC Managers*. Pretoria: Department of Health.
- Pogoloff, F. 2004. Facilitative positive relationships between parents and professionals. *Intervention in School and Clinic*, 40(2), 116-119.
- Polgar, S. & Thomas, S.A. 2008. *Introduction to research in the health sciences*. 5thedn. Edinburgh: Churchill Livingstone.
- Polit, D.F & Beck, C.T. 2004. *Nursing research: Principles and methods*. 7thedn. Philadelphia, PA: Lippincott, Williams and Wilkins.
- Polit, D.F. & Hungler, B.P. 1991. *Nursing research principles and methods*. Philadelphia, PA: Lippincott.
- Republic of South Africa. 1996. *Constitution of South Africa (Act 108:1996)*. Pretoria: Government Printer.

Republic of South Africa. 2001. Mental Health Policy issues for South Africa Cape Town. Multimedia.

Republic of South Africa. 2002: The New Mental Health Care Act (*Act No. 17. of 2002*) Cape Town, Government Printer.

Republic of South Africa. 2005. The South African Nursing Council. 2005: *The Nursing Act (Act No. 33. of 2005)*. Pretoria: Government Printer.

Rossouw, D. 2003. *Intellectual tools: Skills for the human sciences.* . (ed.). Pretoria Van Schaik.

Selanders, L. 2010. The power of environmental adaptation: Florence Nightingales' original theory for nursing practice. *Journal of Holistic Nursing*, 28(10), 81-88 [28/1/81]

Sewell, M., 2008. Qualitative evaluation and research methods. [Online] Available from: [http:// ag. Arizona. Ed/fcr/cyfar evalgde. htm](http://ag.arizona.edu/fcr/cyfar/evalgde.htm).

Sibiya, M. & Gwele, N. 2009. Analysis of the meaning of integrated primary health care from the KwaZulu-Natal primary health care context. *Curationis*, 32(2):31-37.

Silverman, D. 2011. *Doing Qualitative Research*. London: Sage Publication.

Sokhela, N.E. 1999. The integration of comprehensive psychiatric/mental health care into the primary health system: Diagnosis and treatment. *Journal of Advanced Nursing*, 30(1), 229-36.

South African Nursing Council. 2005. Approval of and minimum requirements for education and training of a nurse (general, psychiatry and community) and midwife leading to registration. Regulation 425 of 22 February.

South African Nursing Council, 2005: *The Nursing Act, Act 33 of 2005*, Pretoria: SANC.

Speziale, H.J & Carpenter, D.R. 2007. *Qualitative research in nursing*. 4thedn. Philadelphia, PA: Lippincott Williams & Wilkins.

Streubert-Speziale, H. & Carpenter, D.R. 2007. *Qualitative research in nursing: Advancing the humanistic imperative*. 4thedn. Philadelphia, PA: Lippincott Williams

Sullivan, T.J. 2001. *Methods of social research*. Fort Worth, Texas: Hallcourt College Publishers.

Sullivan, D. & Decker, P. 2005: Effective leadership and management in nursing. Houston: Pearson, Prentis Hall.

Terre Blanche, M., Durrheim, K. & Painter, D. (eds.). 2004. Research in practice. Cape Town: University of Cape Town Press.

The South African Nursing Council. 2005: *Nurses' rights* [Online]. Available: <http://www.sanc.co.za/policyrights.htm> [Accessed 5 March 2007].

Thornicroft, G., & Szmukler, G. 2001. Text book of Community Psychiatry. (eds) Oxford Press.

Tint, K.S., Fonn, S., Khuzwayo, N. & Robertson, E. 2000. Jeopardisation of preventive services of primary health care: A consequence of providing integrated services. *Women's Health Project Newsletter*, 36, 15-16, November.

Toomey, L.C. 2000. Functional integration of primary health care within the district health system. Bisho: Equity Project.

Uys, L. & Middleton, L. 2007. Mental health nursing. A South African perspective. Cape Town: Juta.

Valenzuela, D. & Shrivastara, P. 2008. Interview as a method of qualitative research [Online]. Available: <http://www.public.asu.edu/~kroel/www500/interview%20Fr i.pdf> [Accessed: 2 November 2008].

Vhuromu, E.N., & Dhavana-Maselesele, M. 2009. The implementation of the integrated management of childhood illness (IMCI) Strategy guidelines in Botswana. University of South Africa.

Walley, L., Lawn, J.E., Tinker, A., Francisco, A., Chopra, M., Ruda, I., Bhutta, Z.A. & Black, R.E. 2008. Primary HealthCare: Making Alma Ata a reality. *The Lancet*, September 13, 372(9642), 1001-1007.

Walsh, K., Nicholson, J., Keough, C., Pridham, R., Kramer, M. & Jeffrey, J. 2003. Developing of a group model of a community mental health nursing team. *International Journal of Nursing Practice*, 9, 33-39.

Wand, T. & White, K. 2007. Exploring the scope of the emergency department mental health nurse practitioner role. *Journal of Mental Health Nursing*, 16(6), 371-456 Wiley- online Library.

Wilkinson, J.E., Rushmer, R.K. & Davies H.T.O. 2004. Clinical governance and the learning organisation: *Journal of Advanced Nursing Management*, 11, 367-375.

Whittaker, A. & Williamson, G.R. 2011. Succeeding in research project plans and literature reviews for nursing students. Exeter, UK: Learning Matters.

WHO. World Health Organisation 2002: Advisory Committee on health research: Report to the Director-General on its Fortieth Session held at WHO headquarters, in Geneva. 17-19, June

WHO. 2008. World Health Report. Health systems: Integration of healthcare delivery. Geneva, Switzerland: World Health Organization.

WHO & WONGA. 2008. *Mental health primary health care services* [Online] Available: <http://www.Capegateway.Gov.za/eng/directories/services/11505/6435> [Accessed 6 March 2011].

Zorn, W.M.K. 2008. Qualitative research methods: Qualitative data teaching resource: Exploring diverse interview types [Online]. Available: <http://www.esds.ac.uk/qualidata/support/interviews/semi>. [Accessed 6 November 2008].



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UFH/UREC, 12 - REC-270710-028

Application for clearance from the University of Fort Hare's Ethics Committee

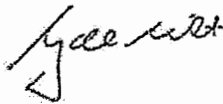
Project title: Investigation on integration of mental health services into primary health care at Buffalo City Clinics

Chief Researcher: Nontobeko Beatrice Mhlahlo

Supervisor/Co-supervisor: Dr N Tshotsho
Mrs N Magadla

Date of application: 29 March 2012

Having consulted the Dean of Research, I hereby grant permission to conduct the research.



Professor G de Wet
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

10 April 2012



Eastern Cape Department of Health

Enquiries: Zonwabele Merile
Date: 28th June 2012
e-mail address: zonwabele.merile@impilo.ecprov.gov.za

Tel No: 040 608 0830
Fax No: 043 642 1409

Dear Ms NB Mhlahlo

Re: Investigation on integration of mental health services into primary health care at Buffalo City clinics

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT



Ikamva elizaqamhileyo!



Province of the
EASTERN CAPE
HEALTH



Amathole District

Buffalo City Sub-district:

Enquiries: Mrs N.V.Nelani

9 Vincent Road, Vincent, East London, 5200, Eastern Cape
Private Bag x 9015, Main Post Office, East London, 5200, Eastern Cape
Tel No. +27 (0)43 711 1100 Fax No. +27 (0)43 721 1972
Website www.ecdoh.gov.za

To:	Nontobeko Beatrice Mhlahlo
From:	Buffalo City Sub-District Manager
Subject:	Agreement for research study to be conducted in Buffalo city Sub District
Date:	04/09/2012

Dear Ms. N.B.Mhlahlo

Permission is herewith granted to you to conduct research in Buffalo City Sub District as requested. Kindly familiarize yourself with the conditions below before commencing with your study.

1. The researcher will conduct the study without compromising client's confidentiality and the smooth running of the service.
2. The researcher will not provide/publish any reports/statements without prior discussion with and permission of the sub district.
3. A copy of a letter of approval by the ethics committee will be submitted to the sub district office before commencing the study.

I accept the conditions as stated in the abbreviated version of Department of Health Agreement Clause for researchers.

NONTOBENKO MHLAHLA N.V. Nelani

10-09-2012

Full Name & Surname

Signature

Date

N.TOMBELHAYA Ntombela

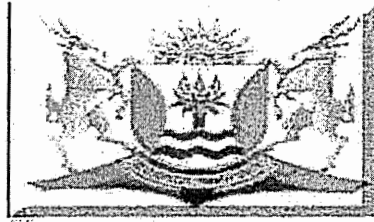
[Signature]

10.09.2012

Witness Name & Surname

Signature

Date



PROVINCE OF EASTERN CAPE

Department of Health

Isebe LeZempilo

BUFFALO CITY LSA

EMPILWENI GOMPO COMMUNITY HEALTH CENTRE

Private Bag X 9047, EAST LONDON, 5200

Tel: (043) 733 1289

Fax: (043) 733 9211

Enquiries: N.E.KWATSHA

Date: 11/10/2012

ATTENTION : Mrs N. B.MHLAHLLO

REQUEST TO CONDUCT INTERVIEWS AT EMPILWENI GOMPO COMMUNITY HEALTH CENTRE BUFFALO CITY EAST LONDON:

TITLE : INVESTIGATION OF MENTAL HEALTH SERVICES INTO PRIMARY HEALTH XCARE AT BUFFALO CITY CLINICS

This communiqué serves to inform you that, the Management of the above mentioned institution has no objection in granting you permission to conduct interviews at the above mentioned institution especially that you brought the correspondence from the Epidemiological Research & Surveillance Management Directorate.

With the hope that you will follow all the steps outlined by the Epidemiological Research and Surveillance Management Directorate. We wish you good luck in your research project

Thank you in advance

Mrs. Ngqandu-Nase N. A.:
Nursing Service Manager

PROVINCE OF THE EASTERN CAPE
DEPARTMENT OF HEALTH
EMPILWENI GOMPO COMMUNITY HEALTH CENTRE
NURSING SERVICE MANAGER

2012 -10- 11

Signature:.....

ANNEXURE 'E'

18 Wembley Drive
Chiselhurst
East London
5247

The Participants

04.07.2013

REQUEST: CONSENT TO PARTICIPATE IN A RESEARCH STUDY

The researcher is registered as a Master's Degree student (student No. 201100497) at University of Fort Hare for M. Cur. Degree. The title of my study is: To identify the reasons in relation to lack of integration of mental health care services with general health care services by Professional Nurses at the Buffalo City Clinics, in the Eastern Cape Province and develop a model.

The purpose of the study is to identify the reasons in relation to lack of integration of mental health care services with general health care services by Professional nurses at the Buffalo City Clinics, and develop a model.

I wish to request permission of you to participate in the above-mentioned research study by answering a few interview questions. I will be very grateful if you can spare 30 to 45 minutes of your time for attending to the questions. The Information that will be obtained will add to the body of knowledge.

This study will not benefit you financially, but your input will contribute towards improvement of quality service delivery at the Buffalo City Clinics.

Your participation is voluntary, kindly be informed that confidentiality and anonymity will be maintained. You have a right to withdraw from the project at any time, with no penalty to be imposed against you. If you agree to participate in the study, your name will not appear in the study.

Your participation will be highly appreciated.

Yours sincerely

Nontobeko Beatrice Mhlahlo (Master's student)

ANNEXURE 'F'

WRITTEN INFORMED CONSENT FOR RESEARCH PROJECT

I,..... Voluntarily agree to participate in a research project of a descriptive study of an investigation on integration of mental health services into Primary health Care in the Buffalo City clinics and community health centres in the Eastern Cape.

I understand what the project is about, as it was explained to me by the researcher and I understand that I incur no risk by participating.

I have a right to withdraw or to refrain from answering a question if I feel like doing so.

Confidentiality of the information given is ensured by anonymity and only the researcher and the supervisor will have access to the data.

I understand that there are no anticipated risks in the study.

Contact details are provided for further questions about the research project.

Contact details: Mrs N.B. Mhlahlo- cell 0731651804.

Participants

Signature..... Date.....

Researcher's

Signature..... Date.....

ANNEXURE 'G'

INTERVIEW GUIDE

Section A: DEMOGRAPHIC DATA

Participant No:

Age:

Name of Institution:

Work experience as a professional nurse:



SECTION B:

University of Fort Hare
Together in Excellence

INTERVIEW QUESTIONS:

- Tell me about the factors that influence lack of integration of psychiatric services into Primary Health Care as required by integration policy?
- What hinders integration?
- What can be done to promote integration of mental health services with general health care?

NB: Follow-up and probing questions will be guided by the participant's responses.

ANNEXURE 'H'

Hester Honey
91 Brandwacht Street
Stellenbosch 7600

12 December 2013

Declaration of Language and Technical Care

I, Hester Honey, hereby declare that I have read through the thesis

**AN INVESTIGATION OF INTEGRATION OF MENTAL HEALTH SERVICES
INTO PRIMARY HEALTH CARE AT BUFFALO CITY CLINICS
IN THE EASTERN CAPE**

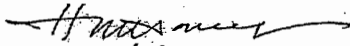
by NONTOSBEKO BEATRICE MHLAHLA
(S.N. 201100497),

which is submitted for the degree of
M.CURATIONIS

in the School of Health Sciences
at the University of Fort Hare

and have suggested adaptations regarding language use and technical aspects to be implemented by her.

Yours sincerely,



15 August 2012