

**EXPERIENCES OF MENTAL HEALTH CARE PROVIDERS REGARDING
INTEGRATION OF MENTAL HEALTH CARE INTO PRIMARY HEALTH CARE AT
THE ILEMBE HEALTH DISTRICT IN KWAZULU- NATAL**

Mdumiseni Zuma

Dissertation submitted in fulfilment of the requirements for the Degree in Masters
of Technology in Nursing in the Faculty of Health Sciences at the University of
Zululand

Supervisor : Dr. R.M. Miya
Co-supervisor : Dr S.T Madlala
Date : September 2018

Declaration

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is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).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

Signature of student

Date

Approved for final submission

Dr R.M. Miya
D.Lit. et Phil

Date

Dr S.T. Madlala

Abstract

Introduction

Institutionalisation of mental health care users was a prevalent treatment approach in the apartheid era in South Africa. The introduction of community based mental health care is aimed at improving mental health care services, and this integration into primary health care improves access to mental health services, enables mental health care users to maintain family relationships, to be employed while receiving treatment and to access psychosocial rehabilitation. The professional nurses are rendering mental health care services at the primary health care level implementing the integration.

Aim of the study

The aim of the study is to explore and describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.

Methodology

A qualitative research study that was exploratory, descriptive and contextual in nature was conducted. Semi-structured interviews were conducted with 13 professional nurses. Data was transcribed verbatim then organised into codes.

Results

The study revealed that the majority of the participants experienced and faced challenges regarding integration of mental health into primary health care. Professional nurses state that they lack skills and knowledge regarding integration of mental health and mental health services. Other challenges mentioned such as

staff shortage, lack of funding to mental health and inadequate working resources. Professional nurse were of the opinion that the management did not care about their challenges and did nothing to resolve the challenges.

Dedication

I dedicate this dissertation to God who gave me an opportunity and the ability to take advantage of it. My loving family, especially my daughter Zoe and her mom Dunah for their patience, love, motivation and encouragement during this long process. To Untunjambili Hospital health workers especially Dr Phakathi thanks a lot for your understanding and support. To all professional nurses who continue to uphold the nursing pledge of serving the community on daily basis your efforts are noted and this is for you.

Acknowledgements

I would like to express my heartfelt gratitude and sincere appreciation for the support guidance and motivation from different individuals and from the institutions they represent, without them this dissertation would not have been successful. Special thanks to the following people:

- Dr R.M. Miya my supervisor, for his insight, passion, drive, patience, continual support and invaluable contribution to the success of this study.
- Dr S.T. Madlala, my co-supervisor, for his motivation, words of encouragement, support and guidance throughout this study.
- The KwaZulu-Natal Department Health, iLembe Health District Office and the selected hospital, for granting me permission to conduct this study.
- Dr. N.L. Phakathi and the whole Untunjambili hospital staff for allowing me to take time off and do the study.
- All professional nurses who were participants in the study for making time for me during the data collection phase.
- I thank the Almighty whose divine intervention made this dissertation possible.

TABLE OF CONTENTS

Declaration.....	ii
Abstract.....	iii
Dedication.....	v
Acknowledgements.....	i
Table of Contents	Error! Bookmark not defined.
List of Tables	Error! Bookmark not defined.i
List of Figures	Error! Bookmark not defined.
List of Annexures	Error! Bookmark not defined.x
Glossary of Terms	Error! Bookmark not defined.
List of Acronyms	xError! Bookmark not defined.
CHAPTER 1 : OVERVIEW OF THE STUDY	2
1.1 INTRODUCTION AND BACKGROUND	2
1.2 PROBLEM STATEMENT	4
1.3 AIM OF THE RESEARCH.....	5
1.4 RESEARCH OBJECTIVES	6
1.5 SIGNIFICANCE OF THE STUDY	Error! Bookmark not defined.
1.6 OUTLINE OF THE DISSERTATION	Error! Bookmark not defined.
1.7 CONCLUSION	7
CHAPTER 2 : LITERATURE REVIEW	8
2.1 INTRODUCTION.....	8
2.2 FORMAT OF LITERATURE REVIEW.....	9
2.3 DATA SEARCH STRATEGY	9
2.4 CRITERIA FOR INCLUSION AND EXCLUSION OF LITERATURE	10
2.5 APPRAISAL OF IDENTIFIED STUDIES FOR LITERATURE REVIEW.....	11
2.6 POLICIES OF MENTAL HEALTH INTEGRATION.....	15
2.7 BUDGET FOR MENTAL HEALTH NURSING SERVICES.....	16
2.8 CHALLENGES AFFECTING MENTAL PRIMARY HEALTH INTEGRATION.....	17
2.9. RESOURCES FOR MENTAL HEALTH SERVICES.....	17
2.10 MENTAL HEALTH EDUCATION.....	18
2.11 MENTAL HEALTH CARE ACT.....	19

2.12. DEINSTITUTIONILISATION	19
2.13 THEORETICAL FRAMEWORK WHICH GUIDED THE STUDY.....	20
2.13.1 The unfolding of the theoretical framework in this study.....	21
2.14. CONCLUSION	23
 CHAPTER 3 : RESEARCH METHODOLOGY.....	24
3.1 INTRODUCTION.....	24
3.2 RESEARCH METHODOLOGY	24
3.3 RESEARCH DESIGN	25
3.3.1. Exploratory research	25
3.3.2 Descriptive research.....	25
3.4 RESEARCH SETTING.....	26
3.5 SAMPLE AND SAMPLING PROCESS	26
3.5.1. Population and target population.....	26
3.5.2.Sampling	26
3.5.2.1. Inclusion criteria of participants	27
3.6. DATA COLLECTION PROCESS	27
3.7. PRE-TESTING OF THE DATA COLLECTION TOOL.....	29
3.8. DATA MANAGEMENT	29
3.9. DATA ANALYSIS	30
3.10. TRUSTWORTHINESS.....	32
3.10.1.Credibility	33
3.10.2.Dependability.....	33
3.10.3.Confirmability.....	33
3.10.4.Transferability.....	33
3.11. ETHICAL CONSIDERATIONS.....	34
3.11.1.Respect of persons	34
3.11.2.Beneficence.....	34
3.11.3.Justice	35
3.11.4.Consent.....	35
3.11.5. Confidentiality.....	36

3.12. PRESENTATION OF RESULTS	36
3.13. DISTRIBUTION OF RESULTS	36
3.14. CONCLUSION	36
 CHAPTER 4: PRESENTATION OF THE RESULTS	 37
4.1. INTRODUCTION.....	37
4.2. DEMOGRAPHIC DATA	38
4.3. EMERGENT THEMES AND RESEARCH FINDINGS	39
4.4.THE DISCUSSION OF THEMES AND SUB-THEMES.....	42
4.4.1. Objective number 1	42
a. Administration.....	43
i. Staffing of professional nurses.....	43
ii. Referral system.....	44
b. Resources.....	44
i. Availability and proper allocation of funds.....	45
ii. Availability of working material.....	45
c. Knowledge and skills.....	45
i. Guidelines and policies.....	46
ii. Training.....	46
iii. Scope of practice.....	46
4.4.2. Objective number 2.....	47
a. Service delivery.....	47
i. Poor service delivery.....	47
ii. Service below expected standards.....	48
b. Influence on professional nurses.....	48
i. Increase in the stress levels.....	49
ii. Escalating levels of absenteeism.....	49
iii. Lost interest in mental health.....	49
c. Influence on the care of mental care users.....	50
i. Mental health care users relapse.....	50
ii. Early discharged of mental health care users in hospitals.....	50

4.5. SUGGESTIONS MADE TO IMPROVE MENTAL HEALTH INTERGRATION INTO PHC.....	51
4.5.1. Modifiable factors.....	51
4.5.2. Non- modifiable factors.....	52
4.6. CONCLUSION	52
CHAPTER 5: DISCUSSION OF THE RESULTS	53
5.1. INTRODUCTION.....	53
5.2. RESEARCH OBJECTIVES AND THEORETICAL MODEL.....	53
5.3. SUMMARY OF DATA COLLECTION	53
5.4. Findings of the study based on the research objectives.....	54
5.4.1. Objective no. one.....	54
a. Staffing of professional nurses	54
b. Referral system.....	55
c. Availability and proper allocation of funds.....	56
d. Availability of working material (medication).....	56
e. Guidelines and policies.....	57
f. Training	57
g. Scope of practice.....	58
5.4.2. Objective no. two.....	58
a. Poor service delivery.....	58
b. Service below expected standards.....	58
5.5 INFLUENCE ON PROFESSIONAL NURSES.....	59
a. Increase in stress levels.....	59
b. Escalating levels of absenteeism.....	59
c. Most staff members resigning.....	60
5.6 INFLUENCE ON THE CARE OF MENTAL CARE USERS.....	60
a. Mental health care users relapse.....	60
5.7. CONCLUSION	61
CHAPTER 6: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS..	62
6.1. INTRODUCTION.....	62

6.2. CONCLUSION 62

6.3. STUDY LIMITATIONS 62

6.4. RECOMMENDATIONS 63

 6.4.1. Administrators 63

 6.4.2. Education 64

 6.4.3. Staffing 64

 6.4.4. Further research 65

REFERENCES 66

ANNEXURES.....72

LIST OF TABLES

Table 2.1: Summary of primary research work reviewed	11
Table 3.1: Tesh's steps and their application to this study.....	30
Table 4.1: Summary of professional nurse who were participants in the study.	37
Table 4.2: Summary of themes in relation to Donabedian framework	38

LIST OF FIGURES

Figure 2.1: Donabedian's tripartite framework20

LIST OF ANNEXURES

Annexure 1: Permission letter to Untunjambili Hospital	95
Annexure 2: Approval letter from Untunjambili Hospital.....	97
Annexure 3: Permission letter to Research Director Department of Health	98
Annexure 4: Approval letter from Research Director Department of Health...	100
Annexure 5: University ethics clearance certificate.....	94
Annexure 6: Letter of information.....	104
Annexure 7: Consent form	106
Annexure 8: Interview guide	107
Annexure 9: Example of an interview transcript.....	108

GLOSSARY OF TERMS

Deinstitutionalisation

Is the process of replacing long stay psychiatric hospital with less isolated community mental health services for those diagnosed with a mental disorder or developing disability (Tansella 1986)

Professional nurse

It means the person registered as such in terms of section 31 of Nursing Act (Republic of South Africa 2005).

Mental health care provider

According to the SANC 2013 are professionals who diagnose mental health conditions and provide treatment. Most have at least a master's degree or more advanced education, training and credentials. It must be licensed to provide mental health services.

Mental health care user

It means a person receiving care, treatment and rehabilitation services aimed at enhancing the mental health status of user (SANC 2013).

Primary health care

It is the first point of contact for health care for most people. It is mainly provided by general practitioners and care provided at clinics (WHO 2013).

LIST OF ACRONYMS

Acronym	Full term
m	
CINAHL	Cumulative Index of Nursing and Allied Health Literature
KZN	KwaZulu-Natal
MHN	Mental Health Nursing
PN	Professional Nurse
PHC	Primary Health Care
RSA	Republic of South Africa
SANC	South African Nursing Council
UNIZULU	University of Zululand
WHO	World Health Organisation

CHAPTER 1 : OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Institutionalisation of mental health care users was a prevalent treatment approach in the apartheid era in South Africa. The post-apartheid Department of Health prioritised improvement in mental health care by recommending, inter alia, deinstitutionalisation and reintegration of mental health care users into the community (Skeen, Kleintjes, Lund, Petersen, Bhana & Flisher, 2010). Ten years later these interventions have proved difficult to institute as many mental health care users are still hospitalised (Lucas & Stevenson, 2005). The introduction of community based mental health care is aimed at improving mental health care services, and this integration into primary health care improves access to mental health services, enables mental health care users to maintain family relationships, to be employed while receiving treatment and to access psychosocial rehabilitation.

WHO (2014) states that the integration of mental health services into primary health care was not rated as highly as other methods for facilitating deinstitutionalization but nonetheless, the importance of mental health services in primary care was noted. WHO's Mental Health Action Plan for 2013 to 2020 proposed that countries shift systematically from long-stay in mental institutions towards community-based settings using a network of linked community-based mental health services, including short-stay inpatient care, comprehensive mental health centres, and day care centres, support of people with mental disorders living with their families, and supported housing.

A mental health policy is articulated in the South African Mental Health Act 17 of 2002 aiming at protecting the human rights of the persons with mental disorders and ensures that the individual have access to treatment and care, discourage stigma and discrimination, and sets standards for psychiatric

practice psychiatry in South Africa. The United States uses collaborative care models to provide a pragmatic strategy to deliver integrated mental health and medical care for mental health care services served in primary care settings (Goodrich, Kilbourne, Nord & Bauer, 2013). These are team-based intervention to enact system-level redesign by improving patient care through clinical information systems as well as engaging mental health care users in their care through self-management support and linkages to community resources (Goodrich, Kilbourne, Nord & Bauer, 2013). Almeida, Mateus and Tome (2015) support the deinstitutionalization intervention stating that in Europe, reduced bed occupancy in mental health hospitals, transfers of mental health care users to community services and residential facilities have played a key role in deinstitutionalisation. According to Jack-Idel, Uys and Middleton (2012), Nigerian lacks such legislation compared to other countries.

South African mental health system has strength regarding some of the resources such as facilities for psychotropic medications and outreach clinics. The National mental health policy in South Africa promotes deinstitutionalisation and treating mental health as an integral part of primary health care (WHO, 2015). This promotes short hospital stay, while encouraging the use of primary health care services. When the necessary budgetary provisions are not made, this will result in lack of community resources that is essential for continuity of care for the mental health care users. However, the majority of participants had not been adequately informed about their illnesses (Kotzé, van Delft & Roos, 2010). The slow discharge of long-term mental health care users from Hospital into the community has not matched the national and international drive towards deinstitutionalisation. The available facilities do not have the expertise to care for the more severely disabled and disturbed mental health care users (Krüger & Lewis, 2011).

In KwaZulu-Natal, the implementation of the mental health Act 17 of 2002 have improved access to mental health care services in the province, although significant gaps such as the infrastructure, staffing, training and administrative requirements needs to be addressed before the implementation can be deemed a success (Miya, 2016). WHO (2014) maintains that the principles of

community-based services must be in place. In order to be in line with WHO, former institutional residents need access to mental health services, including evidence-based clinical care, and also access to social services for help with housing, employment as well as community reintegration. In this province all the mental health care users are admitted at the three main mental health institutions in KwaZulu Natal based on the severity of their illnesses thereafter the period active steps are taken to prepare them for discharge should they be considered fit for discharge. In order to expedite the discharge process, mental health care users will be sent out on 'leave of absence' to specialised forensic units, which are nearest to their place of residence (Mkize, Green-Thompson, Ramdass, Mhlaluka, Dlamini & Walker, 2004).

Nurses indicated that they do not provide quality mental health because they experience shortages of staff (Burns, 2014). Staff shortages in primary health care clinics are a barrier towards provision of quality mental health care, especially in rural clinics because these clinics are overburdened with multiple programmes and high patient workload (Dube & Uys, 2015).

1.2 PROBLEM STATEMENT

The integration of mental health care into primary health is the approach implemented worldwide as mental health was not priority in many developing countries in terms of services (WHO, 2010a). There are many challenges encountered from this approach and studies have identified and recommended solutions. According to WHO 2014 treatment rates for mental disorders are even more worrisome ranging from 13% to 33% in high-income countries, and from 5% to 13% in low- and middle-income countries and Inevitably, redesigning health systems and services towards integrated care poses serious challenges to existing infrastructure, budgets, and health workers.

Laura, Murray, Stephanie, Skavenski and Bass (2014) state that despite advances in global mental health evidence and policy recommendations, the uptake of evidence-based practices in low- and middle-income countries has been slow and lower resource settings have several challenges, such as limited

trained personnel, lack of government resources set aside for mental health, poorly developed mental health systems, and inadequate child protection services. In the South African context almost 80% of the clinical staff reported that they do not have sufficient knowledge of and did not feel sufficiently equipped to perform Psychological rehabilitation practice, which is not surprising since past mental health policies and training failed to emphasize this component of psychological and psychiatric care (Pillay & Kramers-Olen, 2012). In the study done South Africa KwaZulu-Natal participants highlighted the following challenges, lack of mental health facilities, problems of distance travelled to access mental health services, lack of respect by mental health practitioners while being treated, lack of clinics in communities and lack of professional personnel or specialist (Maruping, 2012).

Despite several studies conducted around the concept of deinstitutionalisation of mental health care users and related challenges, little is known about the experiences of professional nurses regarding integration of mental health care into Primary health care, hence, the current study seeks to explore and describe the experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu- Natal.

1.3 AIM OF THE RESEARCH

The aim of the study is to explore and describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.

1.4 RESEARCH OBJECTIVES

The objectives of the study are to:

- Explore experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.

- Describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- Identify challenges faced by the professional nurses regarding integration of mental health into primary health care.
- Develop recommendations to facilitate the integration of mental health into primary health care.

1.5 SIGNIFICANCE OF THE STUDY

According to WHO's Mental Health Action Plan for 2013 to 2020 proposed that countries shift systematically from long-stay mental hospitals towards community-based settings and using a network of linked community-based mental health services, including short-stay inpatient care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

The integration of mental health services into primary health care was not rated as highly as other methods for facilitating deinstitutionalization. Nonetheless, the importance of mental health services in primary care was noted (WHO, 2014). There is treatment gap in the region of 80%, 75% of individuals with common mental disorders in South Africa do not receive any treatment. Interestingly, this treatment gap also correlates closely with the recent finding from KZN that the province has only 25% of the psychiatric beds and 25% of the psychiatrists required to comply with national norms (Burns, 2014).

There are challenges in South Africa such as services still concentrated at institutional level, shortage of community-based centres and poor accessibility, shortage of human resources to deliver community-based services, negative attitudes and resistance among staff to treating mental health (Marais & Petersen, 2015). The current study will assist address all issues around integration of mental health into primary health care and make specific recommendations on how to address such challenges if any exist.

1.6 OUTLINE OF THE DISSERTATION

Chapter 1: Introduction and background.

Chapter 2: Literature review.

Chapter 3: Research methodology.

Chapter 4: Presentation of the results.

Chapter 5: Discussion of results.

Chapter 6: Conclusion, limitations of the study and recommendations.

1.7 CONCLUSION

This chapter introduced the reader to the background of the study and the problem statement, the aim of the study, research questions and the significance of the study. The next chapter will focus on relevant literature that was reviewed in order to gain more insight and understanding and to support the relevance of the study.

CHAPTER 2: LITERATURE REVIEW

2.1. INTRODUCTION

Chapter 1 presented the background to the study and the problem statement that set the basis for the study of experiences of professional nurses regarding integration of mental health nursing into primary health care. This chapter presents a literature review, which focuses specifically on related literary sources that look at mental nursing practice, deinstitutionalisation and mental health policies, quality mental nursing care and specific challenges in global, African, south African and KwaZulu-Natal context. As acknowledged earlier, despite several studies conducted around the concept of deinstitutionalisation of mental health care users and related challenges, little is known about the experiences of professional nurses regarding integration of mental health care

into Primary health care, hence, the current study seeks to explore and describe the experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu- Natal. To foreground this noted knowledge-gap, the current review of literature aims to provide a comprehensive overview of current viewpoints and existing research evidence, to determine prominent viewpoints in this study area.

Brink, Van der Walt and van Rensburg (2012) offer a definition of literature reviews as being written sources relevant to the topic of interest. A literature review involves finding, understanding and forming conclusions about the published research and theory as well as presenting it in an organised manner. It is a systemic search of what is known about the topic of interest. A literature review aims to provide the researcher with the foundation and the existing evidence of the problem being addressed and to develop an argument that demonstrates the need for the new study. Polit and Beck (2008) further state that a literature review offers guidance to the researcher as to which gaps exist and how best to fill such gaps for example which methodology or conceptual framework to utilise.

In addition to the synthesis function, this review is concerned with drawing attention to the range of previously published issues related to practice breakdown in maternity units. According to Brink, Van der Walt and van Rensburg (2012: 76), for the reviewer to get accurate literature she/he must first clarify the research topic, identify the keywords and concepts so as to be able critically present insight and awareness of the different arguments, approaches and theories.

2.2. FORMAT OF LITERATURE REVIEW

This review will include a number of key sections such as an overview of a data search strategy, a tabular summary of reviewed sources and the review proper of related literary sources. The presentation of literature will be presented in contexts related to the study of experiences of professional nurses regarding integration of mental health into primary health care.

2.3. DATA SEARCH STRATEGY

Initially the university library was used to search for books and journals that related to the topics of experiences of midwives regarding nursing practice breakdown. The use of libraries simultaneously with the use of electronic databases is seen as an excellent starting point as it allows the gathering of information and access to alternative sources. The researcher must be able to identify the literature that is relevant to the study topic (Brink, Van der Walt and van Rensburg 2012). Before engaging in the searches, a set of keywords and concepts were decided upon. In order to assemble the group of keywords that would be used in the search, a mind map was drawn so that all relevant publications in the area of interest could be identified (Brink, Van der Walt and van Rensburg 2012). Relevance of the publication refers to how closely the information relates to the topic. As highlighted earlier, little is known about the experiences of professional nurses regarding integration of mental health care into Primary health care. Identifying keywords for the subject before initiating any literature search would ensure that correct results are obtained. The following keywords and phrases were used:

- Mental health nursing.
- Primary mental health nursing.
- Deinstitutionalisation.
- Attitude of professional nurses towards mental health.
- Mental health nursing policies.

The resources that were available for the literature search were books and journals, which included hardcopy and electronic databases. The initial hard-copy library search did not reveal many current sources and therefore, primary focus was on searching various electronic databases such as OVID database (searches across several medical and nursing online sources) (1984-2016) and physical search of local South African journals at the local health authority library.

Vast array of library resources of University of Zululand (UNIZULU) were optimally utilised for global, African, south African and local input through the

inter-library loan (ILL) system which did not yield many results in terms of hard copies. Various electronic library databases were consulted including those of the UNIZULU, University of South Africa (UNISA) and Durban University of Technology. The archives, databases and websites of other local and international sources of information, such as the SANC, the International Council of Nurses (ICN), and the World Health Organisation (WHO) were consulted in the quest of obtaining a multi-perspective approach to the research topic.

2.4. CRITERIA FOR INCLUSION AND EXCLUSION OF LITERATURE

The initial search, using each of the primary search terms independently, identified over 400 potential sources. However, the inclusion of other parameters, such as 'primary research' and 'English', led to an enormous reduction in the potential references of interest to 54. This reduction was accomplished when detailed inclusion and exclusion criteria, listed below, were applied to the literature or studies obtained for review. Inclusion criteria: studies focussing on

- Mental health nursing practice.
- Deinstitutionalisation.
- Primary mental health nursing.
- Studies published in English.
- Given the difficulties that exist in authenticating data from the worldwide web (internet), only literature from validated academic databases such as OVID via Athens and CINAHL were considered for inclusion within the review.

Furthermore, the reviewer as a means of validating their existence, where possible, sourced hard copy paper versions of studies retrieved from Internet sources.

The following exclusion criteria were applied to literary sources:

- Studies whose academic credibility could not be authenticated.
- Studies written in languages other than English.

- Studies published before 2012 were excluded simply because of the five years gap from the current year.

After applying each of the above criteria, only 30 literary sources (23 of which were original research) met the strict criteria for inclusion, and also satisfied the academic and scientific rigour expectations for inclusion in the review. The primary research studies that fully satisfied the inclusion criteria are reviewed in this chapter. Data is categorised according to global, African, South African and local or KwaZulu-Natal perspectives.

2.5. APPRAISAL OF IDENTIFIED STUDIES FOR THE LITERATURE REVIEW

Table 2.1 below offers a summary of the primary research studies that were conducted in South Africa and are included within this literature review. Once identified for inclusion within the literature review, the process of reviewing each study was based on established and validated models of critical appraisal; in essence, the review of individual studies was weighted according to the knowledge-contribution made to the current understanding of mental health nursing and integration into primary health nursing and deinstitutionalisation. To be more specific, the studies were evaluated in terms of their rigour, validity, reliability, dependability and transferability to the practice context (Polit and Beck 2008). Further attention was given to the handling of data within each of the reviewed sources, including how well researchers addressed potential limitations of their studies.

Table 0.1: Summary of primary research work reviewed

Author/Date	Title of paper/Aim of study	Key Findings
--------------------	------------------------------------	---------------------

Jack-Ide, Uys and Middleton (2012)	A comparative study of mental health services in two African countries: South Africa and Nigeria	The findings of the study revealed that the comparison with South Africa highlights considerable gaps in mental health service provision in Nigeria in particular, with the non-implementation of integrating mental health care into the nation's primary health care services over 20 years after the adoption of this policy. As the intention of the policy were to bridge inequalities of access to mental health service, its lack of implementation raises questions about equitable access to mental health care for its citizens.
Burns (2014)	The burden of untreated mental disorders in KwaZulu-Natal Province – mapping the treatment gap	The findings of the study revealed In keeping with previous estimates, these results provide evidence that the 'treatment gap' for acute inpatient and ambulatory mental healthcare in KZN is ~80%. This rate is similar to the estimated mental health resource gap in the province, suggesting that gross inadequacies in mental health service provision translate directly into major unmet needs for those living with mental disorders
Author/Date	Title of paper/Aim of study	Key Findings

Dube and Uys (2013)	Primary health care nurses' management practices of common mental health conditions in KwaZulu-Natal, South Africa	The study revealed that based on the results of this study it is evident that psychiatric patients at PHC clinics in the district where the study was conducted do not receive quality treatment according to institutional mental health guidelines.
Ramlal (2012)	The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002-2012	The study revealed that the Act has increased the accessibility of care, yet hospitals face numerous challenges in meeting the legislative mandate. South Africa can be proud of being one of less than 40% of countries worldwide that has mental health legislation that has been passed after 1990 ²³ , but this accomplishment is overshadowed by the absence of a supporting implementation plan.
Author/Date	Title of paper/Aim of study.	Key Findings
Pillay and Kramers-Olen (2012)	Psychosocial rehabilitation in a chronic care hospital in South Africa: views of clinical staff	The findings of the study revealed that It is not surprising that most of the clinical staff in this investigation do not feel sufficiently equipped to perform PSR interventions, considering that past mental health policies and training failed to emphasize this component of mental health care. The need for

		training programmes to address this deficit is evident
World Health Organisation (2014)	Integrating the response to mental disorders and other chronic diseases in health care systems	The findings of the study revealed that Research from low- and middle-income countries is more limited but promising. Additional research is needed in resource-poor settings on how best to achieve integration in the context of already-over- burdened health-care systems. With regard specifically to mental health care, additional evidence is needed on how best to provide supervision and specialist support to primary health workers, especially in contexts where secondary care has itself limited capacity to deliver mental health care.
Author/Date	Title of paper/Aim of study.	Key Findings
Jenskins, Othieno,Okeyo and Aruwa (2013)	Exploring the perspectives and experiences of health workers at primary health facilities in Kenya	These findings suggest that strengthening mental health training for primary care staff is worthwhile even where health systems are not strong and where the medicine supply cannot be guaranteed.
Schierenbeck, Johansso Andersson and Rooyen	Barriers to accessing and receiving mental	The findings of the study revealed that this research shows the importance of

(2013)	health care in eastern cape, south Africa.	building monitoring procedures that include the experiences and knowledge of staff involved in actual health care provision.
--------	--	--

2.6. POLICIES OF MENTAL HEALTH INTEGRATION

Despite advances in global mental health evidence and policy recommendations, the uptake of evidence-based practices in low- and middle-income countries has been slow (Laura, Murray, Skavenski & Bass 2014). Inevitably, redesigning health systems and services towards integrated care poses serious challenges to existing infrastructure, budgets, and health workers (WHO 2014). There are a number of generic health system weaknesses in Kenya which impact on the ability of health workers to care for mental health care users and these weaknesses include the medicine supply, health management information system, district level supervision to primary care clinics, the lack of attention to mental health in the national health sector targets, and especially its absence in district level targets, which results in the exclusion of mental health from such district level supervision as exists, and the lack of awareness in the district management team about mental health (Jenkins, Othieno, Aruwa, Kingora & Jenkins 2013). This domain describes the type of mental health policies, programs and legislation in both countries. While South Africa has no official mental health policy, its MHCA 2002, drives its mental health services and programs (Uys & Middleton 2012). The aim should be to ensure that all African countries have the appropriate legislation as part of a continent wide move to provide for a most vulnerable section of the population. Whilst such legislation speaks to the unique circumstances of those suffering with a mental illness, legislation is meaningless without appropriate resources to both implement and monitor (Szabo 2013)

2.7. BUDGET FOR MENTAL HEALTH NURSING SERVICES

There is limited budget allocation with mental health services receiving 0.4% of the total health budget in Zambia (Mwape, Swese, Kapungwe, Mwanza, Flisher, Lund & Cooper 2010). And Abdelgadir (2012) states that globally, there is inadequate financial support for

mental health care programs and that early detection of mental illness require more intervention and spending on mental health at all levels, especially primary health care level. The inadequate funding of integrated mental health care and primary health care may challenge the integration because it could be the cause of poor human resources, material resources and trained staff as well as infrastructures (Abdelgadir 2012). . Burns (2010) concludes in his study that inequitable funding, inadequate facilities and significant shortages of mental health professionals pervade the mental health and psychiatric services in KwaZulu-Natal. The median percentage of health expenditures dedicated to mental health is 0.5% in low income countries and 5.1% in high income countries¹⁶ and in KZN the figure is 0.03%-a figure that had not increased over a 10 year period spanning the implementation of the Act. In KZN, a mean increase of 10.2% per annum in budget allocations was made to general hospitals as opposed to 3.8% to public psychiatric hospitals over the same period; in addition (Ramdall 2012)

2.8. CHALLENGES AFFECTING MENTAL PRIMARY HEALTH INTEGRATION

Low- and middle-income countries face greater challenges because of grossly under resourced primary care systems and an even weaker mental health infrastructure. Treatment for most mental health conditions is largely provided in large psychiatric hospitals without adequate referral networks in all levels of care and health systems. Limited human resources, lack of training in mental health, and fragmentation within the health systems pose significant challenges (Ngo, Rubinstein, Ganju, Kanellis & Loza 2013). Despite advances in global mental health evidence and policy recommendations, the uptake of evidence-based practices in low- and middle-income countries has been slow. Lower resource settings have several challenges, such as limited trained personnel, lack of government resources set aside for mental health, poorly developed mental health systems, and inadequate child protection services (Laura, Murray, Skavenski & Bass 2014). Inevitably, redesigning health systems and services towards integrated care poses serious challenges to existing infrastructure, budgets, and health workers (WHO 2014). In South Africa the challenges includes the low prioritisation and stigmatisation of mental illness, weak managerial and planning capacity to develop and implement mental health care plans at provincial and district level, poor pre-service training of generalists in mental health care,

weak orientation to integrated care, high staff turnover, infrastructural constraints, and no dedicated mental health budget (Marais & Petersen 2015). Uys & Dube (2014) revealed that in KwaZulu-Natal treatments are not reviewed every six months, there were no local protocols on the administration of psychiatric emergency drugs and none of the study sites provided mental health care users with education on their medication and its possible side effects.

2.9. RESOURCES FOR MENTAL HEALTH SERVICES

The resources required to deliver mental health services includes human resources, service facilities and budgets have been consistently shown to be inadequate Lund, Petersen, Kleintjes & Bhanafra (2012). Innovations of the proposed human resource package for closing the treatment gaps for prioritized mental disorders lies in task shifting to a new cadre of less skilled but dedicated (Petersen 2012). According to Ramlall, Chipps and Mars (2010) study suggests that significant gaps in infrastructure, staff, training and administrative requirements still must be addressed before implementation can be deemed a success at the regional and district health hospital in KwaZulu-Natal. The starting point for effective integrated care pathways is to specify skill sets necessary to effectively deliver integrated care and plan for the development and deployment of these skills in the context of available human resources (Patel, Belkin, Chockalingam, Cooper & Saxena 2013)

2.10. MENTAL HEALTH EDUCATION

According to Burns (2014) staff received in-service education provided by the mother hospital, but none of the study sites had programmes of in-service training on mental health planned for the year. This was consistent with the findings of the interviews where some of the nurses indicated that they needed in-service education. The study identified a lack of knowledge and skills amongst PHC nurses as contributing factors to the poor management of psychiatric patients in the study sites. Staff shortages in PHC clinics are a barrier towards provision of quality mental health care, especially in rural clinics because these clinics are overburdened with multiple programmes and high patient workload (Uys & Dube 2015). Training and capacity building of Primary Health Care nurses must be an on-going process

because new nurses who have not been trained in mental health are continually being allocated to Primary Health Care facilities. In-service training on mental health would enable PHC nurses to provide quality mental health care (Dube, & Uys 2015). Enhanced health worker skills conferred by the mental health training program may be responsible for the significant improvement in outcome of mental health care users in the intervention clinics and strengthening mental health training for primary health care staff is worthwhile even where health systems are not strong (Jenkins, Othieno, Aruwa, Kingora & Jenkins 2013). Pre-service training of Primary Health Care workers in mental health care was limited to a few hours or days in all districts of the following countries except South Africa where it formed a substantial percentage of the training time (20%). No in-service training had been conducted in Ethiopia or Nepal districts. In Uganda, India and South Africa, in-service training was sporadic and not comprehensive in terms of personnel (Hanlon, Luitel, Kathree, Murhar & Shrivasta 2014). Given the increasing burden of mental illness, it is incumbent on medical graduates to have adequate knowledge and skills, which should be further consolidated through dedicated rotations through psychiatric units during their internship years, leading to independent practice as medical practitioners or further training as specialists (Zabo 2013)

2.11. MENTAL HEALTH CARE ACT

The decision to incorporate mental health care into primary care in accordance with the Mental Health Care Act has in Eastern Cape resulted in some mental health care users being incorrectly referred in the health care system. There is the lack of properly trained staff admitting at primary level care as the main reason for this shortcoming (Schierenbeck, Johansson, Andersson & van Rooyen 2013). The South Africa Mental Health Care Act 17 of 2002 state that mental health care should be fully integrated into primary health care and mental health care practitioners should take responsibility for mental health care needs. The South African MHCA 2002 underpins a stronger human rights approach to mental health care service than previous legislation. The Act ensures that hospitalizing persons involuntarily due to harm of self and others does not take away their right. It requires certifying such persons within a 72-h assessment period, allowing a period where they can potentially be stabilized and be cared for in the community.

2.12. DEINSTITUTIONILISATION

The introduction of psychiatric nurse practitioners has facilitated numerous improvements, admissions to the psychiatric hospital have been reduced, outpatient services have increased and community-based prevention and promotion programmes are now in place (WHO 2014).

In United States uses collaborative care models to provide a pragmatic strategy to deliver integrated mental health and medical care for mental health care services served in primary care settings and are team-based intervention to enact system-level redesign by improving patient care through clinical information systems as well as engaging patients in their care through self-management support and linkages to community resources (Goodrich, Kilbourne, Nord, & Bauer 2013). Although these services are being integrated into some primary care settings in the United States and other high- income countries, the collaborative care model has not been widely adopted. A deinstitutionalized and integrated primary mental health care system is essential for increasing access, improving service quality within a human rights framework and restructuring mental health services in post-apartheid South Africa (Peterson 2012). A typical scenario for many South Africans living with these disorders is that they experience a first episode of illness, frequently in early adulthood, and are admitted to either a secondary or tertiary facility for acute management of their condition. Once stabilized they are discharged to the community, and referred to primary care clinics, which they are expected to attend to receive medication and monitoring of their mental health status on on-going basis. In most instances (Lund, Petersen, Kleintjes & Bhana 2012).

2.13. THEORETICAL FRAMEWORK WHICH GUIDED THE STUDY

This study makes use of the Donabedian's framework. This framework (Figure 2.1) is relevant to the study as it offers a structure to measure quality of implemented processes through evaluation of structure, process and outcome standards. Donabedian's breaks down the quality of care into three main components, structure, process and outcome, to reflect the whole production process for comprehension (Donabedian's 2005: 700).

As displayed in Figure ,structure means the relatively stable characteristics of the physical and organisational setting in which care takes place and includes in the first instance, providers of care and the equipment and resources they have at their disposal. In addition, structure standards also refer to administrative organisation including management, economic and environmental conditions of the environment (Donabedian's 1980). Structure, therefore, influences process and in turn outcome and is based on assumptions that when certain standards are in place good care is more likely to be provided (Donabedian's 1980).

Process standards refers to skills used to provide health care that could be preventive, diagnostic, therapeutic and rehabilitative services, including procedures and activities required to deliver health care by providers (Donabedian's 1980).

Outcome standards refer to a change in a patient's current and future health status that can be attributed to received health care and its effectiveness (Donabedian's 1980), and includes patient well-being and degree of satisfaction (Donabedian's 1980). The outcome component has limitations in that the patient's outcome health status does not depend only on direct care received, but also on other influencing factors that need to be considered such as social and emotional factors, input from the body's mechanisms, the patient's own contribution, medication and her/his family's contribution.

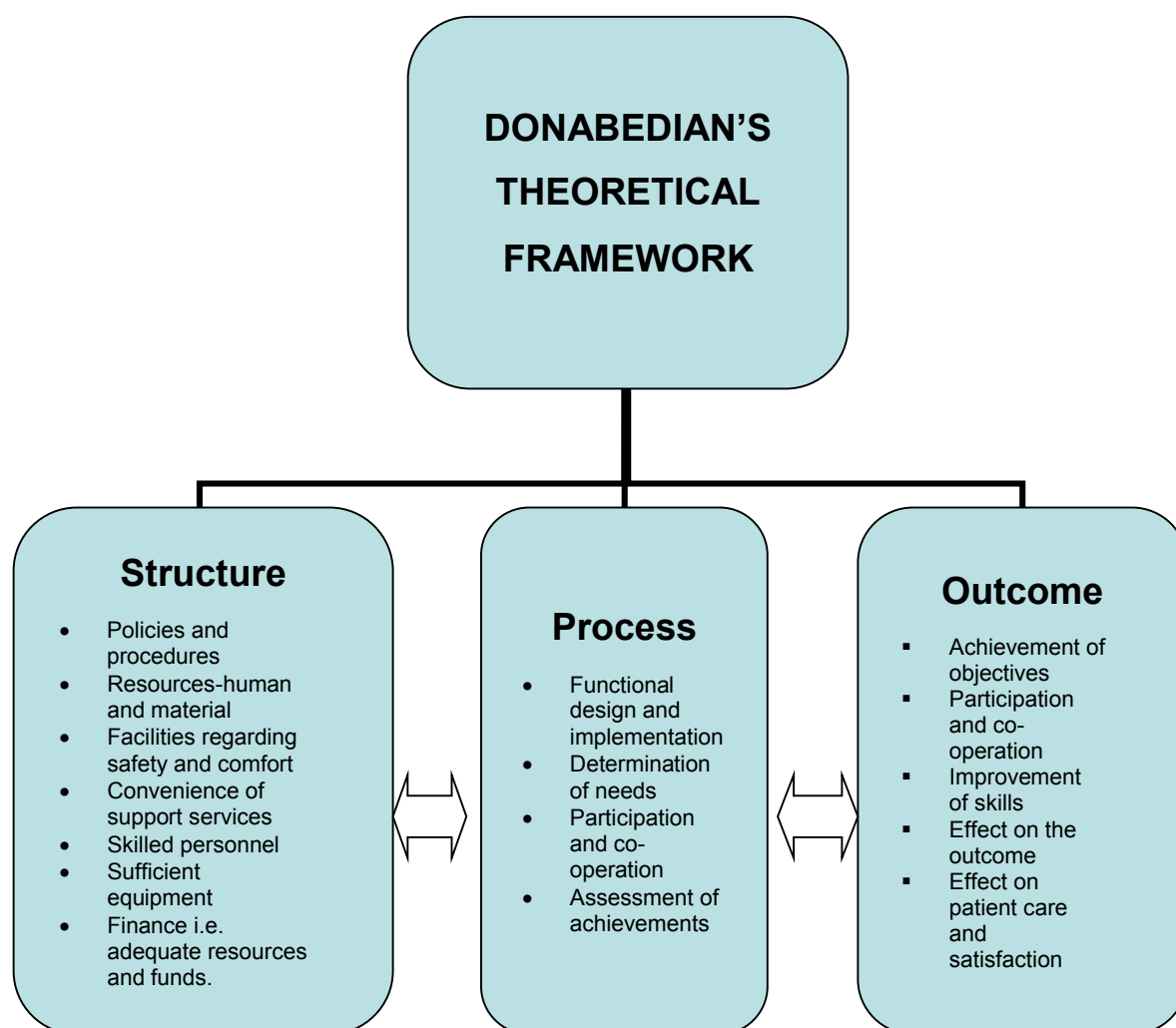


Figure 2.1: Donabedian's tripartite framework

2.13.1 The unfolding of the theoretical framework in this study

Principles from the framework will be integrated into the study inductively for example important concepts highlighted within the framework will be used as reference points to inform the design of data collection and analysis tools. This framework is relevant to the study as it offers a structure to measure quality of implemented processes through evaluation of structure, process and outcome standards. Developing insights into the experiences of mental health care providers regarding integration of mental health into primary health care will be undertaken broadly in line with the 'structure, process and outcome standards' prioritised by the Donabedian's framework.

The model identifies three important influences on care quality and these, as already noted, are structure, process, and outcome. In this study, 'structure' refers to the relatively stable characteristics of the physical and organisational setting in which integration of mental health into primary health care occurs and includes the resources-human and material, skilled personnel, support services and adequate resources and funds. The structure in this study will include professional nurses, hospital, clinics, relatives of MHCU and mental health budget. 'Process standards' refers to the determination of needs, participation and co-operation and assessment of achievements in selected health institution. 'Outcome standards' in this study refer to alleviating of gaps and promotes deinstitutionalisation and primary mental health care integration within hospitals. The research topic and study outcomes shall address structure, process and outcome as perceived by the participant professional nurses. The research topic which is experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal and shall address the structure, process and outcome. The professional nurses as the structure and participants and other structures such resources and finances will determine the effects it has on the integration. Such structures on the framework constitute the primary mental health care and challenges and gaps within structure will be identified to facilitate the process. The integration of mental health into primary health care is a process that needs mentioned structures on the framework to be functional and efficient. If the professional nurses, hospital and clinics follows the correct processes which are guidelines and policies of deinstitutionalisation or integration, the outcomes shall be met this is achievement of objectives. And also the lack of skilled personnel and inadequate funds to facilitate integration of mental health into primary health, in the process will affect the outcome which is the effect on patient care (mental health care users) and improvements of skills such as recruitments of skilled personnel with allocated budget for mental health care.

The Donabedian's model represents an important guiding concept within the current study as it addresses all components of integration of mental health into primary health care.

2.14. CONCLUSION

This chapter highlighted what is relevant to the topic of interest. A number of studies have been conducted by the RSA Department of Health and other researchers regarding the Experiences of professional nurses in mental health. Hence this study aims to explore and describe the experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal.

CHAPTER 3: RESEARCH METHODOLOGY

3.1. INTRODUCTION

The previous chapter focused on a review of the literature with the aim of establishing the relevance of the study by comparing it to previously researched information. The purpose of this chapter is to describe and justify the research design and methodology adopted in this study. This will be followed by a description of the research method for theory generation and measures to ensure trustworthiness.

3.2. RESEARCH METHODOLOGY

This is a step by step systematic process that the researcher took to solve the problem or to answer the research question. The research methodology section includes population, sampling frame, approach and technique, sample size, data collection method, data processing and analysis and report (Brink, Van der Walt and van Rensburg 2012).

3.2. RESEARCH METHODOLOGY

The research methodology section includes population, sampling frame, approach and technique, sample size, data collection method, data processing and analysis and report (Brink, Van der Walt and van Rensburg 2012).

A qualitative design is useful when the researcher wants to examine the experiences of human beings in their natural environment. Qualitative researchers often collect data in the field at the site where participants experience the problem under study (Polit and Beck 2012). A qualitative research approach was selected because the researcher wanted to explore and describe experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal. These experiences were captured through in-depth semi-structured interviews that are representative of qualitative methods of data collection.

3.3. RESEARCH DESIGN

Research design guides the researcher in planning or designing and implementing the study in a way that is most likely to achieve the intended goal (Burns and Grove 2009). A qualitative research study that was exploratory, descriptive and contextual in nature was conducted to explore and describe experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal.

3.3.1. Exploratory research

An explorative research seeks to gain insight into a situation, phenomenon and a community (De Vos, Fouche and Delport 2011). A study of this nature is designed to increase the knowledge of a particular field of study (Grove, Burns and Gray 2013). In this study, the researcher seeks to explore the experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal. During the interview sessions, the researcher used probing questions to explore and gain deeper understanding into the participants' experiences. The researcher listened for unanticipated material and examined their relevance to the study through probing questions (Burns and Grove 2009).

3.3.2. Descriptive research

Descriptive research presents a picture of the specific details of a situation and focuses on the deeper meaning and intensive examination of the phenomenon under study (Brink, Van der Walt and van Rensburg 2012). Descriptive research provides an in-depth description of participants' experiences in a narrative type description. In this study, the researcher intended to explore and describe experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal.

3.4. RESEARCH SETTING

The study was conducted at a public hospital in the ILembe Health District. According to the KZN Department of Health (2015), this selected hospital serves as a referral hospital from its four affiliated clinics and serves a population of 160342 who come from Kranskop area, Ngcolosi area, Mabomvini area, Makhabeleni area, Cele area and Mahlongwa area (Anon, 2016). The hospital is situated in the iLembe district along Kranskop way 10km away till Untunjambili area and a kilometre away from main road. It is a Level I offering services such Primary health care and Psychiatry.

The researcher selected the public hospital because it offers both mental health and primary health care practice and none research ever been conducted at the ILembe Health districts. The researcher felt that he would receive quality data from such an institution.

3.5. SAMPLE AND SAMPLING PROCESS

3.5.1. Population and target population

Brink et al (2012) define population as an entire group of persons or objects that is of interest to the researcher, the entire set of individuals having some common characteristics. In other words, population refers to the group of persons that meet the criteria that the researcher is interested in studying. In this study, the population was professional nurses working with mental health care users in primary health care and hospital setting. The researcher included only professional nurses because of their duties regarding mental health and primary health in caring for mental health care users such as reviewing medication, assessing, prescribing medication and also outreach campaigns and they have rich experience regarding the topic under study.

3.5.2. Sampling

Sampling is referred to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink, van der Walt and van Renburg 2012). The professional nurses working at the hospital wards and selected

clinics are the sample of the study. The study was using purposive sampling because it is a technique based on the judgement of the researcher regarding participants' knowledge or phenomenon being studied.

According to Brink, van der Walt and van Renburg (2012), purposive sampling is based on the judgement of the researcher regarding participants or objects that are typical or representative of the study phenomenon. Sample size was determined by data saturation because a qualitative researcher's sample continues until data saturation.

The sample of the study consisted of professional nurses who were located in the Gateway clinic primary health care and two clinics of the selected hospital. The sample size was determined by the number of professional nurses that were actively involved in the clinics and were available and willing to participate in the study. The sample comprised 15 participants from the Gateway clinic, Kranskop clinic and Mbhekaphansi clinic. The researcher chose three clinics at the hospital and five professional nurses from each clinic. The professional nurses were recruited until saturation of data was reached. In qualitative research studies, there is no set sample size as in quantitative research studies.

3.5.2.1. Inclusion criteria of participants

- All professional nurses working with mental health care users in the selected hospital and clinics was included.

3.6. DATA COLLECTION PROCESS

Once ethical approval was received from UNIZULU Ethics Committee (Annexure 5), KZN Department of Health (Annexures 4 and) and the Hospital CEO (Annexures 2). Data was collected through individual semi-structured interviews with selected professional nurse. Semi-structured interviews assisted in gaining in-depth knowledge since questions were clarified where necessary, using probing and follow up questions (Brink, Van der Walt and van Rensburg 2012).

The in-depth semi-structured interviews were conducted using an interview guide (Annexure 8) in a face to face encounter at the boardroom and some were conducted at the tearooms of clinics. The questions were formulated using the research question of the study, the theoretical framework and the literature review as a guide. Each participant was visited in their work place and the information (Annexure 6) and consent sheets (Annexure 7) were delivered by hand. Time was provided to read the information sheets and to answer questions of participants. The interviews were conducted in English language hence he was dealing with professional people who were proficient in speaking the language. All participants were comfortable in speaking the language. Participants were interviewed for about 30 to 60 minutes.

The interview sessions were audio taped and field notes taken as backup. The participants were encouraged to continue talking using necessary probing questions. Permission was sought from the participants to use a voice recorder to capture the interview data. Field notes were documented by the researcher. After each interview the interview content was transcribed by the researcher, using the actual words of the participants in order to ensure confidentiality as participants may have felt audio taped records could lead to their identification via voice recognition.

Data was collected over 10 days period from to March 2017 in which all professional nursing staff was interviewed. Data saturation was achieved after conducting ten interviews with the professional nurses but the researcher proceeded to do five more interviews before cessation of the interviewing process to further confirm that saturation had indeed been achieved. The researcher stopped scheduling interviews when the interviews did not provide any new information and thus saturation had been reached.

A grand tour questions were asked followed by probing questions to get more data. The following research questions guided the individual interviews:

- Grand tour question number 1: Please tell more about your experiences regarding the integration of mental health care into primary health care?
- Probing questions used:

- Grand tour question number 2: What kind of challenges do you encounter in primary mental health care and mental health care as whole?
- Probing questions used:

- Grand tour question number 3: What do you think can be done or added in the integration to better the challenges mentioned?
- Probing questions used:

3.7. PRE-TESTING OF THE DATA COLLECTION TOOL

The data collection tool was pre-tested so to ascertain whether the research questions were realistic and understood by the participants. The pre-test was conducted by the researcher on three professional nurses were selected by the researcher for semi-structured interview. Professional nurses that were selected for the pretesting phase were employed at the selected hospital. No adjustments were made to the interview questions however the researcher did not add data collected during pretesting phase.

3.8. DATA MANAGEMENT

Research data required proper management to ensure anonymity, usability, long-run preservation and access and indeed the research content can be very sensitive and must be handled with care at all times (Brink, Van der Walt and van Rensburg 2012). Transcribed notes were coded to ensure confidentiality and kept in a password coded laptop, with only the researcher and the research supervisors having access to the material. The original tape recorded data and transcribed data were examined by the supervisors to ensure that data was transcribed correctly and to exclude bias.

All information shared by the participants was treated as confidential. In all transcripts the original name and registration number of participant did not appear. Code names and numbers were used as names for participants. All lists with true identities of participants whether in laptop, audio recorder or written list of participants will be kept privately by the researcher in a safe place. The data will be kept for a period of five years in a secure location with arrangement by the supervisor at UNIZULU and will be disposed of by incineration. Electronic data is kept in a password protected computer.

3.9. DATA ANALYSIS

Data analysis involves a systematic application of a process or processes of managing and organising qualitative data, which brings order, structure and meaning to the mass of data collected (Brink, Van der Walt and van Rensburg 2012: 193). Data analysis involves organising and synthesising what the researcher has seen, heard and read so that data collected can make sense (Jooste, 2010). Qualitative data analysis is an active process where the researcher has to scrutinise carefully and deliberately data that she/he has gathered often reading data over and over again until meaning or deeper understanding of data is achieved (Polit and Beck 2008). Analysis of qualitative data involves categorising data into segments with symbols or abbreviations used to classify words or phrases. This is known as coding (Brink, Van der Walt and van Rensburg 2012).

Data analysis was done concurrently with data collection and was done throughout the study (Brink, Van der Walt and van Rensburg 2012). In this study, data was analysed using Tesch's method of data analysis for qualitative research (Tesch, cited in Creswell 2009). Tesch's steps that were followed and their application to this study are indicated in Table 3.1, to allow the reader to understand how the results were obtained. These are the main source of data in qualitative studies (Polit and Beck 2008). The researcher transcribed data verbatim. Both the transcribed material and audio tapes were examined by the supervisors to exclude bias. Once audio recordings and transcribed data was examined by the supervisors they were handed over to private independent

decoder who further examined the data to ensure exclusion of bias. The points in which the private encoder and the researcher in agreement with the supervisors differed were discussed further to reach points in which there was agreement were taken as correct data. This was done in order to ensure accuracy of the data collected (Polit and Beck 2008).

Table 3.1.: Tesch's steps and their application to this study

Tesch's Steps	Application to this study
<ul style="list-style-type: none"> • Reading through all transcripts carefully so as to get a sense of what was contained in them. 	<p>Each interview conducted was recorded by audiotape. The researcher listened to the audiotapes to check the sense of the whole, to internalise the content and then transcribed the contents verbatim. The researcher also read and re-read all the verbatim transcripts carefully to get an understanding of the interviews and to familiarise himself with the data. Ideas were jotted down as they emerged. Field notes were used as additional data to support that contained in the transcripts.</p>
<ul style="list-style-type: none"> • Picking one transcript randomly. Going through it and asking one-self "what is it about?" Thinking about the underlying meaning of the interview 	<p>The researcher picked up the verbatim transcripts randomly and re-read them.</p>
<ul style="list-style-type: none"> • Jotting down thoughts in the margin. 	<p>The researcher's ideas and thoughts were written in the margin. This was an initial segmentation of Data and open coding.</p>
<ul style="list-style-type: none"> • Repeating this process with all the transcripts and making a list of all topics. Clustering similar topics together into columns, this consisted of themes and sub-themes. 	<p>This process was repeated with all the transcripts, jotting down thoughts and listing the topics and clustering them.</p>
<ul style="list-style-type: none"> • Taking this list of topics and going back to the transcripts. Abbreviating the topics as codes next to the appropriate segments of the text and observing the organisation of data to check if new codes emerge. 	<p>Codes were allocated to similar topics. These codes were written next to the appropriate segments of the text. This exercise was repeated with all the transcripts coding all the topics.</p>

<ul style="list-style-type: none"> • Finding the most descriptive wording for the topics and turning them into categories. Finding ways of grouping the topics that relate to each other and drawing lines between the themes to show their relationships. • Making a final decision on the specific abbreviation for each category and arranging the codes alphabetically. 	<p>The most descriptive wording of topics were identified and used as themes. Topics that related to each other were grouped together in order to reduce the list of themes. Identified themes were used to refine probing questions in further interviews and this allowed for the saturation of themes to occur.</p> <p>Appropriate abbreviations for each of the above were finalised. The data in each category were grouped together. The data was also checked to see if re-coding was necessary and the process of analysis was then finalised (Creswell 2009).</p>
<ul style="list-style-type: none"> • Assembling all the data material belonging to each category in one place and performing a preliminary analysis. • Discussing the themes and sub-themes 	<p>The researcher, together with the independent coder who is an experienced researcher and supervisor in qualitative data analysis, analysed data independently from each other, had a discussion and came to an agreement on the themes and sub-themes identified.</p> <p>The themes and sub-themes that emerged during data collection and analysis are discussed in the following section.</p>

In reporting the research findings, some participants' verbatim responses have been included. Literature control was conducted in order to present results of similar studies and to provide framework for comparing results of a study with other studies (Creswell 2008).

As mentioned in previous chapter data was collected based on the Donabedian's framework which presents data in three main components—structures, process and outcome – to reflect the whole production process for comprehension (Donabedian's 2005).

3.10. TRUSTWORTHINESS

According Lincon and Guba (1985 cited in Polit and Beck 2008), there are four criteria that must be met to develop trustworthiness namely credibility, dependability, confirmability and transferability.

3.10.1. Credibility

This criterion refers to the confidence in the truth of the data and interpretations there of (Brink, Van der Walt and van Rensburg 2012: 172). This includes the enhancing of believability of the findings and taking steps to demonstrate credibility to external readers. For the purposes of this study all interviews were audio taped and field notes taken as back up. Data was interpreted verbatim by the researcher and handed over to the supervisors who checked that data was interpreted correctly.

3.10.2. Dependability

This refers to stability (reliability) of data over time and over various conditions (Brink, Van der Walt and van Rensburg 2012). This criterion seeks to answer the question regarding whether the study would give the same findings again if it were to be repeated. During coding both supervisors served as co-coders so as to ensure that the coded data was dependable. Where opinions about coding emerged such was discussed until consensus was reached. This was done to ensure that the data was as accurate as possible.

3.10.3. Conformability

Conformability refers to the potential for congruency of data in terms of accuracy, relevance and meaning (Brink, Van der Walt and van Rensburg 2012). This criterion seeks to establish that the data represent the information that the participants provided. During the coding the both supervisors serviced as co-coders so as to ensure that the coded data was a true representation of the participants' data.

3.10.4. Transferability

This refers to the ability to transfer the findings to any other group or be applicable in any other setting (Brink, Van der Walt and van Rensburg 2012). Pre-testing of the data collection tool was undertaken to ensure that the research tool was able to yield results that could be trusted and could give

results that could be utilised to develop departmental policies either for the institution where study was conducted or other institutions.

3.11. ETHICAL CONSIDERATIONS

The research proposal was submitted to the UNIZULU Ethics Committee for approval. After the proposal was approved by the committee, the researcher sought gate keeper permission from the Chief Executive officer of Untunjambili Hospital and KwaZulu-Natal Department of Health (Annexure 2). After permission was granted by the above mentioned gate keepers, the researcher approached participants. The information letter and consent form was given to participants (Annexure 6 and 7). To address the ethical issues related to participants, three fundamental ethical principles were respected throughout the research process: respect of persons, beneficence and justice (Brink, Van der Walt and van Rensburg 2012).

3.11.1. Respect of persons

This principle includes the right of self-determination and full disclosure (Polit and Beck 2008: 171). Self-determination says that an individual participant is autonomous; the individual holds right to decide to or not to participate in the study without risking any untoward treatment (Polit and Beck 2008; Burns and Grove 2009; Schmidt and Brown 2009; Brink, Van der Walt and van Rensburg 2012). Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibility and likely risks and benefits. Deception and concealment of information are to be avoided at all costs (Polit and Beck 2008: 172). The participants were all volunteers. Full information was given about the study for example the aims, benefits and risk associated with study. Participants had a right to withdraw anytime they felt it was necessary and no punishment was instituted because of such withdrawal.

3.11.2. Beneficence

The researcher had a duty to minimise harm and discomfort and maximise the benefits. Harm can either be physical, psychological, emotional, spiritual,

economic, social or legal (Polit and Beck 2008; Brink, Van der Walt and van Rensburg 2012). The researcher had an obligation to minimise participants' burden and place as few demands as possible on them (Schmidt and Brown 2009). The study had no physical discomforts for the participants and no financial burdens as the study was conducted in the participants free time and in their natural settings.

3.11.3. Justice

This refers to the participant's right of fair selection, fair treatment and privacy (Polit and Beck 2008; Brink, Van der Walt and van Rensburg 2012). Privacy is an individual's right to determine the time, extent and general circumstances under which personal information will be shared with or with-held from others (Burns and Grove 2009). Participants who accepted to participate in the study had the right to expect that information collected from or about them would remain anonymous and confidential (Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). All information shared by the participants was treated as confidential. In all transcripts the original name and registration number of participant do not appear. Code names and numbers were used as names for participants. All lists with true identities of participants whether in laptop, audio recorder or written list of participants will be kept privately by the researcher in a safe place.

3.11.4. Consent

Once the study was fully explained to the participant including the rights of the participant, the role of the participant, voluntary participation and the risk and benefit of the study, written consent was obtained from the participant (Annexure 7) (Polit and Beck 2008; Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). The understanding of all this information was ensured by eliminating all technical terminology and professional jargon (Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012). A written consent was obtained in a language that the participant could understand.

3.11.5. Confidentiality

Confidentiality was maintained through out the study. In transcribed data no where the names of the participants appears. Only codes appears in transcribed data so that there might be no way of linking transcribed data back to the participants. Burns and Grove 2009; Brink, Van der Walt and van Rensburg 2012) Even in audio tapes the participants are not called by their names all to ensure confidentiality. The consent forms where the names of participants appears were kept by researcher in lockable cupboard

3.12. PRESENTATION OF RESULTS

In a qualitative study, findings are usually presented in terms of the themes that emerged from data. In order to substantiate and illustrate these themes examples of raw data are presented, for instance direct quotes from interview transcription or accounts of observations (Brink, Van der Walt and van Rensburg 2012). Narrative patterns were used to present information.

3.13. DISTRIBUTION OF RESULTS

The data analysis, findings and recommendations will be sent to the public hospital concerned, to participants and provincial office (KZN) and will be published in medical/nursing related journals.

3.14. CONCLUSION

This chapter described the qualitative design and research methodology used in the study, specifically focusing on the assumed and actual target population and resulting sample. Ethical considerations are described as well as the collection and management of the data. The data analysis process is introduced. Data will be presented in Chapter 4.

CHAPTER 4: PRESENTATION OF THE RESULTS

4.1. INTRODUCTION

The previous chapter outlined the methodology adopted in conducting the study. As described in the previous chapter, a qualitative, exploratory and descriptive research design was used to explore and describe experiences of midwives regarding nursing practice breakdown in maternity units. Semi-structured interviews were used to collect data from consenting professional nurses. Within the current chapter the findings of the study are presented, analysed and interpreted within the context of the Donabedian's framework. The objectives of the study were to:

- Explore experiences of professional nurses regarding integration of mental health into primary health care.
- Describe experiences of professional nurses regarding integration of mental health into primary health.
- Identify challenges faced by the professional nurses regarding integration of mental health into primary health care.
- Develop recommendations to facilitate the integration of mental health into primary health care.

Furthermore, the conceptual dimensions of care identified within Donabedian's framework as structure, process and outcome were referred to during the analysis process. As such, each of the emerging themes was grouped either in terms of whether they related to structure, process or outcome as per the theoretical framework. To allow for the development of new insights, issues that did not fall into each of these articulated dimensions were collated as stand-alone themes and were reported. The presentation of data is according to each of the participant themes and in the end a summative overview of overall observed themes is presented. Despite the differentiation between the different participants, the process for data collection with each professional nurse was

identical and involved the identification of themes supported by relevant quotations.

4.2. DEMOGRAPHIC DATA

After a brief explanation about the study and written consent obtained, a total of 13 participants who were all professional nurses employed at the selected hospital which included gateway clinic and clinics participated in data collection processes and as indicated above, took part in a single face-to-face interview. Table 4.1 provides a descriptive overview of key characteristics of the participants including age, area of speciality and work experience.

Table 4.1: Summary of professional nurses who were participants in the study

Partici pant No.	Age	Nursing speciality	Department	Years of experience in Primary health care
1	30	Professional nurse	Gateway clinic	7
2	34	Professional nurse	Clinic	10
3	41	Professional nurse	Gateway clinic	22
4	33	Professional nurse	Clinic	19
5	31	Professional nurse	Gateway clinic	13
6	34	Professional nurse	Clinic	15
7	40	Professional nurse	Kranskop Clinic	11
8	38	Professional nurse	Clinic	17
9	32	Professional nurse	Clinic	9
10	30	Professional nurse	Kranskop Clinic	12
11	30	Professional nurse	Gateway clinic	10
12	41	Professional nurse	Clinic	12
13	49	Professional nurse	Clinic	8

Table 4.1 shows that all 13 participants (100%) had experience in or continued working at the selected hospital in primary health care.

4.3. EMERGENT THEMES AND RESEARCH FINDINGS

‘Theme’ is a systemic method of managing data and aids the researcher to gain access to the data that was collected easily. Theme is also a method of breaking down data to smaller pieces and grouping similar content under one sub-heading. Theme is a recurring viewpoint that emerges from an analysis of qualitative data (Polit and Beck 2008).

During data collection and analysis, a number of themes emerged and these themes and sub-themes are discussed with accompanying quotations from the data that was collected during each of the data collection phases.

For ease of presentation, the themes, subthemes and verbatim statements from participants that emerged from this phase of data collection are summarised in Table 4.2.

Table4.2: Summary of themes in relation to Donabedian’s framework

Theme identified	Sub-themes	Relationship to the Donabedian’s Framework	Exemplar verbatim statements from participants
Administration	<ul style="list-style-type: none"> Staffing of professional nurses Referral system 	Structure	<p><i>There is a shortage of professional nurses in institutions as a whole. One professional nurse is expected to run or oversee most of the programs in the clinic.</i></p> <p><i>Our clinics are busy since we get mental health care users and other patients referred from the hospital for outpatient review and also for minor illnesses.</i></p> <p><i>There are many more patients than nurses and as a result some</i></p>

			<p>mental health care users go unexamined thoroughly.</p> <p>More professional nurses are needed to in the clinics with knowledge of mental health.</p> <p>The hospital refers mental health care users to the clinics just to avoid overload from the hospital without stabilising them.</p> <p>The hospital refers critical mental health care providers to the clinic.</p> <p>Some mental health care users are referred by their families this creates overcrowding.</p> <p>If you are a professional nurse working the clinic, you expected to participate in decreasing the number of mental health care users in the hospital by allowing them to dump patients to you then, you on your own.</p>
Resources	<ul style="list-style-type: none"> • Availability and proper allocation of funds • Availability of working material (medication) 	Structure	<p>Most of the staff has no qualification for mental health and there is less staff with mental health knowledge.</p> <p>We are expected to go out to the community for mental health outreach but there are no funds available.</p> <p>At times medication is not delivered on time because of shortage of it and mental health care users end up relapsing.</p> <p>There are not enough rooms to treat critical mental healthcare users when they had relapsed and unstable users.</p>
Knowledge & skills	<ul style="list-style-type: none"> • Guidelines and policies • Training • Scope of practice 	Structure	<p>The staffs are expected to treat mental health care users according to Mental health care Act 17 of 2002 while we have no knowledge of it.</p> <p>The shortage of mental health care specialist lead to professional nurses acting above their scope of practice because we diagnose and prescribe medication for mental health care users.</p> <p>We often do in-service training according to mental health circular that we get to clinic but no specialist come to train us. In-service training has to be done</p>

			<p><i>always about the guidelines and policies</i></p> <p><i>And the Information that is taught during in-service training is not enough; we as professional nurses need constant training and updating.</i></p>
Service delivery	<ul style="list-style-type: none"> • Poor service delivery • Service below expected standard 	Process	<p><i>The mental health care service that is rendered by the clinics is very poor.</i></p> <p><i>There are many violent mental health care users in the community that should have been stable by now.</i></p> <p><i>At some point you find the clinic being overcrowded by known mental health care users most are unstable and other health user in the clinic end up goes untreated or unseen.</i></p> <p><i>We are supposed to treat mental health care users in the clinic together as with other health users but we end up treating them separate because there are so many unstable from hospital.</i></p> <p><i>Professional nurses find it difficult to handle most the clinics program and they are not happy and this decreases the level of mental health services.</i></p>
Influence on professional nurses	<ul style="list-style-type: none"> • Increase in stress levels • Escalating levels of absenteeism • Lost interest in mental health 	Outcome	<p><i>I have grown to dislike mental health care services.</i></p> <p><i>I am happy to run other program such antenatal or TB but mental health care make me sick.</i></p> <p><i>We work in dangerous condition with violent mental health care users and we scared that we may be hurt.</i></p> <p><i>Other staff members often get absent including me when it comes to mental health care services.</i></p> <p><i>I have lost interest in working in the clinic because nobody care for us and how we copying.</i></p> <p><i>If I had a choice or get the transfer to work in the hospital where mental health care users are discharged to the clinics.</i></p> <p><i>Most of us have developed negative attitude towards working in mental health care services.</i></p>

Influence on care of the mental health care users	<ul style="list-style-type: none"> • Mental health care users relapse • Early discharged of mental health care users in hospitals 	Outcome	<p><i>The relapse of mental health care users due to skipping appointment dates.</i></p> <p><i>Poor tracking of defaulters.</i></p> <p><i>Poor understanding of severe mental illness from the staff.</i></p> <p><i>There is still mental health stigma within families of mental health care users and community at large.</i></p> <p><i>Poor community outreach to families.</i></p> <p><i>Poor understanding of the need to provide psycho education to families.</i></p> <p><i>The hospital discharges unstable mental health care users to community and clinics.</i></p> <p><i>The hospitals give us the all the burden to track families of mental health care users with minimum support.</i></p>
---	---	---------	---

4.4. THE DISCUSSION OF THEMES AND SUB THEMES

The researcher discusses each theme and key sub-themes elicited from each participant based on the Donabedian's framework which focuses on structure, process and outcomes. The objectives of the study are to:

- .Explore experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- Identify challenges faced by the professional nurses regarding integration of mental health into primary health care.
- Develop recommendations to facilitate the integration of mental health into primary health care.

The discussion is also structured according to the objectives.

4.4.1. Objective 1: Explore experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.

Relevant themes identified that formed part of the structure according to framework of the study included:

- Administration
- Resources
- Knowledge and skills

a. Administration

Administration falls under structure in this framework. Administrators are managers of the institution including both the hospital and the clinics. This theme deals with issues that ought to be/have been sorted out by the managers including the nursing managers. Once such problems are sorted out by the management, the clinic will not perform as required. The main subthemes were identified relevant to this theme were:

- Staffing of professional nurses
- Referral system

i. Staffing of professional nurses

There is a shortage of professional nurses in institutions as a whole. One professional nurse is expected to run or oversee most of the programs in the clinic.

Our clinics are busy since we get mental health care users and other patients referred from the hospital for outpatient review and also for minor illnesses.

There are many more patients than nurses and as a result some mental health care users go unexamined thoroughly.

The professional nurses complained of severe shortage of mental health care provided yet there is so much of mental health care users are being referred to the clinics. Statements like: *“we are short staffed”* Participant 02, 03, 07 and 08.

Participants said: *there are more patients at the clinics than professional nurses’* participant 09 and 10. There are many more patients than nurses and as a result some mental health care users go unexamined thoroughly and more

professional nurses are needed to in the clinics with knowledge of mental health.

ii. Referral system

The referral system of mental health care users by the hospitals as form of primary health care integration causes the clinics to have mental health care users who are unstable. Some participants said:

“There is something wrong with this referral system” participant 05 and 06

“If you are a professional nurse working the clinic, you expected to participate in decreasing the number of mental health care users in the hospital by allowing them to dump patients to you then, you on your own” participant 01.

The hospital refers mental health care users to the clinics just to avoid overload from the hospital without stabilising them. Some participants said: *“The current referral system causes the clinics to have untreated mental health care users”* participant 07.

“The hospital referred critical mental health care users to the clinics” participant 08.

The system is having lope holes hence some people have no knowledge of how to referrer their relatives. Participants said:

“Some mental health care providers are referred by their families this creates overcrowding” participant 09 and 10.

b. Resources

According to the framework utilised in the study resources form part of the structure. Resources in this context refer to working material and availability of funds. For quality mental health care services to be rendered resources must be made available to the professional nurses at required working state. Sub themes that were identified include:

- Availability and proper allocation of funds
- Availability of working material (medication)

i. Availability and proper allocation of funds

Most of the staff has no qualification for mental health and there is less staff with mental health knowledge. Participants said:

“If more funds can be allocated in mental health most professional nurses will be trained for mental health services” participant 03

“We are expected to go out to the community for mental health outreach but there are no funds available” participant 01

ii. Availability of working material

Mental health care services require the users to be under medication to remain stable and not harm to the community and adequate infrastructure to conduct mental health classes or sessions. Midwives were of the view that the stores department always seem to have a problem keeping up with demands of maternity units. Participants said:

“There is a shortage of medication at the clinics because it is not delivered on time and mental health care users end up relapsing” participant 03 and 09.

“There are not enough rooms to treat critical mental healthcare users when they had relapsed and unstable users” participant 05 and 10.

c. Knowledge and skills

According to the framework of the study knowledge and skills form part of the structure. All professional nurses during their practice must show evidence of knowledge, skills and competency. Lack of such knowledge and competence and skills may causes breakdown in mental health practice impossible. Sub themes that were identified include:

- Guidelines and policies

- Training
- Scope of practice

i. Guidelines and policies

Failure to follow set guidelines and policies will lead to serious outcomes in mental health care practice. The participants said:

“The prescribed policies are read at the clinics weekly but they are not followed” participant 06.

“Failure to follow guidelines and policies makes it even difficult to treat mental health care users and be part of mental health integration” participant 04

ii. Training

The knowledge, skills and competencies of mental health care providers are questionable. Professional nurses rose that they have not attended the in-service education in a very long time meaning that the knowledge they have is out-dated. The participants said that:

“We often do in-service training according to mental health care circular that we get at the clinic but no specialist comes to train us” participant 01.

“The Information taught to us during in-service training is not enough, we as professional nurses need constant training and updating” participant 06.

iii. Scope of practice

Mental health care providers or professional nurses are all given scope of practice under which they are expected to practice. Practicing above scope of practice puts that health care provider at risk. Participants said:

“The staffs are expected to treat mental health care users according to Mental health care Act 17 of 2002 while we have no knowledge of it” participant 07.

“The shortage of mental health care specialist lead to professional nurses acting above their scope of practice because we diagnose and prescribe medication for mental health care users” participant 08.

4.4.2 Objective 2: Experiences regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal. Relevant themes that were identified which formed part of the process according to study framework included:

- Service delivery

Relevant themes that formed part of the outcomes according to the framework included:

- Influence on professional nurses
- Influence on care of the mental health care users

a. Service delivery

In the research framework this is the process. In their practice midwives render maternity practice which must meet the expected standards. Failure to meet such standards equals poor service delivery. Subthemes identified included:

- Poor service delivery
- Service below expected standard

i. Poor service delivery

Participants are not confident about the service they are giving to the community. The mental health care providers do not feel proud about the service they render hence. Participants said:

“The mental health care service that is rendered by the clinic is very poor”
participant no 04

“At some point you find the clinic being overcrowded by known mental health care users most are unstable and other health user in the clinic end up goes untreated or unseen” participant no 05:

“There are many violent mental health care users in the community that should have been stable by now” Participant no 07

“We are supposed to treat mental health care users in the clinic together as with other health users but we end up treating them separate because there are so many unstable from hospital” participant no 7.

ii. Service below expected standards

The integration of mental health into primary health care is to be implemented according to policies, regulations, protocols and set standards. Services below expected standards lead to professional nurses feeling stressed and it also lead to mental health care users not getting the services they entitled to. Participants said:

“I am sure the service we render does not meet the required standards” participant 01

“I find it difficult to handle many the clinic programs and they are not happy and this decreases the level of mental health services” participant 03

“The way things are currently happening, it is practically impossible to meet required standards”. Participant 06

“I am supposed to treat mental health care users in the clinic together as with other health users but we end up treating them separate because there are so many unstable from hospital” participant 07

b. Influence on professional nurses

This is looking at what impact does the above mentioned factors have on mental health care providers. In the research framework the influence on professional nurses forms part of the outcome. The factors mentioned above influences mental health care providers negatively. Subtheme identified included:

- Increase in stress levels
- Escalating levels of absenteeism

- Lost interest in mental health

i. Increase in stress levels

Most midwives are having elevated stress levels due to work related matters.

The participants said:

"We are taking a risk about our careers here we can be charged" participant no 2

"We work in dangerous condition with violent mental health care users and we scared that we may be hurt" participant 08

ii. Escalating levels of absenteeism

Professional nurses often absent themselves to avoid mental health allocation on that particular week. If one is absent leads to understaffed and other clinics programs suffers or mental health care services are not rendered as required.

The participants said:

"Other staff members often get absent including me when it comes to mental health care services" participant 06

"Most of us have developed negative attitude towards working in mental health care services" participant 11

iii. Lost interest in mental health

The outcome of integration of mental health into primary health care has led to mental health care providers losing interest in mental health. The participants said:

"I have grown to dislike mental health care services" participant 09

"I am happy to run other program such antenatal or TB but mental health care make me sick" participant no 10

"I have lost interest in working in the clinic because nobody care for us and how we copying" participant 01

"If I had a choice or get the transfer to work in the hospital where mental health care users are discharged to the clinics" participant 12

c. Influence on the care of mental health care users

According to the framework that was utilised in the study it has influence on the care of the mental health care users. The integration of mental health into primary health care is having a negative impact not only on the professional nurses but also on the mental health care users. Sub themes identified included:

- Mental health care users relapse
- Early discharged of mental health care users in hospitals

i. Mental health care users relapse

Mismanagement and improper implementation of integration of mental health into primary health care has led to mental health care users not fully rehabilitated. Professional nurses are not supported at the clinics level to facilitate the integration meaning mental health care users suffer the consequences to relapse. Participants said:

“The relapse of mental health care users due to skipping appointment dates” participant 13

“We are not given resources to track down defaulters” participant 06

Knowledge has the influence on relapsing of mental health care users meaning treatment and education is not always given as required.

“We do not fully understand the severity mental illness” participant 07

“There is still mental health stigma within families of mental health care users and community at large” participant 10

ii. Early discharged of mental health care users in hospitals

The simple meaning of mental health integration into primary health care is to treat mental health care users near their homes which are the clinics. The hospitals should discharge inpatients mental health care users when they are stable and fit to be treated as outpatients. Participants said:

“The hospital discharges unstable mental health care users to community and clinics” participants 03, 05 and 11

The resources to support the clinics with discharged mental health care users should be offered.

“The hospitals give us the all the burden to track families of mental health care users with minimum support” participants 08 and 09

4.5. SUGGESTION MADE TO IMPROVE MENTAL HEALTH INTEGRATION INTO PHC

When participants were asked to make suggestion that would improve mental health integration into primary health care the following suggestions were made: Participants then identified issues that they believed they ought to be changed. There were suggestions that might result from their inabilities as professional nurses. Suggestions were differentiated between modifiable and non-modifiable factors that have to change for service delivery to improve.

4.5.1. Modifiable factors

Modifiable factors included equipping mental health care providers or professional nurses with more skills. In support of this, some of the participants said:

“...More professional nurses must be trained and have advanced mental health care” Participant 01.

“...All professional nurses working at the clinics must have advanced mental health care and people must be selected fairly to go for the training” Participant 12.

The participants recommended that there was a need for support from the hospital managers in order to improve the quality of mental health care at the clinics. This is evidenced in the excerpts below:

“...We need support from our hospital managers they must provide us with resources and help us implement integration of mental health into primary health” Participant 02.

Professional nurses were of the opinion that equipping them with mental health skills which include sending them for in-service education and refresher courses would help to improve mental health services.

4.5.2. Non- Modifiable factors

Non-modifiable factors include the mental health consultation rooms at the clinics to avoid overcrowding and improve comfortability of the users. And also to create an environment for mental health care users at the hospital who are not mentally stable for the community.

4.6. CONCLUSION

The current chapter dealt with management of field data. The data was generated from professional nurses working at the clinics. During the management of data, quality was retained and managed through an integrative process using Tesch's method of data analysis. The chapter discussed participants' observations and presented a brief description of qualitative data to complement personal accounts. The narratives were subsequently integrated into themes that spoke to the domains identified by Donabedian's in his work on human systems.

CHAPTER 5: DISCUSSION OF THE RESULTS

5.1. INTRODUCTION

The intention of this chapter is to discuss the most important findings in relation to the research questions and the theoretical framework discussed in Chapter 2. Literature is used where necessary to further clarify findings that emerged from data analysis.

5.2. RESEARCH OBJECTIVES AND THEORETICAL MODEL

In Chapter 1, research objectives were set that gave direction to the study. The objectives of the study were to:

- Explore experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- Describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- Identify challenges faced by the professional nurses regarding integration of mental health into primary health care.
- Develop recommendations to facilitate the integration of mental health into primary health care.

Data collection and analysis was guided by Donabedian's theoretical framework.

5.3. SUMMARY OF DATA COLLECTION

A qualitative, exploratory and descriptive research design was used to explore and describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal. Semi-structured interviews were conducted with midwives employed at the selected hospital in maternity units. As mentioned in the previous chapter, a total of 13 interviews were conducted. Interviews were conducted in the participants' work place. Data saturation was reached at the end of the eighth interview but the researcher proceeded to conduct five more interviews to confirm data saturation. All interviews were voice recorded. The researcher transcribed the interview content verbatim, both the transcribed material and original tapes were handed over to supervisors who examined them and ensured that they coded correctly so as to exclude bias.

5.4. FINDINGS OF THE STUDY BASED ON RESEARCH OBJECTIVES

The findings of the study revealed that professional nurses had challenges regarding integration of mental health into primary health care almost daily. Most of the findings of this study were consistent with the findings of other studies that were relevant to this study. Professional nurses outlined that the experience and challenges regarding the integration of mental health into primary health care were of contributory factors that were often beyond their control. The contributory factors are described below. Findings below are discussed based on the objectives of the study

5.4.1. Explore and describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.

- Early discharged of mental health care users in hospitals

a. Staffing of professional nurses

The study confirmed that there was a shortage of professional nurses and advanced mental health care providers. Participants reported that the shortage

is so bad that they have to run more than one programs at the clinics. The participants reported that they were overloaded with work. The clinics are the first care of the community meaning everyone must get access to first care of health as stated by the Minister of Health but other health program suffers because of shortage of mental health care providers. The reasons were raised for personnel shortage, some of which include unemployment of professional nurses and slow process of training of professional nurses. Nurses indicated that they do not provide quality mental health because they experience shortages of staff (Burns, 2014). Uys and Dube 2015 agrees that staff shortages in PHC clinics are a barrier towards provision of quality mental health care, especially in rural clinics because these clinics are overburdened with multiple programmes and high patient workload.

These findings confirmed the findings of the WHO, which stated that a shortage of professional nurses and mental health care users has been, noted worldwide (WHO 2014). According to the RSA Department of Health, there is a gradual decline in the number of nurses with specialised qualifications such as critical care nursing, child care nursing, and operating theatre nursing, advanced midwifery and advanced psychiatry (RSA Department of Health 2013)

b. Referral system

Participants were of the view that current referral system causes the influx of pregnant mental health care users at the clinics. They felt that it not clear leading to overcrowding of mentally unstable users at the clinics. They felt that it was either the system was not functioning at all or proper referral procedures are not followed. According to RSA, Department of Health (2007) proper criteria for referral must be established. The participants felt that the referral system of mental health care users by the hospitals as form of primary health care integration causes the clinics to have mental health care users who are unstable and the hospital refers mental health care users to the clinics just to avoid overload from the hospital without stabilising them.

The Act ensures that hospitalizing persons involuntarily due to harm of self and others does not take away their right. It requires certifying such persons within

a 72-h assessment period, allowing a period where they can potentially be stabilized and be cared for in the community (Mental Health Care Act 17 of 2002)

c. Availability and proper allocation of funds

Participants were of the view that mental health is not prioritised during allocation of funds. The resources required to deliver mental health services includes human resources, service facilities and budgets have been consistently shown to be inadequate Lund, Petersen, Kleintjes & Bhanafra (2012).

This is evidenced by continuous lack of trained mental health care providers and working material. Abdelgadir (2012) states that globally, there is inadequate financial support for mental health care programs and that early detection of mental illness requires more intervention and spending on mental health at all levels, especially primary health care level. The inadequate funding of integrated mental health care and primary health care may challenge the integration because it could be the cause of poor human resources, material resources and trained staff as well as infrastructures (Abdelgadir 2012).

d. Availability of working material (medication)

Findings of this study also revealed the professional nurses find it difficult to perform their duties because of either limited or non-availability of working material. Mental health care services require the users to be under medication to remain stable and not harm to the community and adequate infrastructure to conduct mental health classes or sessions. Some participants reported there is shortage of medications at the clinics because it is not delivered on time and mental health care users end up relapsing. Professional nurses should be supported by management when caring for psychiatric patients with mental illnesses (Smith, 2013)

e. Guidelines and policies

Participants were of the view that policies and guidelines are read weekly but they are not followed. Failure to follow set guidelines and policies often leads to serious outcomes in health practice including mental health care services and makes it even difficult to treat mental health care users and be part of mental health integration into primary health care. The National mental health policy in South Africa promotes deinstitutionalisation and treating mental health as an integral part of primary health care (WHO, 2015).

f. Training

The study also revealed that some professional nurse were not given constant training and had out dated knowledge of mental health care. Professional nurses were of the opinion that often does in-service training according to mental health circular provided at the clinic but preferably with the psychiatrists. Lack of knowledge made it impossible for professional nurses to note signs relapsing and the proper way of preventing such. The available facilities do not have the expertise to care for the more severely disabled and disturbed mental health care users (Krüger & Lewis, 2011).

The study also revealed that most professional nurses had not done workshops or even in service education in a long time this made the researcher is of the opinion that they have information that is out-dated. Delivery of mental healthcare within primary healthcare systems requires a radical role transition of mental health professionals, from mainly service delivery to programme design, training, supervision, consultation-liaison for complex cases and,

evaluation of programmes at the primary healthcare level and in the community (Patel, 2009; Thornicroft & Tansella, 2013)

Professional nurses were of the opinion that there was favouritism when professional nurses were chosen to go for post basic studies like advanced in mental health. According to participants many reasons for this were identified for not organising training, the main reason being constant complaints of lack of funds from the Department of Health.

g. Scope of practice

Participants raised the issue that because of shortage of Psychiatrists and advanced mental health nurses they end up being forced to perform duties above their scope of practice thus putting their careers and lives of mental health care users at risk. Practicing above scope of practice puts that health care provider and health clients at risk. Mental health care providers are all given scope of practice under which they are expected to practice. All mental health care users must practice within their scope of practice (SANC 1991).

5.4.2. Experiences of professional nurses regarding the integration of mental health care into primary health care in KZN ILembe district.

a. Poor service delivery

Professional nurses are of the view that the mental health services that they render in the current status are poor. The professional nurses do not feel proud about the service they render hence it is clear that the service rendered was poor.

b. Service below expected standards

If the service that is rendered is not in line with the policies, regulations, protocols and set standards that mean the service are below expected standards. Services below expected standards lead to mental health providers feeling stressed and it also lead to negative attitude towards mental health and followed by litigations. The RSA Department of Health has admitted that

litigation against it is high (RSA Department of Health 2013). Participants explained that at some point you find the clinic being overcrowded by known mental health care users most are unstable and other health user in the clinic end up goes untreated or unseen. During interviews the participants emphasised that are not confident about the service they are giving to the community. Barriers to a task sharing approach include the significant rates of staff turn- over in many primary healthcare settings, the requirement of substantial training and supervision, and overloading primary health workers with tasks they cannot reasonably perform well (Eaton et al., 2011; Iwu & Holzemer, 2014). The integration of mental health into primary health care is to be implemented according to policies, regulations, protocols and set standards. Services below expected standards lead to professional nurses feeling stressed and it also lead to mental health care users not getting the services they entitled to. The South Africa Mental Health Care Act 17 of 2002 state that mental health care should be fully integrated into primary health care and mental health care practitioners should take responsibility for mental health care needs.

5.5. Influence on professional nurses

a. Increase in stress levels

The study revealed that professional nurses were experiencing high stress which is work related. Stress they experienced was high to such an extent that most participants were no longer wanted to mental health. The participants were of the opinion that they were neglected. During the interviews, participants reported that absenteeism levels were very high among mental health care provider, resulting in increased stress levels.

Working under stressful conditions can result in practice breakdown (Makhanya 2012). Therefore, it is imperative that health care institutions should focus on improving working conditions by promoting healthy workplace environments.

b. Escalating levels of absenteeism

Professional nurses have resorted to absenting themselves from work to avoid mental health care services. If one is absent leads to understaffed and other clinics programs suffers or mental health care services are not rendered as required.

c. Most staff members resigning

The study is view that the outcome of integration of mental health into primary health care has led to mental health care providers losing interest in mental health. Professional nurse intentions to leave the organisation stems from their job dissatisfaction. Job dissatisfaction encompasses feelings and emotions that employees attribute to their poor working conditions (Horwitz and Pundit 2008).

5.6. Influence on the care of mental health care users

a. Mental health care users relapse

The study has shown that the mismanagement and improper implementation of integration of mental health into primary health care has led to mental health care users not be fully rehabilitated. Participants have viewed the opinion that there is no support at the clinics level to facilitate the integration meaning mental health care users suffer the consequences to relapse. Given their prevalence and evidence for effective task shifting, common mental disorders, such as depression, anxiety and alcohol use disorders are most suitable for treatment by non-specialists within healthcare settings (Patel et al., 2013).

The participants state that they had no training which led to relapsing of mental health care users meaning treatment and education is not always given as required.

b. Early discharged of mental health care users in hospitals

The simple meaning of mental health integration into primary health care is to treat mental health care users near their homes which are the clinics. The participants reported that the hospitals are taking advantage of the integration

of mental health into primary health care by discharging mental health care users to clinics and community to avoid over flow from the hospital.

5.7. CONCLUSION

This chapter dealt with reporting of the findings of the study. The study revealed that professional nurses were not satisfied with integration of mental health into primary health care and there challenges encountered. The next chapter will present the recommendations emanated from the study.

CHAPTER 6: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1. INTRODUCTION

The intention of this chapter is to discuss the most important findings in relation to the research question and the theoretical framework discussed in Chapter 2. Literature is used where necessary to further clarify findings that emerged from data analysis.

6.2. CONCLUSION

Mental health care is a unique profession and mental illnesses are illnesses that affect the psychological aspect of the human being. All living human being are prone to mental illness as it takes triggering factor to suffer from it. All mental health care providers in the profession have been trained to care and to render safe and efficient mental health care services. The integration of mental health into primary health care is an initiative program to fully rehabilitate mental health care users. Primary health care services are offered at the clinics so as mental health services so it is important to note that integrating these services will rehabilitate affected people and educate the communities at large about living with mental illness. Integration of mental health care into primary health care to be successful, supporting structures such as hospital managers and Department of health must support Professional nurses working the clinics as they running the program.

6.3. STUDY LIMITATIONS

Qualitative research design was used in this study. Conducting the study utilising the other research design might yield other results. The study was conducted at a public hospital and its various clinics, which is a Level I hospital situated in a rural area of iLembe District. The study can also be performed in a semi urban area where the hospital is a Level II hospital. The study was conducted in one district which was iLembe district therefore the findings obtained cannot be generalised to other district hospitals, as they may have different infrastructure, development and geographical features.

6.4. RECOMMENDATIONS

The following recommendations were made based on the findings of the study:

6.4.1. Administrators

At the national and provincial levels the administrators must formulate guidelines and policies that support and helps the professional nurses at the clinics rendering mental health services. The National Department of Health must develop a strategy that will prioritise professional nurses in mental health services. A compensation model must be developed for professional nurses who work especially in mental health care at the rural areas and provision for safety or danger allowance. An appraisal for professional nurse who specialised in any of the speciality areas relevant to mental health care which might include advanced mental health.

At the district and institutional levels nurse administrators must ensure a working apparatus are provided for professional nurses at the clinics for integration of mental health into primary health. Nurse administrators must offer emotional and physical support for professional nurses or even refer to Psychologist so that professional nurses may feel important. The administrators must organise a debriefing sessions with professional nurses and nurse administrators. Nurse administrators must make mental health care services department a priority when funds are allocated of funds is to be done.

The implementation of a proper support system for professional nurses will be beneficial.

The formulation of forums for mental health providers at the clinics where challenges and issues are discussed to facilitate integration of mental health into primary health care. Consistent monthly or trimester meetings between the professional nurses and mental health coordinators might help by offering them a platform to air their grievances and also the implementation of the employee assistance programme may be effective in this regard.

6.4.2. Education

Mental health guidelines should be implemented for professional nurses working at the clinics. The policies of such guidelines must outline the importance of revising them weekly. The researcher feels that professional nurse should be allowed to study post basic diplomas of mental health care on their own because waiting period to study is too long. The policies regarding selecting professional nurses for post basic courses should be amended and professional nurse must be encouraged to do mental health care related post basic courses. The professional nurses should continuously be taken for refresher courses and workshops. The institution has to constantly liaise with iLembe Health District mental health specialist regarding in-service education for the professional nurses so that they are up to date. Constant skills assessment by the district management must be conducted in the clinics to ensure if the integration of mental health into primary health is of quality and facilitated accordingly. Quality assurance practitioners must constantly assess the quality of work done at the clinics regarding mental health care services.

All professional nurses must acquaint themselves with new guidelines and policies and in-service training on mental health care must be done daily in the morning. It remains the duty of nurse administrators to ensure that the professional nurses are aware of new policies and guidelines.

6.4.3. Staffing

Professional nurses must be allocated according to off duties drafted by the management to avoid over flowing of more one clinic programs and mental health. Professional nurses who absent themselves as a reason of disliking the allocation to mental health must be disciplined accordingly. Career development should be considered as another option to attract and maintain more mental health care providers. All vacant posts must be filled timeously. The clinic must at least have two mental health providers with post basic diploma of mental health. Support staff must be employed including ward the security guard in case of unstable mental health care users with dangerous objects with the aim of harming others or self. The Department of health should emend the staffing nursing agencies as the other option that can assist in alleviating shortage of professional nurses at the clinics for mental health care services.

6.4.4. Further research

Further studies will be on the assessment of the mental health care services at the Primary health care facility regarding the integration of mental health care into primary health care. To ascertain whether such integration implemented has an effect on the target and the influence of mental health care users and community to the integration.

References

Anon. 2016. Department of health in Kwazulu-Natal. Available: www.kznhealth.gov.za (Accessed 13 July 2016)

Bailliere's Nurses' Dictionary. 2010. 25th Ed. London: Bailliere Tindal Elsevier.

Betancourt, O A and Herrera, M M.2010. Community rehabilitation for schizophrenia patients: Is it feasible in South Africa? 16 (3):66-68.

Botma, Y., Greef, M., Mulaudzi, F.M. and Wright, S.C.D. 2010. *Research in health sciences*. Cape Town: Pearson.

Bradshaw, L.K. 2011. A phenomenological exploration of the value of caring nursing practice (online). Master of Science in Nursing, Utah Valley University. Available: <http://contentdm.uvu/cdm/compoundobject/collection/UVUTheses/id/574/rec8> (Accessed 14 August 2017).

Brink, H. Van der Walt. C and Van Rensburg, G.2012. Fundamentals of Research Methodology for Healthcare Professionals.3rd ed. Cape Town.Danya Rastic.

Burns, N. & Grove, S.K. 2009. The practice of nursing research: appraisal, synthesis, and generation of evidence. Sixth edition, St. Louis: Saunders.

Creswell, J.W. 2009. *Research design: Qualitative, Quantitative and Mixed method approaches*. 3rd ed. California - SAGE publishers Inc.

Creswell, JW. 2012. *Research Design: Qualitative, Quantitative and Mixed Method approaches*. Four edition. Lincoln: Sage Publications.

De Vos, A.S., Fouche, C.B. and Delport, C.S.L. 2011. *Research at grassroots*. 7th Ed. Pretoria: Van Schaik.

Donabedian, A. 1980. Explorations in quality assessment and monitoring, Volume I: The definitions of quality and approaches to its assessment. *Medical Care*, 19(10): 1066-1067.

Donabedian, A. 2005. Evaluating the quality of medical care. *The Milbank Quarterly*, 83(4), 691-729.

Dube, FN and Uys, LR. 2015. Primary health care nurses management practices of common mental health conditions in KwaZulu-Natal, South Africa.38 (1)1168. Available: <http://dx.doi.org/10.4102/curationis.v38i1.1168>. (Accessed 01 June 2016).

Egbe, CO., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G and Petersen I. 2014. Psychiatric stigma and discrimination in South Africa. Perspectives from key stakeholders. 14:19. Available: <http://creativecommons.org/publicdomain/zero/1.0/>. (Accessed 15 June 2016).

Fentianah, N.A.A. 2012. Impact of nursing competence on quality of nursing care and safety of nursing practice (online). Doctor of Health Administration, University of Phoenix. Available: <http://media.proquest.com/media/pq/classic/doc/2766678581> (Accessed 14 September 2016).

Grove, S.K., Burns, N. and Gray, J.R. 2013. *The practise of nursing research: appraisal, synthesis, and generation of evidence*. 7th Ed. St Louis: Elsevier.

Goodrich, DE. Kilbourne,L., Nord K M, and Bauer M S. 2013. Mental Health Collaborative Care and Its Role in Primary Care Settings. 15(8):381.Available: doi: 10.1007/s11920-013-0383-2. (Accessed 11 June 2016).

Hanlon, C., Luitel, NP., Kathree, T., Murhar, V and Shrivasta, S.2014.Challenges and Opportunities for Implementing Integrated Mental Health Care. A District Level Situation Analysis from Five Low- and Middle-Income Countries. 9(2): e88437.Available: doi:10.1371/journal.pone.0088437. (Accessed 11 June 2016).

Hennink, M. Hutter, I. and Bailey, A. 2011. *Qualitative research methods*. Thousand Oaks, CA: Sage.

International Council of Nurses (ICN). 2012. The ICN code of ethics for nurses (online). Available: http://www.icn.ch/images/stories/documents/about/ICNcode_english.pdf (Accessed 14 June 2016).

Jack-Ide, IO. Uys, LR and Middleton, L E. 2012. International Journal of Nursing and Midwifery. A comparative study of mental health services in two African countries: South Africa and Nigeria. 4(4):50-56.Available: www.academicjournals.org/IJNM. (Accessed 30 May 2016).

Jenkins, R., Othieno, C., Aruwa, J., Kingora, J and Jenkins, B. 2013. BMC Health Services Research. Exploring the perspectives and experiences of health workers at primary health facilities in Kenya following training.13:368. Available: <http://www.biomedcentral.com/1472-6963/13/368>. (Accessed 20 June 2016).

Jooste, K. 2009. *Leadership in health services management*. 2nd ed. Lansdowne: Juta.

Jooste, K. 2010. *Ethos and professional practice, management, staff development and research*. 1st ed. Pretoria. Van Schaik.

KwaZulu-Natal (KZN) Department of Health. 2013. *Department of Health Annual Report 2012/2013*. Pietermaritzburg: Department of Health.

KwaZulu-Natal (KZN) Department of Health. 2014. *Department of Health Annual Report 2013-2014*. Pietermaritzburg: Department of Health.

KwaZulu-Natal (KZN) Department of Health. 2015. *Health facilities*. Pietermaritzburg: Department of Health.

Lund, C., Petersen, I., Kleintjes, S and Bhanafra, A J. 2012. Psychiatry Mental Health Services in South Africa: Taking stock. 2012; 15:402-405. Available: doi: <http://dx.doi.org/10.4314/ajpsy.v15i6.48>. (Accessed 01 June 2016).

Nakiganda, B., Lund, C., Fred, V N., Kizza, D., Nakku, J., Sebunnya, J and Ndyabangi, S. 2015. Development of a district mental healthcare plan in Uganda. Available: DOI: 10.1192/bjp.bp.114.153742. (Accessed 04 June 2016).

Nkosi, S.P. 2014. An analysis of perceptions of health professionals on service delivery challenges at Ngwelezana Hospital. Master's Degree in Public Administration, University of Zululand.

Ngo, V.K., Rubinstein, A., Ganju, V., Kanellis, P and Loza, N. 2013. *Grand Challenges: Integrating Mental Health Care into the Non-Communicable*

Disease Agenda. PLoS Med 10(5):e1001443. Available: doi: 10.1371/journal.pmed.1001443. (Accessed 23 June 2016).

Marais, N and Petersen, I. 2015. International Journal of Mental Health Systems (2015) 9:14. Available: DOI 10.1186/s13033-015-0004. (Accessed 04 June 2016).

Padmanatha, P and De Silva, MJ.2013. Social Science & Medicine. The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries.57:85-86.Available: www.elsevier.com/locate/socscimed. (Accessed 30 May 2016).

Patel, V., Belkin, GS., Chockalingam, A., Cooper, J., and Saxena, S .2013. Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. 10(5):e1001448. Available: doi: 10.1371/ journal.pmed.100144. (Accessed 19 June 2016).

Petersen, I., Lund, C., Bhana, A., Flisher, A J and the Mental Health and Poverty Research Programme Consortium.2012. Human resources and costs for primary mental health care. A task shifting approach to primary mental health care for adults in South Africa: human resource requirements and costs for rural settings.27 (1):48-50.Available: <http://heapol.oxfordjournals.org>. (Accessed 30 May 2016).

Polit, D.F. and Beck, C.T. 2008. *Nursing research generating and assessing evidence for nursing practice*. 8th Ed. Philadelphia: Lippincott Williams & Wilsons.

Polit, D.F. and Beck, C.T. 2010. *Essentials of nursing research appraising evidence for nursing practice*. 7th Ed. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. and Beck, C.T. 2012. *Nursing research: Generating and assessing evidence for nursing practice*. 9th Ed. New York: Wolters Kluwer/Lippincott Williams and Wilkins.

Republic of South Africa (RSA). 2005. *Nursing Act No 33 of 2005*. Pretoria: Government Printers.

Republic of South Africa (RSA). Department of Health. 2011. *National Core Standards for Health Establishments in South Africa*. Pretoria: Government Printers.

Republic of South Africa (RSA). Department of Health. 2013. *The National Strategic Plan for Nurse Education Training and Practice 2012/13-2016/17*. Pretoria: Government Printers

Schmidt, N. A. and Brown, J.M. 2009. *Evidence based practice for nurse's appraisal and application of research*. Sudbury, Massachusetts: Jones and Barlett Publishers.

South African Nursing Council (SANC). 1991. *Regulation relating to the scope of practice of persons who are registered or enrolled under nursing act 1978* (online). Available: www.sanc.co.za/regulat/reg-scp.htm (Accessed 4 July 2016).

South African Nursing Council (SANC). 2013b. *Professional misconduct cases for the period June 2013 to December 2013* (online). Available:

<http://www.sanc.co.za/pdf/Diciplinary%20Stats%202013-06%20to%202013-12.pdf> (Accessed 3 July 2016).

South African Nursing Council (SANC). 2015b. Age distribution (online). Available: <http://sanc.co.za/stat2014/Age%20stats%202014.pdf> (Accessed 14 July 2015)

World Health Organisation (WHO). 2006. *Quality of care: a process for making strategic choices in health systems*. Geneva: WHO.

Yin, R. K. 2009. *Case study research design and methods*. 4th Ed. Thousand Oaks, CA: Sage Publications.

ANNEXURES

Annexure 1: Permission letter to Chief Executive Officer



Faculty of Science and Agriculture

Department of Nursing Science

University of Zululand

PO Box X1001

KwaDlangezwa

3886

To : CEO: Untunjambili Hospital

Chief Executive Officer

Date

Dear Ms/Mr

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a registered Master's student in the Department of Department of Nursing Science at the University of Zululand. My supervisor is Dr RM Miya (D.Lit. et PHIL)

The proposed topic of my research is: Experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu- Natal

The objectives of the study are:

- a) To explore experiences of mental health care providers regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- b) To describe experiences of mental health care providers regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal
- c) To develop recommendations to facilitate the integration of mental health into primary health care.

I am hereby seeking your consent to conduct a research project.

To assist you in reaching a decision, I have attached to this letter:

- (a) A copy of an ethical clearance certificate issued by the University
- (b) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Researcher: M Zuma (Master's Degree student) KwaDlangezwa Campus 0711017912

Research supervisor: Dr RM Miya (D.Lit. et PHIL) KwaDlangezwa Campus-0837103551

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely

Signature.....

Name: Mr M Zuma

Annexure 2: Approval from Untunjambili Hospital

 health Department: Health PROVINCE OF KWAZULU-NATAL	Directorate Chief Executive Officer
Untunjambili Hospital Private Bag X216, Kranskop, 3268 Tel. 033-4440818. Fax 033-4440987. Email lungile.phakathi@kznhealth.gov.za www.kznhealth.gov.za	
18 August 2016	

To: Mr Mdumiseni Zuma

RE: REQUEST FOR RESARCH STUDY SUPPORT LETTER

1. Your letter dated 16 August 2016 refers.
2. The request to conduct research at Untunjambili Hospital is noted.
3. Please request for approval from Dr E. Lutge at Head Office Natalia Office 10-120 Epidemiology 033 395 2046.

Wishing you well in your studies.

Kind Regards



Dr NL Phakathi
CEO/MEDICAL MANAGER

FIGHTING DISEASE, FIGHTING POVERTY, GIVING HOPE

Annexure 3: Permission letter to Research Director (KZN DOH)



Faculty of Science and Agriculture

Department of Nursing Science

University of Zululand

PO Box X1001

KwaDlangezwa

3886

To : Research Director: KZN DOH

Dr. Ludgte

Date

Dear Ms/Mr

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a registered Master's student in the Department of Department of Nursing Science at the University of Zululand. My supervisor is Dr RM Miya (D.Lit. et PHIL)

The proposed topic of my research is: Experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu- Natal

The objectives of the study are:

- a) To explore experiences of mental health care providers regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal.
- b) To describe experiences of mental health care providers regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal
- c) To develop recommendations to facilitate the integration of mental health into primary health care.

I am hereby seeking your consent to conduct a research project.

To assist you in reaching a decision, I have attached to this letter:

- (a) A copy of an ethical clearance certificate issued by the University
- (b) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Researcher: M Zuma (Master's Degree student) KwaDlangezwa Campus 0711017912

Research supervisor: Dr RM Miya (D.Lit. et PHIL) KwaDlangezwa Campus-0837103551

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely

Signature.....

Name: Mr M Zuma

Annexure 4: DOH KZN APPROVAL



HRKM Ref: 071/17
NHRD Ref: KZ_2016RP 18_712

Date: 1 March 2017
Dear Mr M. Zuma
University of Zululand

Approval of research

1. The research proposal titled '**Experiences of mental health care providers regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu- Natal**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Untnjambili Hospital.

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

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

Yours Sincerely


Dr E Lutge

Chairperson, Health Research Committee

Date: 06/03/17

Fighting Disease. Fighting Poverty. Giving Hope

Annexure 5: ETHICAL CLEARANCE UNIZULU



**UNIVERSITY OF ZULULAND RESEARCH ETHICS COMMITTEE (UZREC)
ETHICAL CLEARANCE APPLICATION FORM
(2016)**

Project Title	Experiences of professional nurses regarding integration of mental health care into Primary health care at the Ilembe Health district in KwaZulu-Natal.					
Principal Researcher(s)	Mr M Zuma					
Student/Staff number	201640112					
Email Address	Mdumisenizuma9@gmail.com			Contact Number: 0711071912		
Supervisor and Co-supervisor	Dr RM Miya			Mr S T Madlala		
Department	Nursing Science					
Faculty	Science and Agriculture					
Nature of Project	Honours/4 th Year	<input type="checkbox"/> Master's Mini-dissertation	<input type="checkbox"/> Master's Full dissertation	<input checked="" type="checkbox"/> Doctoral	<input type="checkbox"/> Departmental Projects	
Research involves	Human Health	<input checked="" type="checkbox"/> Animals	Human Health and Animals	Data collection from people		
Children (Non-therapeutic research)	Children (Therapeutic research)	Other vulnerable persons	Special health and safety considerations	Desktop, field work or laboratory research only		
Environmental hazards/pollution	Interference with nature	Intellectual Property (IP)	Equipoise /Conflict of interests (researcher, funder or participants)	Social value/Benefits from this research		
Risk Classification	<input type="checkbox"/> Low Risk	<input type="checkbox"/> Medium Risk	<input checked="" type="checkbox"/> High Risk	<input type="checkbox"/> Other		




**UNIVERSITY OF ZULULAND RESEARCH ETHICS COMMITTEE (UZREC)
ETHICAL CLEARANCE APPLICATION FORM
(2016)**

Documents submitted for ethical clearance consideration	Project proposal	X	Participant Informed Consent	x
	Survey Instrument/Questionnaire		Translation (where appropriate)	
	Translation (where appropriate)		Guardian Informed Consent	
	Open-ended question sheet		Translation (where appropriate)	
	Translation (where appropriate)		Letter requesting access to sites/ information/ participants	x
	Observation sheet		Letter granting access approval	
	Research instrument permission		Other documentation:	
	Copyright permission		Information sheet	x
			Audio taping consents	x
			Interview guide	x

Faculty comments, e.g.:	REC	<p>Approval recommended.</p> <p>Institutionalisation of mental health care users was a prevalent treatment approach in the apartheid era in South Africa. The post-apartheid Department of Health prioritised improvement in mental health care by recommending, inter alia, deinstitutionalisation and reintegration of mental health care users into the community. Ten years later these interventions have proved difficult to introduce as many mental health care users are still hospitalised. The introduction of community based mental health care is aimed at improving mental health care services. This integration into primary health care improves access to mental health services, enables mental health care users to maintain family relationships, to be employment while receiving treatment and to access psychosocial rehabilitation. In a study done in KwaZulu-Natal, participants highlighted the following challenges, lack of mental health facilities, problems of distance travelled to access mental health services, lack of respect by mental health practitioners while being treated, lack of clinics in communities and lack of professional personnel or specialist.</p> <p>The aim of the study is to explore and describe experiences of professional nurses regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal. The current study will assist in addressing all issues around integration of mental health into primary health care and make specific recommendations on how to address such challenges if any exist.</p> <p>It is a medium risk study as people will be interviewed and they can be sensitive</p>
--------------------------------	------------	---



**UNIVERSITY OF ZULULAND RESEARCH ETHICS COMMITTEE (UZREC)
ETHICAL CLEARANCE APPLICATION FORM
(2016)**

	to the subject. Participation is voluntary and confidentiality shall be maintained. All participants will sign a form of consent. After the proposal is approved by the UZREC, the researcher will request a supporting letter from the Chief Executive Officer of Untunjambili Hospital and KwaZulu-Natal Department of Health. This letter can only be requested after ethical clearance for this proposal is received. All letters are attach to proposal.	
Faculty	REC	Date
Chairperson's Signature		16 November, 2016
Print Name	Prof. NW Kunene	

Annexure 6: Letter of information



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) LETTER OF INFORMATION

Title of the Research Study: Experiences of professional nurses regarding integration of mental health care into Primary health care at the ILembe Health district in KwaZulu-Natal

Principal Investigator/s/researcher: M Zuma

Supervisor: Dr RM Miya (D.Litt. et PHIL)

Purpose of the research: Describe and explore experiences of mental health care providers regarding integration of mental health into primary health care at the iLembe district in KwaZulu-Natal and identify challenges faced by the mental health care providers regarding integration of mental health into primary health care.

Outline of the Procedure: A semi structured interview schedule shall be used in one on one interview for 30 minutes until data is saturated.

Risks or Discomforts to the Participant: None

Benefits:

- Positive aspects of the study will be highlighted and challenges will be identified
- Develop recommendations to facilitate the integration of mental health into primary health care.

Reason/s why the Participant May Be Withdrawn from the Study: None.

Remuneration: None

Costs of the Study: None

Confidentiality: No names of participants will be written on the research documents.

Participants will be assigned codes.

Research-related Injury: Nil

Persons to Contact in the Event of Any Problems or Queries: Researcher/ Supervisor

Researcher: M Zuma (Master's Degree student) KwaDlangezwa Campus 0711071912

Research supervisor: Dr RM Miya (D.Lit. et PHIL) KwaDlangezwa Campus-
0837103551

Annexure 7: Consent



INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC) CONSENT

Statement of Agreement to Participate in the Research Study:

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

- Exclusion criteria: all other nursing staff not actively involved in the care of mental health care users shall be excluded

Full Name of Participant Date Time Signature / Right Thumbprint

I, _____ (name of researcher) herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher Date Signature

Full Name of Witness (If applicable) Date Signature

Full Name of Legal Guardian (If applicable) Date Signature

Annexure 8: Schedule interview



1. Please tell more about your experiences regarding the integration of mental health care into primary health care?
2. What kind of challenges do you encounter in primary mental health care and mental health care as whole?
3. What do you think can be done or added in the integration to better the challenges mentioned?

NB: these questions can be restructured at any time during probing to obtain rich data

Annexure 9: Example of an interview transcript

Interviewer: Please tell more about your experiences regarding the integration of mental health care into primary health care?

Interviewee: Shortage of staff leading to lots of negligence to clients for example there many patients at the clinic and we have juggle to all health programs such consulting for acute minor illnesses while mental health is waiting or vice versa. By the time you finish other patients already went home complaining of not getting the services.

The other problem is the problem is that we do not have Psychiatrists at the clinic so if you need an expert's intervention on the mental ill clients it is very challenging. As a result some mental ill patients would go home with the same treatment as last visit or come back presenting with the same problem as the last time. When you refer the client to the hospital they send him or her back to the clinic.

The other challenge is lack of skill and mental health education. The other main problem we face is that we do not have post basic diplomas in mental health; it is like the blind leading the blind. We are not sent to study the diploma of mental health and when it happens, it take long period of time to send another professional nurse and we do not understand the system used allocate for post basic diploma studies by the Hospital. When we ask about going to study they said there are no funds by the Department of health.

Interviewer: What kind of challenges do you encounter in primary mental health care and mental health care as whole?

Interviewee: At the clinic we have no space or rooms for mental health services; mental ill patients come from the hospital discharged without being stable and still aggressive. As I said before we have little knowledge about mental health care and handling of acute mental ill patients. We do not have cars to track defaulters and to do mental health campaign to the community.

Interviewer: How long have you been working in mental health care services?

Interviewee: More than five years but it feels like I never learn.

Interviewer: why don't you change to other health programs at the clinic?

Interviewee: I am more willing to change but other professional nurses less prefer mental health so I cannot let mental health users goes unseen or untreated.

Interviewer: What impact do all these challenges have on your emotional and psychological well-being?

Interviewee: We sleep every night tired and have headache because of too much work and less nurses. And stress level is very high can't even cope at home after work.

Interviewer: what is your strategy to deal with such challenges?

Interviewee: As for lack of skill and knowledge I make sure that every day after work at home I read and study mental health books just to equip myself for mental ill patients but sometimes I feel like send home without being treated because mental health is not funded like other health departments.

Interviewer: In your own experience and thoughts how would you compare mental health in public clinics and private clinics or settings?

Interviewee: I have not ever worked at a private setting so I would know but I think it's much better there.

Interviewer: What do you think can be done or added in the integration to better the challenges mentioned?

Interviewee: The government must create more post for professional nurse at clinic level and get as much nurses to work and coordinate mental health care into primary health care. Ensure that current professional nurse working with mental health are sent for post basic diploma to get knowledge and skills using a fair selection to go and study like first come in, first served. And management must offer support for professional nurses providing mental health care services at the clinics.

Interviewer: The management don't support you at all?

Interviewee: Yes they do not. As a professional nurse you must coordinate mental health on your own and identify gaps and you have tried by all means to fill those gaps because in future you will be the one facing them. There was this case of mental health care users defaulting almost all of them and the management was told and nothing was done but at the end of the week they want statistics.

Interviewer: How many communities is this clinic serving?

Interviewee: There are about three different large communities we are serving.

Interviewer: How many professional nurses work with mental health at the clinic?

Interviewee: It always been one professional nurse but rotating monthly but sometimes mental health does not rotate but others do.

Interviewer: Thank you for your time I will certainly compile everything the result of the study and give the feedback to Hospital manager.

Interviewee: We will very much appreciate if things can sorted so that we work to deliver the expected service and mental health care users can get services they are entitled to.