Suggestions from multidisciplinary team members at a mental health care establishment for integrating mental health services at primary level

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DECLARATION

I, Ms LC Ellie, M. Cur student, solemnly declare that the study regarding the suggestions from multidisciplinary team members at a mental health care establishment to integrate mental health services at primary health care level, is my own contribution. Plagiarism was avoided and all authors cited are in the reference list provided.

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Date: February 2020

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ABSTRACT

Key concepts:
multidisciplinary staff, mental health care establishment, mental health care user/users, primary health care, mental health services and suggestions.

The integration of mental health care at Primary Health Care level revealed major problems such as lack of dedicated mental health care staff, deficiency of allotted funding, poor accountability for quality service delivery and most professional nurses in PHC facilities do not have a mental health care nursing qualification and are expected to attend to mental health care users (MHCUs). The multidisciplinary team members were interviewed because they experienced an escalation in MHCU numbers as the down referral mechanism, which is in place, does not function. The down referred MHCUs kept coming back to the mental health care establishment (MHCE) and there was also an increase in relapses within three months after discharge of the MHCE.

The objective of the study was to explore and describe suggestions from multidisciplinary team members working at the MHCE in a sub-district of the North West Province which could contribute to the successful integration of mental health care services in a sustainable and effective way at PHC level.

A qualitative research design was used in this study with explorative, descriptive and contextual strategies. Semi-structured interviews were conducted with doctors, psychologists, different categories of nursing and a dietitian. Content analysis assisted the researcher to derive suggestions for North West Department of Health, the health district and sub-district to integrate mental health care services at PHC level for their perusal.

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- I dedicate this work to my mom for her kindness and wisdom through my life. Daddy thank you for always push us to reach higher peaks but remain humble and responsive.

Commit your works to the LORD, and your thoughts will be established (Proverbs 16:3 New King James Version)

ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
APC:	Adult Primary Care
CHW/s:	Community Health Worker/s
DCST:	District Clinical Specialist Team
DoH:	Department of Health
EDL:	Essential Drug List
HIV:	Human Immune Deficiency Virus
HREC:	Health Research Ethics Committee
ICDM:	Integrated Chronic Disease Management
MDT:	Multidisciplinary Team
MHC:	Mental Health Care
MHCE:	Mental Health Care Establishment
MHCU/s	Mental Health Care User/s
NDoH:	National Department of Health
OPD:	Out Patient Department
PACK:	Practical Approach to Care Kit
PHC:	Primary Health Care
PN:	Professional Nurse
WBOTs:	Ward Based Outreach Teams
WHO:	World Health Organisation

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CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

African countries use health guidelines as set out by the World Health Organisation (WHO). Decision-makers from the various countries adapted these guidelines to suit the needs of the specific country (Hattingh *et al*., 2012:10; Machingaidze *et al*., 2017:31). The African continent has to deal with developing and under developed countries' conditions namely a high-density population and diseases like Human Immune Deficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) infections, tuberculosis, sexually transmitted infections as well as chronic diseases which include non-communicable and communicable diseases (Hattingh *et al*., 2012:98). All the above mentioned conditions have devastating effects on various aspects of the health care system. South Africa uses Primary Health Care (PHC) services as the first level of contact in health care in conjunction with Ward Based Outreach Teams (WBOT's). The WBOT's main function is to extend service delivery in communities by using team leaders (professional nurses) and community health workers (CHW) who are trained by the Department of Health (DoH) to provide community-based services (DoH (b), 2010; Dennill & Rendall-Mkosi, 2012:4; Pillay *et al*., 2015:37; Sewankambo, 2013:168). The rendering of PHC services in South Africa is not without limitations. The main limitations and challenges include policy implementation, human resources to deliver integrated PHC services, physical infrastructure, as well as challenges experienced with the implementation of community-based services by the WBOT's (Edwards, 2008:31; Freeman *et al*., 2015:81; Dennill & Rendall-Mkosi, 2012:4; Rangwaneni *et al*., 2015:133). To reduce the patient load at PHC facilities, the DoH developed the integrated chronic disease management (ICDM) program. The Kenneth Kaunda District in the North West Province was part of the development team of the ICDM program as well as a pilot district for the implementation thereof (Mahomed *et al*., 2015:4; Mahomed *et al*., 2016:1248).

The ICDM program was developed and the focus of this program was to ensure a problem-free transition of stabilised chronic health care users from PHC facilities to community-based services (Mahomed *et al*., 2016:12). The ICDM program is overseen by the district clinical specialist team (DCST) to monitor integration of chronic diseases as well as how PHC facilities progress with regard to indicators (DoH, 2010b:116). Currently the following conditions are managed under the ICDM program: HIV/AIDS, tuberculosis, down referred multi-drug resistant tuberculosis, mothers that commenced with antiretroviral treatment during pregnancy, children on the prevention of mother-to-child transmission program, hypertension, diabetes, asthma, chronic obstructive airway disease, epilepsy and mental Illnesses (DoH, 2010b:16).

However, the integration of mental health care to primary health care level revealed major problems such as lack of dedicated mental health care staff, deficiency of allotted funding, poor accountability for quality service delivery and most professional nurses in PHC facilities do not have a mental health care nursing qualification and are expected to attend to mental health care users (MHCUs) (Shilubane & Khoza, 2014:378; Dube & Uys, 2016:119). According to Davis *et al.* (2016:333) the integration of mental health care nursing to PHC level appears to be neglected, although users prefer to receive their treatment from a PHC facility or from a WBOT as indicated by Davis *et al*. (2016:334) and Uys & Middleton (2014:12). Another research study conducted in KwaZulu-Natal reveals that only emergency management of MHCUs are available at PHC facilities even though the continuous delivery of chronic medication at home by the ICDM program has been effectively decentralized (Glover, 2014:47).

Furthermore, constraints on budgets for human resources have left many districts with the deficiency of professional nurses who can act as team leaders and provide supervision to CHW's in rendering community based services to all users suffering from a chronic disease, including MHCUs (Freeman *et al*., 2015:82; Marcus *et al*., 2017). Aggravating this problem, staff rendering PHC and WBOT services are not equipped with the required skills to render quality mental health care services (Dube & Uys, 2016:211). If quality PHC and WBOT services are not available for MHCUs it compromises quality of life for them and their families within the community (Uys & Middleton, 2014:12; Davis *et al*., 2016:333; Freeman *et al*., 2015:81). This argument is supported by Rangwaneni *et al.* (2015:134) who claim that there is a severe shortage of nurses providing mental health care in most of the low and middle income countries globally, as well as a lack of adequate opportunities for education and training in mental health care during basic professional nurse training.

In addition, research revealed that professional nurses with or without training in mental health care show apprehensive and avoidant behaviour with regard to providing care to MHCUs (Rangwaneni *et al*., 2015:134; Dube & Uys, 2016:119). This argument is further supported by claims that community service nurses who completed the four (4) year nursing degree or diploma programme (General, Psychiatric and Community) and Midwife leading to Registration (R425) also felt inadequately prepared to manage MHCUs on their own (Shilubane & Khoza, 2014:379). The same abovementioned study indicates that only 13 out of 45 PHC professional nurses in the Vhembe district were trained in mental health care, reiterating the problem of a lack of knowledge, skills and experience to provide quality mental health care services at PHC level (Shilubane & Khoza, 2014:381; Dube & Uys, 2016:119).

Furthermore, limited communication between staff assigned at a mental health care establishment (MHCE) and PHC facilities contributes to the relapse of discharged MHCUs. A

lack of coordination of mental health care services from sub-districts, especially in rural areas presents a constant challenge, aggravated by insufficient training and implementation of quality mental health care services as part of the ICDM program (Freeman *et al*., 2015:81; Khumalo *et al*., 2015:115). MHCUs are constantly readmitted within 3 months after discharge at the MHCE. These MHCUs should ideally be managed as out-patients within the ICDM program (Khumalo *et al*., 2015:115). This background assists the researcher to formulate the problem statement.

1.2 PROBLEM STATEMENT

Although WBOT's were established to extend PHC service delivery in communities (DoH (b), 2010; Dennill & Rendall-Mkosi, 2012:4; Pillay *et al*., 2015:37; Sewankambo, 2013:168), mainly general chronic conditions were addressed by this program. Furthermore, Freeman *et al.* (2015:81) stated that only a quarter of the WBOT's were completely functioning. Uys and Middleton (2014:12) agreed that the PHC approach in mental health care nursing was unsatisfactory, while Davis *et al.* (2016:333) held the conviction that the integration of mental health care nursing to PHC level was neglected.

Adding to the problem, staff rendering PHC and WBOT services were not equipped with the required skills to render quality mental health care services and often showed apprehensive and avoidant behaviour towards MHCUs (Rangwaneni *et al*., 2015:134; Shilubane & Khoza, 2014:379; Dube & Uys, 2016:119). Another challenge in the adequate provision of mental health care services included limited communication between staff assigned at a MHCE and staff at PHC facilities. This led to repeated re-admission of down-referred MHCUs at MHCE (Khumalo *et al*., 2015:115).

Being at the brunt of this overburdening, MHCE multidisciplinary staff was seen as the first-line contact with MHCUs. The staff experienced challenges to ensure that MHCUs remained stable after being discharged. They were knowledgeable regarding mental health care, the management of MHCUs, and they made valuable suggestions to integrate mental health care at PHC level. However, no studies could be found which indicated how suggestions from multidisciplinary team members at a MHCE could assist to enhance sustainable and effective integration of mental health care services at PHC level in a sub-district of the North West Province.

1.3 RESEARCH QUESTION

Based on the background and the problem statement the following research question was formulated:

As a multidisciplinary team member working at the MHCE, can you provide suggestions to assist with successful integration of mental health care services at PHC level?

1.4 RESEARCH OBJECTIVE

The objective of the study was to explore and describe suggestions from multidisciplinary team members working at the MHCE in a sub-district of the North West Province which could contribute to the successful integration of mental health care services in a sustainable and effective way at PHC level.

1.5 CONCEPTUAL FRAMEWORK

The framework of a study plays an important role in the development of the research study (Burns & Grove, 2009:126). The conceptual framework was developed by the researcher through identifying and defining concepts and proposing relationships between these concepts that would assist in setting boundaries for the research. The conceptual framework (Brink *et al*. 2012:26) was developed from concepts in the problem statement and background that would be used during this study. The ICDM program was supposed to incorporate mental health care services at PHC level. When MHCUs are discharge from MHCE they should be followed up by PHC facilities until their condition stabilised. There after the ideal situation is that the MHCUs would be referred down to the WBOTs. Currently PHC facilities, as well as WBOTs, do not have the capacity to incorporate MHC services at PHC level due to various reasons e.g. the shortage of mental health trained nurses (Burns, 2011:101). Furthermore, a lack of coordination of mental health care services from the sub-district, whereby communication between assigned staff and MHCE are inadequate (Freeman *et al*., 2015:115). In addition to this deficiency of dedicated mental health staff, inadequate funding and poor accountability for quality service delivery (Shilubane & Khosa, 2014:378; Dube & Uys, 2016:119). This lack of capacity led to relapses and readmissions at MHCE. This allowed the multidisciplinary team to provide valuable suggestions to assist with the incorporation of mental health care services at PHC level. Figure 1.1 illustrates the conceptual framework for this research.

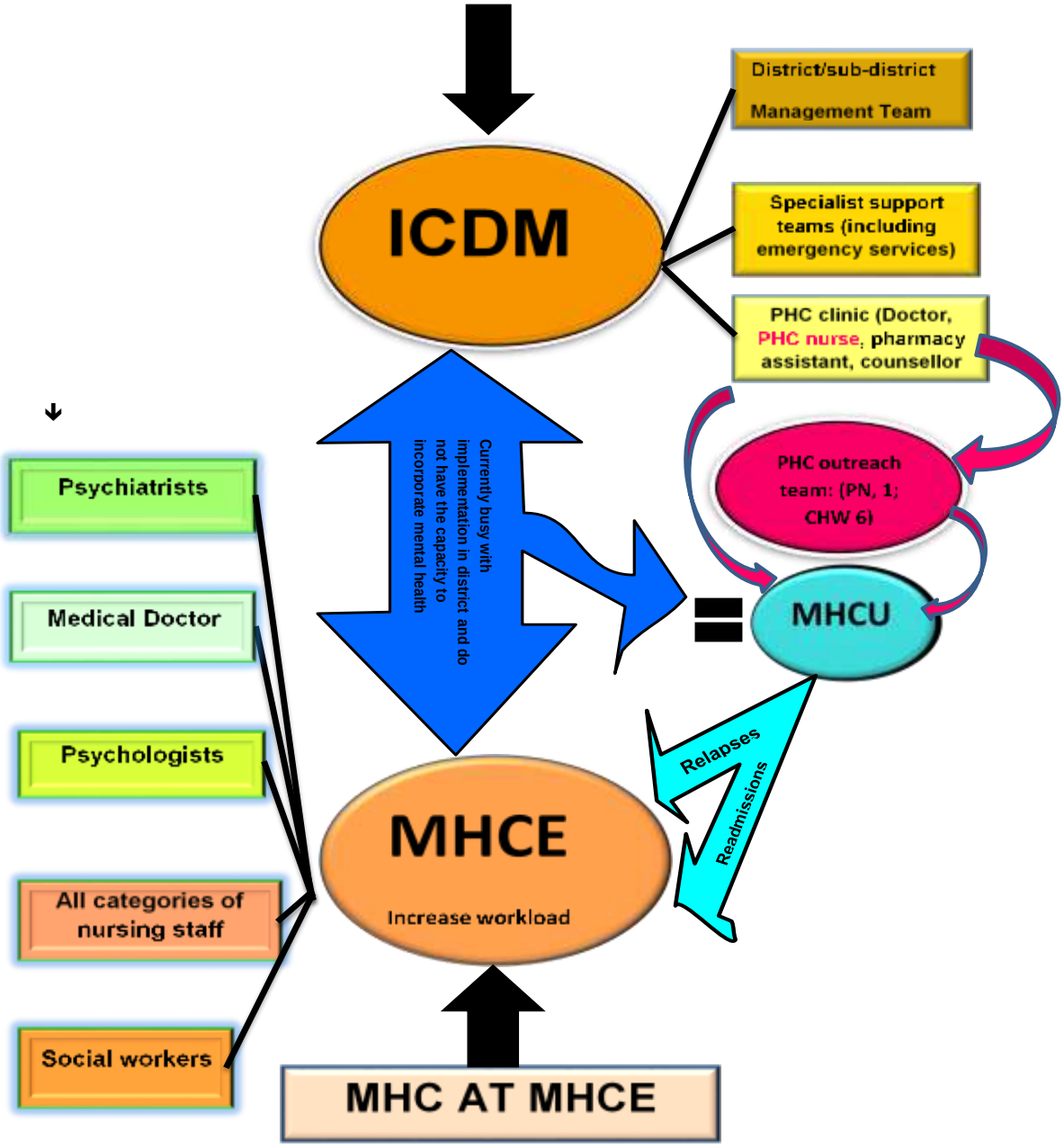

Figure 1.1 **Conceptual framework for rendering services to MHCUs developed by the researcher to enhance understanding of concept links.**

The conceptual definitions followed in the next section.

1.5.1 Conceptual definitions

The core concepts associated with this study will be defined in the following paragraphs.

Mental Health Care Establishment

Mental health care establishments refer to institutions, facilities, buildings or places where persons receive mental health care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions and/or other health services as needed (Mental Health Care Act no. 17 of 2002). In this research, a mental health care establishment refers to a specialist public hospital rendering services to MHCUs with mental illness, intellectual disability and substance-related disorders, on an inpatient and outpatient basis.

Mental Health Care Multidisciplinary Team

The mental health care multidisciplinary team consists of professionals from various backgrounds with the focus on specific aspects of caring for the mental health care user in order to ensure holistic management (Kneisl & Trigoboff, 2013:26; Uys & Middleton, 2014:39). In this research all members who can provide suggestions on how to integrate mental health care services at PHC level for example psychiatrists, psychologists, social workers and all categories of nursing staff.

Mental health care user

According to the terms of the Mental Health Care Act No 17 of 2002, the mental health care user (MHCU) is an individual who receives health care, MHC treatment and rehabilitation at a health care facility and/or mental health care establishment to enhance and promote the mental health state of the individual.

Primary Health Care

Primary Health Care (PHC) represent the first level of a healthcare service to the community of South Africa and the quality of health service delivery in a country is usually judged on this level according to set indicators (Couper *et al*., 2007:124). In this research, suggestions to enhance quality mental health care implementation as part of the ICDM program at PHC level will be obtained from multidisciplinary team members at a mental health care establishment.

Integrated chronic disease management program

The ICDM program is a model designed to provide integrated care to health care users diagnosed with a non-communicable or communicable chronic disease. This program aims to reduce stigma and to prevent further complications by appropriate management and rehabilitation and are rendered at PHC level. The ICDM program was implemented to ensure a seamless transition for stabilised health care users from the PHC facility to assisted self-

management within the community (Mahomed *et al.,* 2016:11). Mental health care is part of this program.

Suggestions

Suggestions can be ideas, plans or recommendations. In this study, such were made by multidisciplinary team members employed at a MHCE in a sub-district of the North West Province (Concise Oxford English Dictionary, 2011:1442).

1.6 STUDY DESIGN

A qualitative research design was used in this study. A research design assisted the researcher to control external factors which could influence trustworthiness of the study (Burns & Grove 2009:696). The study followed explorative, descriptive and contextual strategies (Burns & Grove, 2009:359). The research design will be described in more detail in chapter 2.

1.7 RESEARCH METHODS

With a qualitative design, the aim was to obtain sufficient reliable data until a saturation point was reached. Different steps were followed to assist the researcher to conduct the research in a systematic way as discussed in the following paragraphs.

1.7.1 Population and study context

The population (N), were multidisciplinary team members who worked at a MHCE in the North West Province and met the inclusion criteria, see Chapter 2 for more detail. Potential participants from the specific MHCE outpatient department and psychiatric unit, in the North-West Province, included 35 multidisciplinary team members who met the inclusion criteria. These team members included medical doctors, psychiatrists, nursing staff, psychologist, pharmacist, social workers and a dietician.

The specific MHCE was chosen because the out-patient department manager expressed concern regarding the overburdening of MHCE, by MHCUs, which could be accommodated at PHC level. For the year 2017, 10 868 MHCUs were seen at the outpatient department, of which 209 were first visits and 10 659 were follow up visits. The average re-admissions, in a 3 months' period, after discharge, was 63 MHCUs. The average number of MHCUs, seen in a day at the outpatient department, was 83 (Ferreira, 2019 [personal interview]). The high number of follow up visits at the outpatient department and subsequent re-admissions supports the ICDM initiative that many of these MHCUs should be deferred to PHC level and WBOTs for follow up to prevent unnecessary relapses (Mahomed *et al.,* 2016:1249). The researcher contacted the

acting sub-district manager and the ICDM program manager about a possibility to conduct the research in the sub-district at the PHC facilities and with WBOT team leaders. However, they revealed that the implementation of WBOTs were enrolled in different electoral wards and not fully functional as yet. Interviews with WBOT leaders and ICDM program managers at PHC facilities could thus not assist in reaching the objectives of the study due to the problems surrounding the implementation of the ICDM program (Chauké, 2018 [personal interview]). In spite of this, there were alternative feasible mental health care establishments in the North West Province with large urban and rural catchment areas. More information on sampling of multidisciplinary members will follow.

1.7.2 Sampling

The purposive sample was participants working at the outpatient department and in the readmission psychiatric unit of the MHCE. After informed consent was obtained, a list was drawn up with the names of all interested participants who met the inclusion and exclusion criteria and, with the assistance of a mediator (an experienced psychiatric nurse), participants who could provide rich data, were selected (Brink *et al*., 2012:139; Botma *et al*., 2010:200). See chapter 2 for more detail.

1.7.3 Data collection

Ethics approval was obtained from the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences at the North-West University (Addendum A) as well as permission to conduct the research from the provincial Department of Health (Addendum B). The Chief Executive Officer of the MHCE and applicable operational managers also gave goodwill permission (See chapter 2 for more detail).

A semi-structured interview could be seen as a carefully planned interview where the focus was on the collection of data and discussions determined by the researcher (Botma *et al*., 2010:208). An interview was the best method of data-collection in this study as it provided a broad range of information and laid out new perspectives (Botma *et al*., 2010:210). Therefore, in this study, data was collected by means of a semi-structured interview (See chapter 2 for more detail).

1.8 TRUSTWORTHINESS AND CREDIBILITY

The strategy to ensure truth value is credibility. This required the researcher to establish confidence in the truth of the research findings. The researcher followed the protocol in the execution of the research and carefully documented all occurrences. The researcher, with a

specialist psychiatric qualification and years of experience working in a MHCE, had knowledge and experience of the context in which the research was conducted.

Trustworthiness was seen as the scientific value and since the research outcome was associated with it (Burns & Grove, 2009:54), it substantiated the soundness of the research. Trustworthiness in a qualitative research design has four epistemological standards: truth value, applicability, consistency and neutrality (Guba and Lincoln as cited in Botma *et al.,* 2010:232) with a fifth standard of authenticity (Botma *et al.,* 2010:232). These standards were adhered to (see chapter 2 for more detail).

1.9 ETHICAL NORMS AND STANDARDS OF THE STUDY

The importance of adherence to ethical considerations when conducting a research study is outlined in the National Department of Health (NDoH) research ethical guidelines (South Africa, 2015:3). Ethical consideration was essential to ensure that the research study was conducted in a responsible and ethical manner.

The ethical norms and standards applicable to this study is outlined in the paragraphs below.

Relevance and value of research

The relevance of this research study is outlined in the background and problem statement sections. The study contributed to acquire suggestions, by interviewing multidisciplinary team members, on how mental health care services could be integrated or improved at PHC level. Suggestions could be submitted to the Provincial DoH, District management and at sub-district level.

Scientific Integrity

The scientific integrity of this study was built into the study's design and methodology (NDoH, 2015:16). An explorative, descriptive, contextual and qualitative design was chosen as the researcher wished to generate methodological options to do justice to the clinical questions that intrigued the researcher why mental health care services was not integrated effectively at PHC level (See chapter 2 for more detail). Mental health care services should be integrated at PHC level, according to the ICDM program.

Role player engagement

The success of this research depended largely on the roles of the independent person who received training about the research project with multidisciplinary team members by means of a

PowerPoint presentation. Multidisciplinary team members were given an opportunity to ask questions about the research study before they were required to make an informed decision regarding their participation in the study. No deliberate harm was inflicted on any participant. Potential participants were given 24 hours to decide whether they wished to participate or not. The independent person was responsible to co-sign the informed consent with multidisciplinary members after any questions were clarified. The cooperation of multidisciplinary team members as participants was needed to share their experience during a semi-structured individual interview. The ability of the study leaders was used to assist the researcher to conduct a semi-structured interview in such a way that a dense description was obtained in answering the research questions. The study leaders assist with conceptualisation, how to improve data collection techniques, data analysis, writing up of results and conclusion (DoH, 2015:15). The study was monitored by the study leaders by ensuring that the research practice was within the set ethical standards and research frame. Monitoring reports needed to be submitted at yearly intervals to HREC.

Favourable risk benefit ratio

The risk level for this study was estimated to be low. Individual participants could be nervous sharing their opinions and experience minimal emotional discomfort during the semi-structured interview. If this occurs, the researcher did arrange that a psychiatric nurse / psychologists be available during the data collection period for counselling purposes. The participant would also be assured that anonymity and confidentiality is maintained with interviews or transcribing, as only a number would be assigned to the individual. There would be no direct benefits for the participants. The indirect benefits of the study to the participant would be that their suggestions could assist to integrate mental health services at PHC level to reduce presence of unnecessary readmissions and return visits. The agreed-upon interview and time schedule would be respected and adhered to by the researcher.

Fair selection of participants

The participants would be selected fairly and would not be targeted unfairly. The population and the process of sampling have been clearly outlined – for more information, see Chapter 2. Purposive sampling was applied in order to obtain participants that could provide rich data. The researcher also required the assistance of the mediator (an experienced psychiatric nurse) to ensure that the opinion of every category of the multidisciplinary team member was represented in the study.

Informed consent

A cover letter detailing and informed consent was formulated (see Addendum C). Letters to request participation and giving of consent was written to prospective participants to explain the research topic, the objectives of the research, as well as the researcher's expectations of their role. They were also informed about their voluntary participation, as well as their right to withdraw at any stage of the research process without any consequences whatsoever. Two informed consent documents were given to interested participants having attended the research information.

Respect, privacy, anonymity and confidentiality

The respect, privacy, anonymity and confidentiality (NDoH, 2015:17) applied in this study was ensured by using an independent person to obtain informed consent. The researcher ensured privacy, confidentiality and anonymity of all of the participant's information and discussed this issue during the PowerPoint presentation. All members of the research team necessitating access to the data was obligated to sign a confidentiality agreement (transcriber and co-coder) (NDoH, 2015:14).

Data management

The researcher managed collected data in such a way that only researchers involved in the study had access to information. After a day's semi-structured interviews and the digital recording of the researcher's reflections, the interviews were loaded on the researcher's computer in a file and password protected. The interviews were password protected and sent to the transcriber and study leaders. After receiving back, the transcription, the researcher listened to the audio recorder, corrected transcriptions and the final transcriptions were sent to the study leaders password protected. All collected raw data e.g. evidence of data analysis and printed verbatim transcripts will be kept in a locked cupboard in the study leader's office for a period of five years after completing of the study. An electronic backup of all password protected interviews and verbatim transcriptions will also be stored with the raw data in the locked cupboard. The computer that was used for the research purposes is password protected, and all password protected interviews, audio records and name lists were removed. They will only be available on the study leader's computer for five years for audit purposes only. After five years all hard copies will be shredded and electronic data will be removed with the help of Information Technology specialist in order that no data can be retrieved for any purposes (NDoH, 2015:14).

Researcher competence and expertise

The researcher works as a lecturer in psychiatric nursing science and is registered as a specialist psychiatric professional nurse. The researcher has undergone and was found to be competent in her research methodology theory for Masters in Nursing Science. The researcher underwent research ethics training in 2017. The study was supervised by an experienced study leader who had also been part of a larger international research programme dealing with quantitative and qualitative methods for three years. The study leader attended a research internship in Kenya offered by the Canadian Institute for Health Research in 2009. The study leader specialised in PHC and has kept herself up to date regarding the PHC re-engineering as a new DoH initiative and method of extending PHC services in South Africa. The co-study leader is nationally recognised as a qualitative researcher, is a specialist psychiatric professional nurse and offers this post basic course at the School of Nursing Science. The co-coder is an experienced qualitative researcher.

Data dissemination

After completion of the study the researcher would provide feedback to all stakeholders and participants by means of a PowerPoint presentation for participants and a research report to other stakeholders. This would be done to ensure that the research project was ethically conducted and acceptable to all relevant stakeholders (DoH, HREC and District management). The researcher will send in an abstract for the district research day to present the research. If the abstract is accepted by the district research day, all participants will be informed about the opportunity to attend the research day (DoH, 2015:14).

1.10 RESEARCH CHAPTERS

The following chapters as outlined below will provide a detail description of this study.

Chapter 1: Overview of the study.

Chapter 2: Research design and methodology.

Chapter 3: Research results of study supported/compared with literature control.

Chapter 4: Conclusion, limitations and recommendations

1.11 SUMMARY

The background identified the research gap which assisted the researcher to formulate the problem statement, research question and objective. The research design and methodology explained the research methods that would be followed during this study. Ethical considerations were addressed. In chapter 2 the research methodology follows.

CHAPTER 2: RESEARCH ASSUMPTIONS

2.1 INTRODUCTION

Chapter 1 outlined the introduction, background and problem statement of this study together with a brief discussion on the research design. This chapter provides the research perspectives and detailed discussion of the research methodology that was followed. An explanation of the methodology was done describing the comprehensive steps followed by the researcher to reach the outcome of a research study (Hofstee, 2015:107). The strategies followed to enhance trustworthiness were also outline.

2.2 RESEARCHER ASSUMPTIONS

The following meta-theoretical, theoretical and methodological assumptions define the framework within which the researcher conducted this study

2.2.1 Meta-theoretic assumptions

Meta-theoretical assumption refers to the researcher's philosophical orientation and belief about the person as a human being, society, the discipline (mental health services) and the purpose of the discipline (suggestions for multidisciplinary team members to integrate mental health care successfully at PHC level). The general orientation imbedded in the researcher's world view, pertaining to the nature of the research was also taken into consideration. A meta-theoretical assumption is a declaration presumed or to be truthful without methodological verification (Botma *et al*., 2010:187; Grove *et al*., 2015:500). This study was strengthened by a phenomenology approach where the researcher interprets the experiences of mental health care services rendered at the MHCE (Grove *et al*., 2013:60). Phenomenology is an approach for researchers to contend with human beings to gain understanding in human actions that may improve the value of health care services and health of individuals, community and the greater society (McWilliam, 2013:229). Thus phenomenology assists the researcher to explore the meaning or comprehension of human behaviour (in this study multidisciplinary team members) and their experiences (McWilliam, 2013:229). Phenomenology in this research is the underpinning philosophy as an inductive research approach which describes the lived experiences of the participants in the study (Grove *et al*., 2013:60; Mallinson *et al*., 2013:316). Philosophy provides a structure in which the researcher thinks, knows and views human beings in their work environment. In this study it being the multidisciplinary team members at a MHCE (Grove *et al*., 2013:60).

- **Human being**

A human being refers to a person (Frish, 2013:122; Dossey, 2013:28). In this study there is an inter relationship between two persons (the member of the multidisciplinary team rendering mental health care services to the mental health care user) both referred to as a human being. The researcher views the multidisciplinary member as an important person who can share his/her experience on how mental health services can be integrated at PHC level. Thus making mental health care services more assessable for the MHCU and relieving the workload of the MHCE. For the purpose of this study no interviews were conducted with the mental health care user.

- **Mental health**

Mental health refers to more than the absence of disease and illness. It is on the other hand, a state of wholeness in which an individual manages and copes with life stressors of everyday living effectively or become resilient to deal with challenges (Koen & Koen, 2013:6, Uys & Middleton, 2019:16, 830). In this study the mental health user is not healthy and needs mental health care services on a monthly base either at PHC level or at the MHCE.

- **Mental Health Care Establishment**

In this research, a mental health care establishment refers to a specialist public hospital rendering services to mental health care users with mental disorders, intellectual disability and substance-related disorders, on an inpatient and outpatient basis. These services are rendered to MHCUs by PHC facilities and public hospitals. The environment of the MHCE is of such a nature that it delivers holistic care to MHCU by the multidisciplinary team members. The services at this MHCE covers a large catchment area benefiting the MHCUs.

Theoretical foundation of study

The WHO formulated 10 steps to assist countries with the integration of mental health care at PHC level (WHO, 2008). This was the theoretical departure point for this study. Mental health care users who were being discharged from a MHCE were to be followed up for stabilisation at PHC level according to the integrated chronic disease management program. PHC facilities, however, did not have the capacity and skills to deliver mental health care services to MHCUs (Dube & Uys, 2016:120). Patients who were down referred often relapsed and readmissions to a MHCE resulted. The 10 steps the WHO suggest to integrate mental health care at PHC followed in figure 2.1.

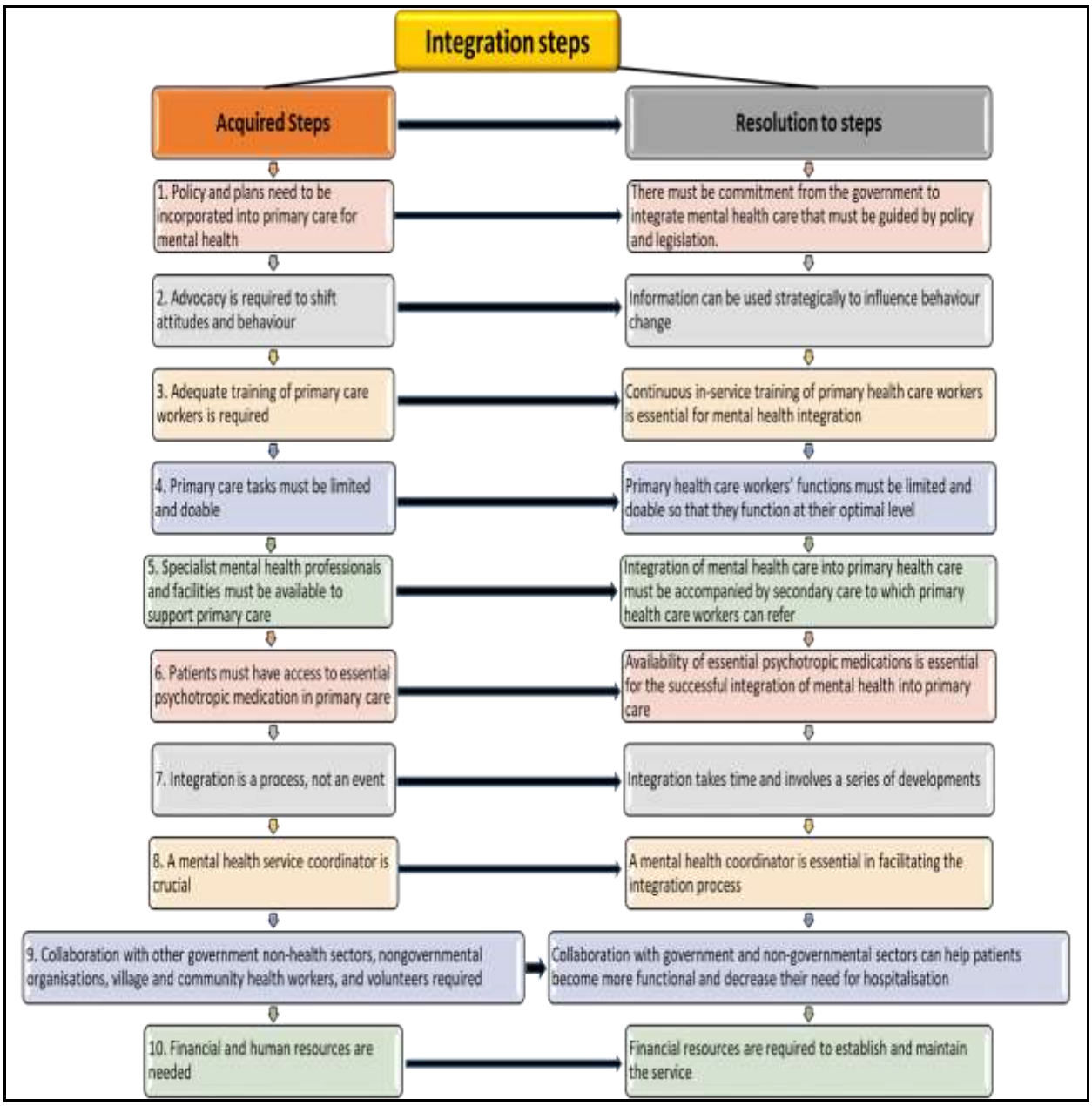

Figure 2-1: Steps to integrate metal health care at primary health care level (adapted from WHO, 2008)

2.2.2 Methodological assumption

Methodology refers to the choice of research design and methods followed in order to reach the objective of the study (Taylor, 2013b:188). The researcher used a qualitative, explorative, descriptive and contextual design (Botma *et al*., 2010:208). The researcher aimed to explore and describe suggestions from multidisciplinary team members working at a MHCE in a sub-

district of the North West Province, who could contribute to the successful integration of mental health care services in a sustainable and effective way at PHC level.

2.3 STUDY DESIGN

A research design provides the researcher with optimal control over factors which could have affected the trustworthiness or rigour of the study. Detail about the design was thus essential to ensure accuracy within the study and that the researcher stayed within the steps as approved by ethical committees (Grove *et al*., 2013:214).

Qualitative: The study is qualitative as the data was 'words' collected during semi-structured individual interviews where straight descriptions of phenomena were desired of a specific topic (Botma *et al*., 2010:208). In this study the focus was to obtain suggestions from multidisciplinary team members at a MHCE to enhance integration of mental health care services at PHC level.

Explorative: In this study, the suggestions of multidisciplinary team members on ways to integrate mental health care services at PHC level was explored in order to reduce unnecessary relapses and readmissions (Brink *et al*., 2012:102; Burns & Grove, 2009:359).

Descriptive: Descriptive research is used to describe actual suggestions and provide meaning about the phenomena under study (Burns & Grove, 2009:359). In this study the researcher aimed to provide a clear picture from the suggestions of the multidisciplinary team members on how MHC services could be effectively integrated at PHC level.

Contextual: This research is contextual in nature and the focus was on a specific MHCE in the North West Province. The study's findings were therefore not generalised to other contexts but was only applicable to the MHCE and the PHC facilities in their catchment area (Brink *et al*., 2012:121).

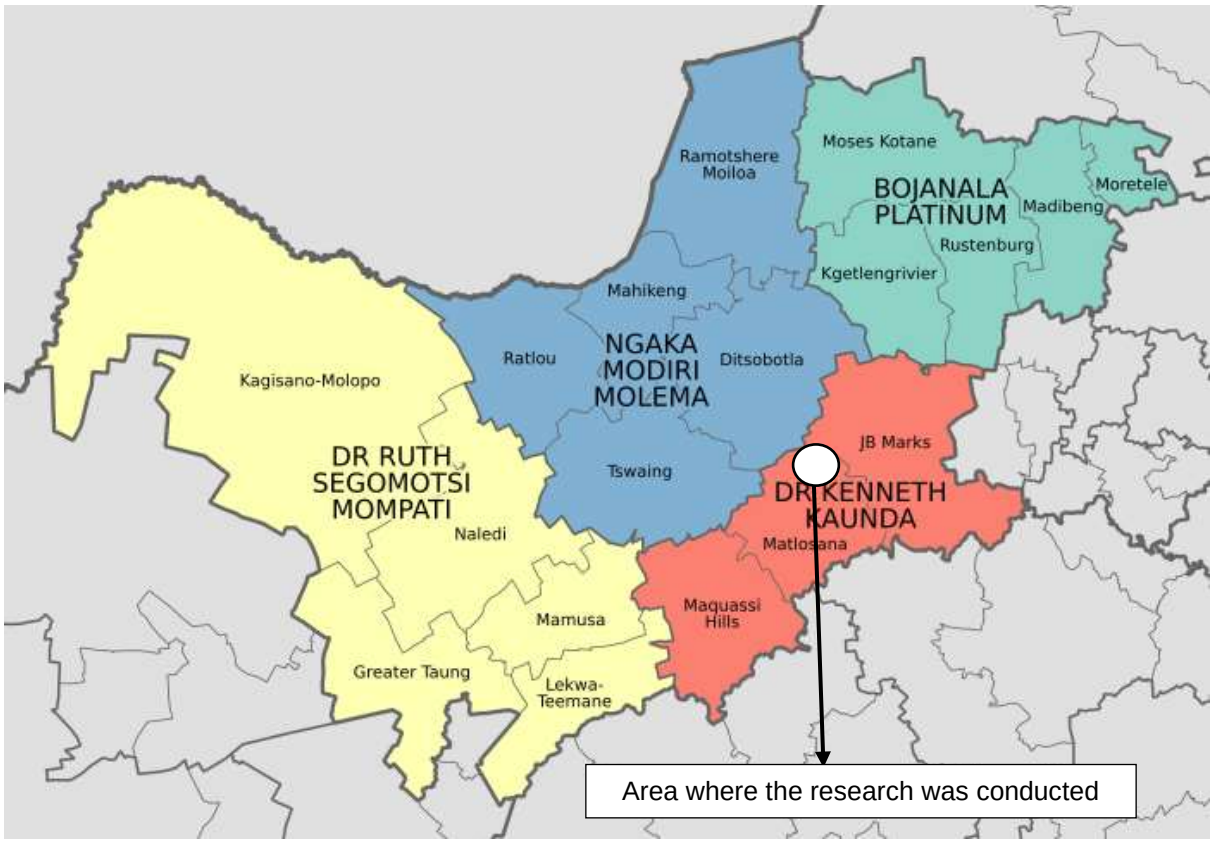

Figure 2-2: Map of Districts of North-West Province
https://municipalities.co.za/

2.4 RESEARCH METHODS

The methodology for this research study consists of a discussion regarding the study context, population and sampling methods, inclusion and exclusion criteria, data collection, data management, dissemination of results, trustworthiness and ethical standards.

2.4.1 Study context

The Dr Kenneth Kaunda District is situated in the North West Province and its neighbouring districts are Dr Ruth Segomotsi Mompati to the west, Ngaka Modiri Molema to the north, and Bojanala to the east. It covers geographically 14,767 square kilometres. The Dr Kenneth Kaunda District consists of three sub-districts i.e. Maquassi Hills, Matlosana, Tlokwe subdistrict (Subsequently Tlokwe and Ventersdorp) merged to form one subdistrict namely the JB Marks district (www.municipalities.co.za). The MHCE provides services to mental health care users, namely, intellectual disabled, psychiatry inpatients (psychotic and mood disorders) as well as physical- and drug addiction rehabilitation. The Outpatient Department (OPD) render services to

treat and control mental disorders, assist with the management of intellectual disabilities and learning and developmental disorders.

2.4.2 Population and sampling

The population, sampling method and size are outlined in the paragraphs below.

2.4.2.1 Population

The study population represents the larger pool from which the sample was drawn. All participants who met the inclusion criteria and were willing to participate voluntarily were included in the sample (Burns & Grove, 2009:344). The population (N) were all multidisciplinary team members working at the MHCE in the North West Province who meet the inclusion criteria. The target population (N)=35. The following inclusion and exclusion criteria was used as outlined in the following table, table 2.1.

Table 2.1 Inclusion and exclusion criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
Must be a member of the multidisciplinary team in the outpatient department or psychiatric unit with a minimum of six months experience in the department or unit.	Newly appointed multidisciplinary team member at the time of the interviews.
Willing to participate voluntarily after signing the informed consent.	Any undergraduate students conducting clinical practice under the supervision of a multidisciplinary team member.
Be able to communicate in English / Afrikaans.	

2.4.2.2 Sample and sample size

A purposive sample was used for participants working at the outpatient department and psychiatric unit of the MHCE. The sample size was determined by two guiding principles: appropriateness and adequacy (Botma *et al*., 2010:199). The appropriateness was ensured by the identification of the best suited participants to inform the research, namely multidisciplinary team members at the outpatient department and psychiatric unit. A mediator from the outpatient department was asked to assist with identifying participants who can provide rich data in order to reach the objective of the study. The mediator in the MHCE was chosen to assist with purpose selection based on working in collaboration with all disciplines and years of clinical

experience. The adequacy was ensured by having enough data to reach data saturation. It was foreseen that a minimum of fifteen (15) interviews be conducted depending on data saturation, however data saturation was reached after 23 semi-structured interviews were conducted. Data saturation can be seen at the point in research were no new or relevant information emerges (Botma *et al*., 2010:200).

2.4.2.3 Recruitment of participants

The participants were recruited by the researcher. An information session about the research study was held by the researcher, arranged with the help of an independent person. This was held on a mutually agreed time at a venue suitable for all prospective participants, the mediator and independent person. During the information session at the MHCE, on the agreed date, the researcher provided the potential participants with clear and comprehensive information regarding the study by means of a PowerPoint presentation and informed them of their right to privacy and that they would be free to choose to participate or to exit from the process at any time without harm. They would not have to provide reasons for withdrawing from the study. Potential participants had the opportunity to put questions to the researcher. Participation was voluntary and there would be no incentives or reimbursement for participating as there was no financial expenses for participating in this study. Thereafter, the informed consent forms (see Addendum C) containing all the relevant information as well as the relevant contact details was distributed by the researcher to potentially interested participants. Potential participants had 24 hours to consider whether they were prepared to participate. Potential participants were requested to take the two informed consent forms to the independent person's office who would explain the informed consent form once again and co-sign both informed consents with the potential participant. Participants were asked to sign two copies of the informed consent document. The independent person stored one signed informed consent form in a non-transparent box and the other informed consent form was kept by the potential participant for their perusal. The researcher collected the informed consents from the independent person.

The independent person who was a senior administrative officer received training on the research study to ensure that the independent person acted ethically. The independent person was not in a managerial position and did not have undue influence on the multidisciplinary team members.

2.4.3 Data collection

According to Babbie (2010:274), interviews are typically done during a face-to-face encounter, but could also be done telephonically. In this study, the data collection method was a face-to-

face, semi-structured interview in order to explore and describe suggestions from multidisciplinary team members providing services at the out-patient and psychiatric departments of the MHCE, in a sub-District of the North West Province, on effective integration of mental health care at PHC level.

2.4.3.1 Interview schedule

An interview schedule was developed based on the research question and refined with the input of subject specialists. The interview schedule was approved by the scientific committees INSINQ and HREC.

The interview questions were:

*Can you elaborate on your role in the out-patient / psychiatric department when rendering services to mental health care users?

*What is your experience about the number of mental health care users you need to provide mental health care services to at the outpatient / psychiatric department on a daily basis?

*What is your opinion about mental health care services rendered at PHC level?

*Readmissions within 3 months of discharge are a problem according to statistics (Ferreira, 2017), what could be contributory factors?

*Can you provide suggestions how mental health care services can be integrated at PHC level?

2.4.3.2 Process of data collection

Interviews were arranged with participants after receiving informed consent from each of the following disciplines: psychiatrist, psychologists, all categories nursing staff (the auxiliary and enrolled nurse works hand in hand with professional nurses) and social workers. Interviews continued until data saturation had been reached. The interviews were conducted at a time that suited both parties and in a convenient, interruption-free venue that ensured privacy (Grove *et. al*., 2013:273). A sign was placed on the door of the venue indicating that interviews were in progress (Burns & Grove, 2009:510). Arrangements were made with the management to limit the disruption of service delivery as the participants relieved each other on the day of the interviews.

The interviews were conducted by the researcher who had received specific training by study leaders in acquiring interview skills (Brink *et al.,* 2013:157) by means of provision of information on the conducting of an interview and practicing through role play during specific training

sessions. The first interview was conducted by the researcher and the password protected audio recording was submitted to the study leaders for review. Only after discussion on how to improve interview skills, did the interviews continue.

The researcher started each interview with a short reminder of the purpose of the research, the role the interview played in the research, the estimated time and the confidentiality of the interview. The importance to allow an audio recording by the researcher was obtained before the interview started. The informed consent was confirmed. Participants were also reminded that they were free to withdraw at any time without any consequences. The researcher then started the interview according to the pre-developed and approved interview schedule (Creswell, 2008:226). During the interviews the interviewer used communication techniques that were effective in establishing a rapport. Such techniques included making eye contact, using an open posture and displaying a non-judgemental attitude and respect. As the aim was to get information from the interviewee, the interviewer practiced active listening, using minimal verbal and non-verbal responses.

The researcher audio recorded detailed field notes directly after each interview session. Descriptive notes were objective notes to describe the physical setting or particular events. Reflective notes were the personal thoughts of the researcher and field notes focused on methodological, theoretical and personal aspects of the interview. The methodological notes referred to the methods used. Theoretical notes were about the researcher's thoughts with regards to what was going on and how to make sense of it. The personal notes included the researcher's feelings and experiences while conducting the interview. The demographic notes included all the demographic information such as time, place and date of the interviews as well as the demographic notes about the participant (Botma *et al*., 2010:218-219). The field notes gave an audio explanation of what the researcher felt, heard, saw, thought and experienced during the entire interview process. This provided a retrospective overview of the interview process (Botma *et al*., 2010:217). The estimated time of each interview was approximately 45 minutes. Audio recordings were downloaded every day onto a computer that was password protected. The researcher listened to the quality of the audio recordings and password protected all audio recordings. The audio recordings of the day were then removed from the digital recorder to ensure confidentiality. The computer and the digital recorder were kept in a locked cupboard in the researcher's office as soon as possible after the interviews. The audio recordings were emailed to the supervisors and to the transcriber, password protected. The supervisors provided feedback on where the researcher should improve with the aim to reach the objective of the study.

2.4.4 Data analysis

Qualitative data analysis was not a once-off occurrence, but a process that started with the first interview and continued during data collection as the researcher and the study leader overseeing the analysis reflected on the raw data as the audio recordings and digital field notes became available as well the interviews that were transcribed (Taylor, 2013a:243). Conducting an analysis of qualitative data assisted the researcher to focus and shape the study as it progressed. The preliminary data analysis occurred as a very informal process: the researcher recorded ideas on dated memos as a record of insights regarding the reading and re-reading of transcripts and field notes. With reading of the transcripts, field notes and listening to the same audio recordings, the researcher became immersed in the data and this assisted in recalling observations and experiences. Audio recordings contained more than just words; they contained feelings as well as cues of non-verbal communication (Burns & Grove, 2009:521).

Content analysis was a systematic process of looking at data from different angles with a view to identifying codes in the transcripts that would assist the researcher in understanding and interpreting raw data. Content analysis was an inductive and iterative process in which the researcher looked for similarities and differences in text that contributed to rich descriptions of, in this study, experiences and suggestions of multidisciplinary team members working at the out-patient and psychiatric department at a MHCE. Content analysis as summarised by Creswell (2009:184) was used in this study. Each transcription was read as a whole to get a sense of emerging patterns. The researcher then started to code the transcribed data by reading through each transcript again and divided it into meaningful analytical units. All meaningful segments were assigned with a code. In this study the researcher used descriptive words to code transcripts. The result of initial coding was the identification of numerous concepts relevant to the subject under study. After initial coding the researcher summarised and organised the data, and this step enhanced refining and revising of initial codes, categorising and searching for relationships and patterns in the data (Babbie, 2010:400-404; Creswell, 2009:184; Burns & Grove, 2009:522; Nieuwenhuis, 2012:105-110).

The researcher verified the transcriptions by listening to the recording while reading through and correcting the transcription where necessary as the transcriber was not trained in the health care field (Botma *et al*., 2010:214).

Data was analysed according to the six generic steps of Creswell (2009:184), namely:

1. The data will be organised and prepared by transcribing the interviews, typing of field notes in different categories in order to arrange the different types of data.

2. A general sense of the data will be obtained by reading through the data and writing notes in the margin and general thoughts on the data.
3. Content analysis using open coding of Tesch (1990, cited in Creswell, 2009). These eight steps include:
    - Reading through the transcriptions to get a sense of the whole.
    - Picking the shortest or most interesting transcription and ask: “What is it about?”
    - Reading through multiple participant’s data and repeating the previous question in order to make a list of topics that come to mind.
    - Use the topic list and go back to the data, abbreviating the topics into codes and writing them down next to the appropriate text segments to see if new codes emerge.
    - Creating categories through identifying descriptive wording for the identified topics. Reduce sub-themes if they relate while drawing lines between categories to show interrelationships.
    - Decide on final abbreviations for all codes and alphabetise them.
    - Group data belonging together to perform preliminary analysis.
    - Recode existing data if necessary.
4. Identify and describe themes.
5. Represent the findings by means of narrative describing.
6. Make an interpretation of the meaning of the data.

The researcher acted as one of the coders during data analysis in collaboration with study leader to derive themes and sub-themes. The co-coder would be an experienced coder who also needed to sign a confidentiality agreement. The co-coder was provided with a protocol on how to do the analysis based on an analytical framework. Both the researcher and an independent, experienced co-coder conducted data analysis according to the above-mentioned principles and steps and held consensus meetings to finalise the codes, sub-themes and themes. After the consensus discussions, the findings were presented as a rich descriptive summary. Data analysis was supported with quotes from the transcripts and were embedded with the findings of scientific literature (See Chapter 3 for more detail).

2.5 TRUSTWORTHINESS AND CREDIBILITY

Trustworthiness referred to the strategies used to enhance research quality. In order to ensure trustworthiness, Lincoln & Guba (1985:290-294) outlined four epistemological standards, strategies and criteria by which the quality or worth of a qualitative study could be evaluated, namely, truth value, applicability, consistency and neutrality cited in Botma *et al.* (2010:233). A fifth strategy was added namely authenticity and these strategies were used to ensure research quality. Table 2.3 outline the measures which were taken to ensure trustworthiness.

Table 2.2: Measures to ensure trustworthiness in this study (Botma *et al*., 2010:233)

STANDARD	STRATEGIES	STEPS IMPLEMENTED BY RESEARCHER
Truth value Truth value assesses the researcher's confidence on the truth of the findings with participants (Botma *et al*., 2010:233).	CREDIBILITY	The interviewer engaged in discussions with each participant for periods not exceeding 45 minutes to gain the trust of the participants. The interviewer made field notes as well and audio record it after the interview. The researcher followed the protocol in the execution of the research and carefully documented all occurrences. The researcher, with a specialist psychiatric qualification and years of experience working in a MHCE, had knowledge and experience of the context in which the research was conducted.
Applicability This is the extent to which the results of this study can be applied to a different setting or group and are likely to reflect expected results. (Botma *et al*., 2010:233).	TRANSFERABILITY	Applicability was assured in this study by using appropriate inclusion and exclusion criteria and all-inclusive sampling, guided by the principles appropriateness and adequacy (Botma *et al*., 2010:199). The researcher continued conducting interviews and analysed data until no newer information emerged during the interviews (saturation of data). Applicability could thus be ensured by prolonged engagement by conducting interviews until data saturation was reached, in other words no more themes or sub-themes could be identified (Klopper & Knobloch, 2010:319).
Consistency This standard considers whether the findings would be consistent should the inquiry be replicated with the same participants and in a similar context (Botma *et al*., 2010:233).	DEPENDABILITY	All processes followed for data collection were recorded, and the data collected kept safe for audit purposes in the supervisor's office on a password protected computer and all hard copies will be kept in a locked cupboard for 5 years.
Neutrality Neutrality guards against biases and motives during the research process and results description (Botma *et al*. 2010:233)	CONFORMABILITY	Conformability referred to the unbiased and objective status of the researcher during the research. The researcher did declare the limitations in the research and maintained the ethical considerations. Objectivity was enhanced by the experienced co-coder in the data-analysis and interpretation of the research results (Botma *et al*., 2010:233).

STANDARD	STRATEGIES	STEPS IMPLEMENTED BY RESEARCHER
Authenticity This refers to the extent to which the researcher fairly and faithfully shows a range of different realities (Botma *et al*., 2010:234).	TRUTHFUL	Both the researcher and the study leaders were involved in the process of coding a framework on how themes and sub-themes emerged which would be provided to the co-coder. Furthermore, an experienced co-coder did code data independently to ensure that the results would be free from any bias.

2.6 ETHICAL CONSIDERATIONS

It was imperative that ethical considerations were adhered to while conducting a research study to certify that the research was valid and truthful. The National Department of Health (NDoH) research ethical guidelines (2015:3) outlined the ethical considerations to be followed. Ethical considerations were comprehensively discussed in chapter 1 and therefore not repeated in this chapter again.

2.7 SUMMARY

This chapter outlined the researcher's assumptions, theoretical model, research design and methods followed to ensured trustworthiness of the study. In the next chapter the data analysis follows as well as literature to support or oppose findings.

CHAPTER 3: DATA ANALYSIS FINDINGS

3.1 INTRODUCTION

In the previous chapter the research methodology followed was outlined. In this chapter data is analysed and reported. In this chapter data was analysed according to the research questions. Data was analysed according to content analysis which was done concurrently with data collection. Initially codes were identified as the researcher listened to the audio recordings. After receiving transcripts back from transcriber, the researcher listened to audio recordings again and read the transcripts to ensure that the final transcript was a verbatim presentation of audio recordings. The initial codes were reformulated and after the researcher was well acquainted with the data, themes and sub-themes were formulated. All discussions were embedded with literature findings. A summary finalised the chapter.

3.2 DATA ANALYSIS FINDINGS

A discussion about the data analysis follows in the following section.

3.2.1 Biographical information

Content analysis was used to analyse data (See Chapter 2). Twenty-three (23) participants contributed to the results of this research. Biographical information about all the multidisciplinary team members participating in this research are outlined in table 3.1. Participants were outlined in no specific order of importance as all were key role players in rendering mental health care services.

Table 3.1 Total number of multidisciplinary team members participating in the research

MULTIDISCIPLINARY MEMBERS PARTICIPATING IN RESEARCH	TOTAL PARTICIPANTS
Medical Doctors	**3**
Professional Nurses	9
Enrolled Nurses (Staff Nurses)	4
Enrolled Nursing Assistants (Assistant Nurse)	3
Social workers	2
Psychologist	**1**
Dietitian	1

The following paragraphs provide the outlay of themes and sub-themes and a discussion their off.

3.2.2 Themes and sub-themes emerged in this research

The first question asked was to define the role of the multidisciplinary team members in the outpatient- or psychiatric department. The following Table 3.2 outlines the role of each multidisciplinary team member in the MHCE. This is not the specific job description but only contributes to a narrow description of each team member's role.

Table 3.2. The role of multidisciplinary team members in a mental health care establishment.

MULTIDISCIPLINARY TEAM MEMBERS						
Nurse assistant (auxiliary nurse)	**Enrolled nurses (staff nurses)**	**Professional Nurse**	**Medical doctor**	**Psychologist**	**Social Worker**	**Dietitian**
®Ensure clean environment to enhance MHCU safety. ®Assist with vital signs and report abnormalities to the professional nurse. ®Administer monthly injections before sending them to the pharmacy depart-ment to receive monthly medication.	®Ensure clean environment to enhance MHCU safety. ®Assist with vital signs and report abnormalities to the professional nurse. ®Administer monthly injections before sending MHCUs to pharmacy department to receive monthly medication. ®Enter details in computer to ensure follow up of defaulters.	®Oversee reception of MHCUs. ®Act as a multi-disciplinary team member discussing management of new MHCUs. ®Assists the doctor with language barriers during six monthly follow up visits. ®Ensure MHCUs receive medication. ®Write a report of interventions done. ®Responsible for tracing defaulters monthly.	®See 6 monthly follow up visits of MHCUs. ®Assess them for compliance, stability and any side effects from medication. ®Refer for blood tests to monitor blood levels where applicable, assess MHCUs in psychiatric wards. ®Assess all new MHCUs individually and as part of multi-disciplinary team. ®Manage aggressive MHCUs with assistance from other team members.	®Assist MHCU with first visits. ®Doing admissions. ®Rendering psychotherapy services to MHCUs, visiting discharged MHCUs, complete legal documents. ®Interview MHCUs with Mental Health Care Act 04 forms in order to collect all information.	®Obtain collateral information from family about admitted MHCU. ®Establish highest level of education. ®Establish cause of admission, e.g. stressors, socio-economic, psychological or environmental reasons. ®Explain MHCU condition to MHCU (if not aggressive) and to family. Identify causes that can be improved by admission of MHCU. ®Provide admission procedure information. ®Educate MHCUs to function optimally e.g. continue to work and to find peace jobs. ®Becomes a liaison officer between MDT and MHCU/family. If problem at work contact employer and explain situation and obtain cooperation.	®Focus on nutritional value – psychiatric medication has side effects such as weight gain, metabolic syndrome. ®Education of MHCUs. ®Group sessions with non-psychotic MHCUs in the ward, ® Educate on side effects of medication. ®Focus on general healthy life style. ®Main concern of weight gain.

With question two, the multidisciplinary team members were asked how they experienced the number of MHCU's in the outpatient department. The majority of participants revealed there was an escalation in MHCUs with negative consequences. Table 3.3 outlines the themes and sub-themes of question 2. Below the table of the theme and sub-themes a discussion follows.

Table 3.3 Question 2: Experiences of multidisciplinary team members about the number of MHCU visiting the outpatient department

THEMES	SUB-THEMES
Escalation in MHCU numbers	Increase in waiting time for service
	Time consumed tracing defaulters
	Effect of increased MHCU numbers on staff
	Bed occupation rate high – no space to admit new and readmissions of MHCUs

3.2.3 Experiences of multidisciplinary team members about the number of MHCU visiting the outpatient department

The main theme derived during data analysis was an ***escalation in MHCU numbers***. The follow quotes revealed these findings.

"*Jah. Over… over… for the past four years that I have been here there's been an increase in the number of patients coming to outpatients."*

"It's too many... too many patients"

"Uhmmmm…unfortunately the number increases a lot… a lot. Each and every year it increases. Remember the… the… the mental healthcare users like nowadays most of them they use drugs, neh. Most of them the drugs can lead them to end up being ah… mentally not well in the worst state. So now the thing of this drugs increases our… our stats…."

"The number is growing. Jah. For… for… the number is growing each and every year."

The abovementioned quotes revealed an escalation in MHCU numbers at the MHCE. Globally it is estimated that one out of four people suffers at least once, during their lifespan, with a mental disorder, however not every person receives assistance at PHC level. They are mainly treated for other conditions (Dube & Uys, 2016:119). No scientific peer reviewed articles could be

identified regarding information about an escalation in MHCU numbers at MHCEs. In the National mental health policy framework and strategic plan for South Africa, 2013 – 2020, the Minister of Health admitted that there is only one mental health indicator measuring mental health services in South Africa, and this is in the District Health Barometer. This indicator only measures mental health care visits, which are totally insufficient (South Africa, 2013:15). In the District Health Barometer 2016/17 the only reference to mental health care services was the cost of mental health services at PHC level which was R 911 137 712.00 for a headcount of 1 765 514 mental health care users. The total cost per MHCU is R539.00 per month (Massyn *et al*., 2017:22). A telephonic follow up with a statistical consultant at the MHCE involved in this research, revealed an increased total of 323 MHCUs per year, being considerable if taking into account that if the MHCU is a relapse, the process of consulting followed a first visit admission process (Ferreira, 2019).

The sub-themes identified are presented in the paragraphs below.

- ***Increase in waiting time for service***

MHCU's complained that they had to wait longer for service and according to participants this was due to an increase in MHCUs. The following quotes reveal complaints about longer waiting times.

"Ah, it's… now it means they take almost the whole day here, jah, for services because there is a whole lot of them and we don't have enough staff."

"Jah. The waiting time basically. It's a problem."

"No, we can't service all of them. We have a waiting list for patients to attend to psychologists for therapy. I mean I… every month I have a waiting list. So it's… we can't render services to all of them."

"….patients complains that staff are too slow or not doing their job…"

In a Nigerian and Tanzanian study long waiting times in outpatient departments resulted as the patient needed to register first to obtain his/her file, then sit and wait for vital signs to be taken. The patient waited again for the doctor's consultation and thereafter other services such as laboratory and pharmacist services were attended to (Jack-Ide & Uys 2013: online; Ishijima *et al*., 2016: online). Patients visiting district hospitals or other hospitals emergency departments were faced with challenges. Overcrowding of outpatient/emergency departments created anxiety in patients, and caused job dissatisfaction amongst healthcare providers. The multidisciplinary team had to deal with many patients within a limited time (Rauf *et al.,* 2008:

online; Da Silva *et al*., 2014:1015). The same procedure was followed at the MHCE as in the Tanzanian study, however quality improvement steps were implemented. The conclusion can be made that MHCUs do not want to wait long for mental health services at the MHCE and do not realise that there is an increase in the number of MHCUs who need to be attend to.

- ***Time consuming to tracing defaulters***

According to participants the effort to trace defaulters was very time consuming.

" time consuming, you need to phone, sometime a few times….they say they will come…and do not come.."

"…they say they come….next week they did not come…need to phone again…"

"..sometimes we phone the social worker in the community to do a home visit and bring the mental health care user to OPD…"

"..need to teach responsibility of compliance in case of defaulting and not compliance….."

MHCU's show a greater tendency with noncompliance. It is important not to blame the patient when a follow up is made and the health care provider should not see it as the MHCUs inability to return for follow up but should attempt to get the MHCU as soon as possible at the MHCE for treatment. The MHCE should use all possible resources to avoid nonadherence. If this happen it is a health system failure to provide adequate care to meet the MHCU's needs (Moosa *et al*., 2007:40; Kirby *et al*., 2014:1924).

- ***Effect of increased MHCU numbers on staff***

The amount of MHCUs that needed to be seen did have an effect on multidisciplinary team members. The following quotes indicate the effect of the escalation of MHCUs.

"…..high numbers of patients demoralizing to staff…."

"…be very hectic because we will have to cope with the number of patients that we have and then we have a lot to do with those patients and those patients they have different conditions. Others are aggressive, others… nja… you cope… we have so many things to cope with…."

"…we have shortage of staff and then we end up being... our passion… it's not that much…"

"… staff becomes tired and very irritated with MHCUs….."

"…the only demoting thing…MHCUs defaulting of non-compliance"

"..it's… sometimes it can reflect bad on our statistics because now it means they take almost the whole day here, jah, for services because there is a whole lot of them and we don't have enough staff.."

"… doctor patient ratio becomes very high….hectic to deal with"

Rising levels of burnout and poor well-being was associated with multidisciplinary teams working in MHCEs and is a concern for health systems. The abovementioned quotes prove that action and interventions should be taken which target mental healthcare staff. A study that was conducted by Johnson *et al.* (2017:20) looked into the causes, implications and current interventions which were used to assist mental healthcare staff and this study revealed that mental healthcare staff suffered more from burnout and depression as staff in other sectors in healthcare. Poor wellbeing and higher burnout led to poor quality service delivery, high rate of absenteeism and high turnover rates. Furthermore it appeared that interventions were only effective for the minority of mental healthcare staff and further research should be undertaken aiming for stronger links between healthcare providers and universities with the focus to design interventions targeting burnout and improving patient care (Johnson *et al*., 2017:20).The main causes for burnout in healthcare staff included inadequate staff, excessive workload, lack of support and opportunity for further training and continuous professional development. Mental health services carry an additional load which contributed to burnout and that included emotional labour, as they care for MHCUs with high levels of violence, aggressive behaviour and those who self-harm (Johnson *et al*., 2017:22). The following quotes highlight this additional emotional care which is expected from mental health care staff.

"…those patients and those patients they have different conditions. Others are aggressive, others… nja… you cope… we have so many things to cope with and then mostly now because now we are also admitting the substances, it's even worse now because we'll also… and the substances are very difficult, they are very difficult patients…."

"…it can be about twenty something patients and then most of them they are psychotic. (stammering) They will be aggressive, we have to cope with patients because they'll be fighting each other, fighting the staff."

"Others they won't even when they go to the bath they would just be messing up… messing up the bathroom."

"some of them they will come, they will be suicidal… we need to make sure that they swallow their pills… they swallow their pills because others they can even keep them up until they accumulate them and then they commit suicide."

"They strangle themselves with the bra…"

A South African study identified four main themes which mental health nurses used as coping mechanism to care for MHCUs namely psychosocial support, coaching and mentoring, and stakeholder support. The psychosocial support included provision of an employee assistance program, appreciation by operational managers for mental health care nurse's contributions and requesting their input when decisions needed to be taken. With regard to mentoring and coaching, weekly reflective meetings, opportunity for professional development by allowing short courses to be attended or opportunity to specialise e.g. specialist psychiatry nurse was essential as this would motivate staff to be passionate about their job. Stakeholder support included support from family, friends, management, government and spiritual leaders (Molehabangwe *et al*., 2018: online).

- ***Bed occupation rate high – no space to admit new and re-admissions of MHCUs***

Some of the staff member's complained that the bed occupancy rate was high and had a negative influence on MHCUs in the MHCE especially if a MHCU needed to be admitted. The following quotes emphasize this sub-theme.

"…sometimes patients discharged to make bed for others…"

"…the ward divided where patients are admitted form OPD, mild or very aggressive. Sometimes for mood disorders there is no beds…"

"…the ward are always full…"

"…certain that we admitting more patients…"

"…we are an acute hospital so we only admit for short term"

An international study conducted in Bhutan, South East Asia revealed that the majority of admissions were for mental and behavioural disorders caused by substance abuse. Mental conditions were aggravated by the use of alcohol and drugs. The average bed occupation rate is one to two weeks in the psychiatric ward, as the hospital policy states that patients are not allowed to stay longer than two weeks (Pelzang, 2012:52). According to Massyn *et al.* (2017:26) the average length of stay in a district hospital in the Province where the research was conducted is five days, however they did recognise that this was not applicable for TB, HIV/AIDS and mental health patients.

The following theme and sub-themes were derived from question 3 and formulated in table 3.4. A discussion of the theme and sub-themes follows below the table.

Table 3.4 Question 3: Experiences of multidisciplinary team members about rendering mental health services at PHC level.

MAIN THEME	SUB-THEMES
Down-referral mechanism	Unavailability of psychotropic medication
	Stigma
	Patient assistance at PHC facility is a tedious process
	Negative attitude of staff with regard to mental illness

3.2.4 Down-referral mechanism

The next question asked was: What is your experience about mental health care services rendered at PHC level? According to Dube and Uys (2016:120), in South Africa mental health policies to ensure the integration of mental health services at PHC level do exists, however the integration of mental health services is a challenge. The down referral mechanism is in place for stable MHCUs and the MHCE do refer to a PHC facility of their choice for mental health services. The mental health policy was formulated without consideration of knowledge and attitudes of PHC nurses (Dube & Uys, 2016:120). The following quotes indicate that PHC level is reluctant to integrate mental health services.

"…at clinic medication for mental health care patients already packed…they just need to collects and just leave like that, no observation, no control for compliance…."

"…or maybe they are… jah… or maybe they are treated differently when they go there"

"…At the clinics we find the nurses, OK, it's fine the nursing staff and the doctor can be there at times but specifically there in no much like the psychiatrist, the psychologist that deals specifically with the mental health…"

"…and most of the time you would hear them complains, saying there was no medication for them and then patients need firstly to make an appointment before they come for their revisit day so that they should collect but at some point there is no medication…"

"…There is not enough psychologists"

"…The services from the primary healthcare, for me is very low. That is all I can say for now. Because due to the relapsing, due to the readmissions it simply means they don't receive their medication on time…"

A study conducted in Ghana emphasized that MHCUs should receive mental health care services in their community as large sums of money were invested in the building of psychiatric hospitals, however this does not happen. This study revealed that down referral of mental health services could only be possible if there was enough infrastructure of community facilities and appropriate human resources (Akpalu *et al*., 2010:110). The Minister of Health was committed to focusing more on mental health services at PHC level, however the budgets and health system designs did not reflect these commitments. Currently the WBOTs function with a team leader (professional nurse) and 6 health care workers for every 250 households. To assist these teams a District specialist team was established to support all PHC facilities at sub-district level (Dennill & Rendall-Mkosi, 2012:68-69). However, these teams did not include a specialist psychiatric nurse and no posts are available at sub-district level for specialist psychiatric professional nurses (Jack *et al*., 2014: online). The WBOTs are the focus of South Africa's PHC re-engineering system. Wards are smaller sections of a community and the ultimate aim is to allocate, in each ward, at least one outreach team. The number of teams per ward depends on the size of the population, the geographical area and other influencing factors such as the disease burden and epidemiology. Literature differs on the number of community health workers to be allocated in an electoral ward, but the ideal is between 6 and 8. The role of the community health workers is to visit each household allocated to them and register each household. The curriculum of training of community health workers focuses on community mobilisation, health promotion and disease prevention, functioning in a team and priority health issues such as HIV/AIDS, TB and maternal, child and women's health (Dennill & Rendall-Mkosi, 2012:71-72). Figure 3.1 was adapted to indicate the role of the specialist support teams at district level. No reference was made to mental health services and therefore the conclusion can be made that PHC services are not geared to render adequate mental health services, thus leading to a failure in the down referral mechanism. According to the mental health policy the following should have been in place at PHC level by 2015.

*Routine screening for mental disorders during pregnancy and postnatal and referred when necessary – this is done by community health workers and professional nurses at PHC facilities.

*Clinical protocols for mental disorders (Standard treatment guidelines and Essential Medicine List as well as Adult Primary Care protocols (APC) are available at PHC level.

*Detection and management of child and adolescent mental disorders in PHC facilities or at schools, and referral where appropriate.

*Supervision systems need to be in place to monitor quality of mental health services at PHC level.

*A specialist psychiatric nurse to be incorporated in the specialist support teams at district level to support non-specialist PHC staff and community health workers (South Africa, 2013:23-24).

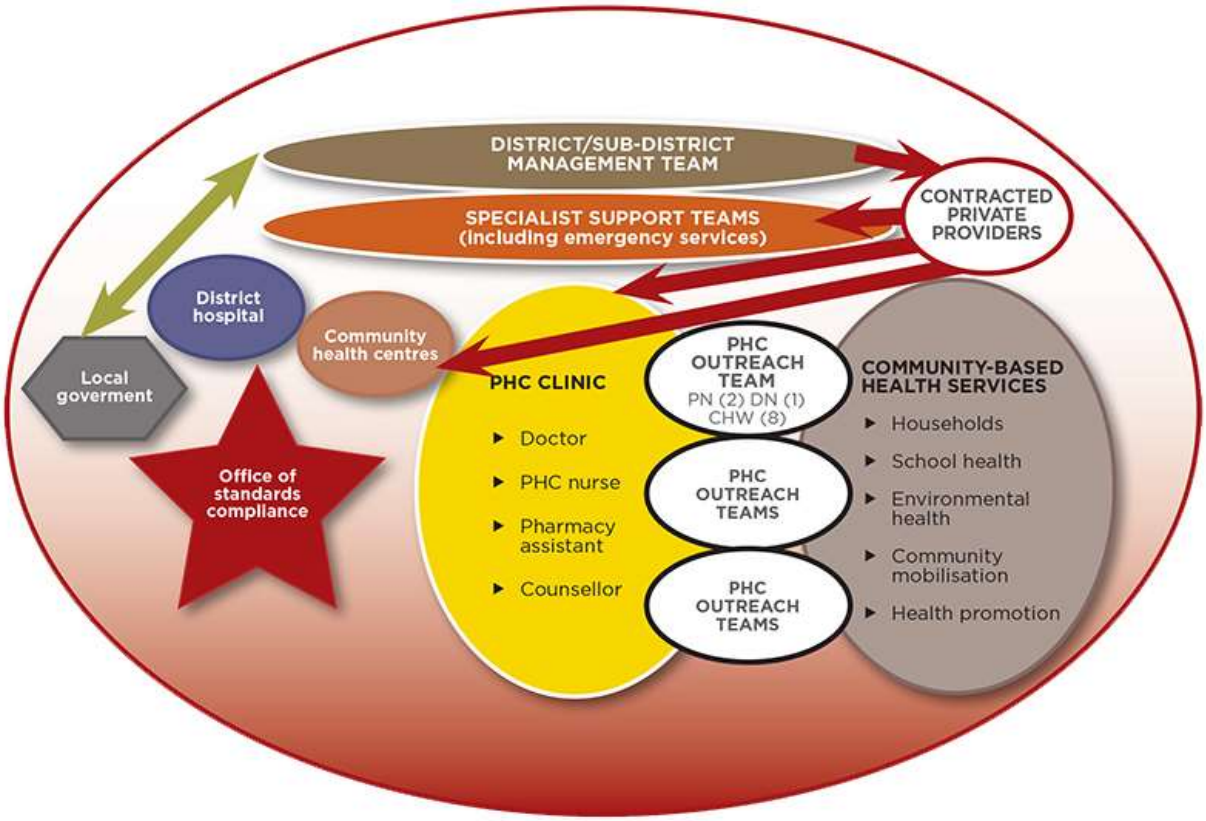

Figure 3-1: Adapted Re-engineering framework based on the District Health Model (Dennill & Rendall-Mkosi, 2012:68)

In the next section the sub-theme, Unavailability of psychotropic medication, follows.

- ***Unavailability of psychotropic medication***

The following quotes provide information about the unavailability of psychotropic medications in PHC facilities:

"I don't think they are… they are helping but they are not doing much because sometimes we send out patients to the clinics and they will tell us there's no medication for psych patients"

"…they say no, we went to the clinic but the medication was not there…"

"….problem that I think I've noticed a lot is then uhm, medication will not be available…"

"….If a patient is discharged here with a certain medication and then is down-referred to a healthcare centre, if they get there and they are told… sometimes they are told that the drugs need to be ordered."

A research conducted in Saudi Arabia revealed that although Cognitive Behavioural Therapy was successful in the treatment of certain mental health disorders such as anxiety and depression but the majority of MHCUs need psychotropic medication. Pharmacotherapy was used to treat the vast majority of mental disorders and proven to be effective, however their MHCUs could not obtain their medication from the community pharmacies (Al-Ruthia *et al*., 2017:745). The Tanzanian Health Systems failed to ensure that MHCUs received mental health care services due to inadequate mental health providers and medication supplies (Iseselo & Ambikile, 2017: online). In South Africa PHC facilities work according to the Standard Treatment Guidelines and Essential Drug List. Chapter 16 deals with acute mental conditions and some of these drugs can be ordered and kept in a locked schedule 5 cupboard, for use in acute conditions, before referring to the MHCE for further management. Down referred MHCUs receive a referral with a prescription from the MHCE. The MHCU receives a month's medication from the MHCE, which should submit the prescription and letter to the PHC facility the MHCU prefers. This does not happen in time and when arriving at the PHC facility the medication is not ordered, leading to problems. The National Mental Health Policy Framework and Strategic Plan 2013-2020 stating that by 2015 "All psychotropic medicines, as provided on the standard treatment guidelines and essential drugs list (EDL) will be available at all levels of care, including PHC clinics", did not realise. Fortunately, most District level hospitals do have these psychotropic drugs and can be ordered from them (South Africa, 2013:65). The conclusion can be made that if the down referral mechanism can be implemented effectively psychotropic prescriptions for patients can be obtained via district level hospitals on time and be available at PHC facilities.

- ***Stigma***

Stigma was identified as a sub-theme why MHCUs did not want to visit PHC facilities for mental health care services as indicate by the following quotes:

"… I really don't know whether is… it the stigma or whatever or maybe they are afraid that people are seeing them when they go there. I really don't know…"

"According to my opinion I think that…I don't know whether… whether it's a stigma or what because once the patient is being referred to the clinics they don't follow up."

"….Uhm, then there's issues of stigma. Uhm, stigma coming from the community, stigma coming from the health profession as well…"

"…firstly viewing mental health problems as any other medical problem, right. We don't have problems with people being diabetic; we don't have problems with people being hypertensive…"

Stigma related with mental disorders is not prevalent in South Africa only. Stigma at PHC level in Cambodia was associated with non-compliance, defaulting, a lower probability of resources and professional nurses not willing to go for specialist psychiatric training (Alfredsson *et al*., 2017: online). In Saudi Arabia, especially the Muslim communities, would rather visit a private physician than a mental health facility for mental disorders mainly due to social stigma (Al-Ruthia *et al*., 2017:745). Even in Tanzania a low budget is allocated to health care workers working with MHCUs resulting in stigmatisation under professionals (Iseselo & Ambikile, 2017: online). Stigma towards mental health disorders is relevant in South Africa as well. Mental disorders disrupt families, social networks, causes discrimination and stigma. Stigmatizing beliefs in South Africa includes people thinking that a person with a mental disorder is bewitched, mad, insane, not capable of doing anything or even unable to think. MHCUs are often neglected, misused, abused, isolated or rejected by family and peers. The conclusion can be made that stigma is a barrier towards assessing health services at PHC level, education, employment, adequate housing and essential basic needs for MHCUs within the South African context (South Africa, 2013:14).

- ***Patient assistance at PHC facility is a tedious process***

Long waiting times at PHC facilities are not acceptable to MHCUs.

"I don't think they get enough (clicking sounds) time to observe or monitor the patient that is why they always referred them to the… to us…"

"…we went to the clinic but the lines… the queues was long…"

Health care support was seen as the last option by MHCUs in a study conducted in South Africa. This can be seen as a health care system failure at PHC level as it denounces accessibility barriers to receiving care at this level. Services were described by MHCUs as unwelcoming and stigmatising. In addition to this, long waiting periods resulted because of a high demand for other services which are rendered at PHC level (Da Silva *et al*., 2014:1013; Cohen *et al*., 2013:275). Another study conducted on mental health services, PHC staff

acknowledged that they lacked sufficient knowledge and skills and that they were not prepared to handle MHCUs. Frustration during consulting of MHCUs with a medical complaint contributed to PHC service providers ignoring signs of mental disorders in their patients (Medina *et al*., 2014: online). Most clinics, in a rural district of Limpopo Province, is staffed by professional nurses who do not have psychiatry nursing as an additional qualification. It is expected from these professional nurses to attend to all patients, including MHCUs. According to these professional nurses they lack training to render the full package of PHC services and it is difficult to provide essential education on mental health conditions. To aggravate the situation even more, some of the MHCUs also visit traditional healers and that contributes to the insecurity of whether to provide, or not, their medications as prepacked by the district hospital (Shilubane & Khoza, 2014:382). All chronic diseases are dealt with according the integrated chronic disease management model and mental disorders are a chronic disease. Patients with a mental disorder do not want to sit in long queues and they can become adamant for service. This led to one of the findings from Jack *et al.* (2014: online) that interventions should be design to ensure integration of mental health services. Interventions should take the needs of MHCUs into consideration when developing integration strategies.

- ***Negative attitude of staff with regard to mental illness***

PHC facilities staff members have negative attitudes towards MHCUs as identified by following quotes:

"….as soon as it is noted (cell phone vibration) that there is a mental health diagnoses, uhm, the staffs attitude change and is more for the negative…"

"…I'm sorry… they can't trust general… generally the primary healthcare system to take care of them adequately. So then it becomes a huge problem. So those are the things that I've noticed at the primary healthcare level, (sigh) jah. Mental healthcare pro…uhm, users have a bad experience".

Cambodia is a country where all necessary resources for treating mental health disorders are limited. The integration of mental health services at PHC level seems to be an effective strategy, however 67% of the staff view mentally ill people as dangerous with unpredictable behaviour and that mental illness only affects adults (Alfredsson *et al*., 2017: online). The attitude of PHC nurses were found to be negative towards MHCUs, according to a study conducted by Dube and Uys, (2016:119) because their skills on how to deal with mental disorders were found to be inadequate. This leads to the fact that PHC staff rendering services to MHCUs do not update their knowledge. However, by challenging their own personal beliefs and attitudes more insight about their views and how to understand behaviour of MHCUs may result (Horsfall *et al*.,

2010:453). To ensure successful integration of mental health services at PHC level the negative attitude of staff towards MHCUs needs to be addressed.

3.2.5 Reasons for occurrence of relapses within three months of discharge

The following themes and sub-themes were derived from data analysis as reasons why MHCUs relapsed within three months of discharge from the MHCE.

Table 3.5 Reasons for occurrence of relapses within three months of discharge

THEMES	SUB-THEMES
Psychosocial and PHC facility contributory factors	Same environment: alcohol, drugs and unemployment
	Medication related factors: Side effects, feeling better, no transport to fetch medication
	Lack of an effective support system (Community, family, employers and PHC level)

- ***Same environment: alcohol, drugs and unemployment***

In this sub-theme it was identified that, MHCUs were being discharged to an unchanged environment where they are exposed to an environment which led them to relapse and to be re-admitted to the mental health care establishment. Alcohol and drug use in itself may cause psychotic and depressive symptoms which could lead to the relapse of a person diagnosed with a mental disorder. Unemployment may contribute to relapse and readmission where MHCUs say they do not have money for travelling to attend MHCE or PHC facilities. They may also not have money for food to take with their psychotropic medication.

"…then you discharge them, then they go back to their community, back to the uhm, environment that led them back… that led them here in the first place, and they come back…"

"…others is using alcohol because when they are here they are taught not to mix mental illness treatment with the alcohol."

"…they usually use the alcohol while they are having the treatment and sometimes they don't even take the medication…"

"…they are going back to the drugs…"

"…maybe they are not employed. They always complain about they didn't have food at home so I can't drink medication when I don't have food to eat."

"…unemployment also because most of them they will be complaining that I didn't take the medication because I didn't have anything to eat. Unemployment also contributes for them to… not to take their medication."

People with mental illness are more vulnerable than the general population and homelessness and improper incarceration may increase their vulnerability. Inhuman and unhygienic living conditions such as physical and sexual abuse, neglect, harmful and humiliating treatment practices in health facilities may lead to stigmatisation whereby the MHCU is excluded from society. This vulnerability may hinder goal achievement in the MHCU's life such as compliance of psychotropic medication (WHO, 2013:8). MHCUs drinking or abusing drugs can become aggressive or develop side effects from psychotropic drugs which make it difficult to manage them. When they get home they do not want to take their medication and they are very manipulative. The family gets tired after years of this type of behaviour and do not want to accommodate them or accept responsibility for them (Strümpher *et al*., 2014:52). Readmission of MHCUs occurs due to substance abuse, i.e. use of alcohol and misuse of prescribed drugs and/or illegal drugs such as marijuana (Takalo *et al*., 2015:236; 241). According to WHO (2013:8), mental illness often contributes to poverty in individuals and families. A study conducted by Maluleke *et al.* (2015:127) discovered that MHCUs are non-compliant to psychotropic medication as a result of lack of basic needs such as food. A study done by Strickland *et al*. (2019:392) who plotted a model for financial strain and non-financial strain over at least eight days indicated non-adherence of psychotropic medications in individuals related to socioeconomic factors such as general-, childhood financial strain, unemployment, and income. According to Strickland *et al.* (2019:392) and Joe and Lee (2016:6) their model reflected a disproportionate increase in non-compliance in comparison to users with less limitations. Their study, consequently emphasises that non-compliance to medication can be associated with financial constraints. A conclusion is made that a reason for relapse within three months after discharge can be associated with the main theme, namely, psychosocial factors and the sub-theme, namely, same environment: alcohol, drug abuse and unemployment, which was the original cause for their admission.

- ***Medication related factors: Non-compliance, side effects, feeling better, lack of insight, no transport to fetch medication***

Non-compliance was a common reason why MHCUs relapsed and in need of re-admission to a MHCE. There were also other factors such as side-effects, recovery (the MHCU feel better with

the use of psychotropic drugs) and transport issues to go for follow up appointments and to collect medication. The following quotes revealed the analysis of this sub-theme.

"…It's non-compliance… non-compliance. Non-compliance of medication…"

"…the fact that there was side-effects till they get unbearable and then they just stop taking the medication."

"…uhm, side-effects. Uhm, and I suppose there's this… there's generally this idea that uhm, patients believe that: no, healthcare professionals know better, so if this medication was given then surely this medication was given to make me feel better and they might not always voice the side effects…"

"…a lot of the times it's the side-effects of the medication, especially the weight gain..."

"…if it's a mood disorder or someone with bi-polar then already they have issues with say now for instance weight or the body image and now we give them medication that yes it maybe makes them feel better or they are stable mentally but then they gain weight and then thy just leave the medication…"

"…Uhm, another one is, they felt feeling… I mean, they left feeling OK and they thought they were well. Uhm, not understanding that the medication were meant to be continued for a certain period of time…"

"…Maybe they feel better and feel that they don't need the medication anymore…"

"…. So I just think they feel better within three months and then they just stop taking it…"

"…people might not have access to uhm, transport to get them to places."

"…definitely transport. People have transport problems so they are unable to follow up on a weekly basis for therapy. So they get discharged back into the community. They don't have the resources to come for follow-up."

Chan *et al.* (2015:307) and Nagesh *et al.* (2016:583) stressed that non-compliance to psychotropic medication is the major contributory factor leading to relapse in MHCUs with schizophrenia. Furthermore, a lack of insight regarding the benefits of psychotropic medication influenced compliance with reference to the fact that these medications control mental disorders or lets a MHCU feel better (Nagesh *et al*., 2016:584; Takalo *et al*., 2015:238). Research conducted with professional nurses working with MHCUs confirmed that transport was a

problem for them as not all mental health services were within walking distance and they did not have money to pay for transport (Strümpher *et al*., 2014:50).

In conclusion, psychotropic medication causes side effects, makes the MHCU feel better and in addition a lack of transport contributes to relapses. Consequently, MHCUs stops drinking their medication or they do not go back to PHC facilities or MHCEs for follow up visits.

- ***Lack of an effective support system (Community, family, employers and PHC level)***

Participants mentioned that families do not give enough support to the MHCU and/or in some instances there is no family available to take care of the MHCU after discharged. There are participants who stated that some MHCUs needed the support of another person in order for the MHCU to take his/her psychotropic medication. Employers are not forthcoming in the support of employees diagnosed with mental illness and reluctantly give the employees time off to collect psychotropic medication and for this reason the employed MHCUs miss their appointments to collect their medication and become non-compliant. Lack of integration and follow up on MHCUs from PHC facilities are other factors contributing to relapse and re-admission. The following quotes affirm the abovementioned findings.

"…Maybe they don't have support system at home and the support system will only be there if the people understands the seriousness of the condition of the patient."

"…Sometimes it's a family problem that they do come across…"

"…the other thing is the family support… the other thing is the family support. The family don't give them enough support… enough support so that they can take their treatment properly…"

"… also the family members… if there is no one who's actually taking care of that patient, monitoring that this patient is drinking medication…"

"…Because when they go home they need someone to support them to take their medications…"

"…those who are employed is trying to get the time off to go and get your medication. Not all employers are so forthcoming and offering for that period of time, even if it is for a few hours for you to go, have your follow-up…"

"…By the time they leave work a lot of places are closed so then it becomes inevitable for them to relapse their medication…"

"…Uhm, there is no follow-up system in the community from the healthcare going to those… those patients…"

"…Uhm, if they could have a sister at the clinic who also like we do here for our section 33's, they phone them when they have to come for their follow-ups and make sure that they actually do come. If there's maybe a sister at the clinic who's got a list of the patients that have to follow up with them…"

Although the family is supportive and reminds the MHCU to take his/her medication, the MHCU could refuse and sometimes lie, saying that they have taken their medication (Maluleke *et al*., 2015:126). According to Maleeka *et al*. (2015:126) the responses, family supports and assists their loved ones in taking their medication once diagnosed but proposes that MHCUs need support from nursing staff outside the MHCE. There is slow integration of mental health at PHC services due to lack of appropriately trained mental health professionals, inappropriate space for private consultation or facilitation at PHC facilities (Strümpher *et al*., 2014:46).

In conclusion MHCUs relapse and are readmitted to the MHCE due to various factors. There is not enough support for MHCUs after discharge with a mental disorder. The family does not always take responsibility to oversee the medication of the MHCU, they expect the nursing staff to manage the medication intake. Treatment, however, could have severe side effects that could lead to readmission or the MHCU could feel better after a few months and just quit the psychotropic drugs not knowing that the medication controls his/her condition. Employers either do not know that an employee has a mental disorder or do not want to give them time off to fetch their medication. PHC facilities progress very slowly with the integration of mental health care services.

3.2.6 Suggestions from multidisciplinary team members to integrate mental health care services at PHC level

The final question asked in this research was: Can you provide suggestions how mental health care services can be integrated at PHC level? The derived themes and sub-themes follow in table 3.6.

Table 3.6 Suggestions to integrate mental health services at PHC level

THEMES	SUB-THEMES
Accessibility of PHC facilities	Training of professional nurses, team leaders of ward based outreach teams, community care workers and other staff working at PHC level
	Collaboration between stakeholders
	Stigma reduction strategies
	Establishment of an effective support system
	Deficiencies at PHC facilities

The main theme is to **ensure that PHC facilities are accessible for mental health care users**. The first sub-theme derived was the need for training of professional nurses, team leaders of ward based outreach teams and community care workers working in these outreach teams.

- ***Training to enhance accessibility for MHCUs at PHC facilities***

The following quotes indicate that there is an urgent need for training before mental health services can be integrated at PHC level.

"…*staff in the primary healthcare uhr, setting should be taken for in-service training regarding mental healthcare users because they are not like all the other patients… are patients who sort of like need special care…"*

"…I don't know whether is because of people working in the clinics they don't have knowledge with mental illness…"

"…maybe if the staff is trained in that regard so that they know that it's not everybody that is mentally ill who needs to be transferred to the hospital and it's not everybody who is mentally ill who can go back home …"

"…they at least need to be… have like sisters that trained in psychiatry, you understand…"

The literature revealed the following about training. A study conducted in Nepal showed that a low resource rural area developed an innovative network to ensure an effective mental health service. The first step in the establishment of the collaborative network was training and supervising of nurses and doctors without psychiatric training by off-site psychiatrists, non-

governmental organisations that specialized in mental health and academia. The training for these professionals and non-professionals who did not have knowledge about mental health included screening, diagnosing and treatment of mental disorders. The research team recruited counsellors (this could be the community health worker in our setting) and trained them to provide basic psychotherapy and care coordination and engaged an off-site psychiatrist to provide supervision and quality control on a weekly base. These strategies were successful at 20 PHC facilities, however payment of community health workers, which is also a current hurdle in South Africa, was a hampering factor (Acharya *et al.*, 2017: online). Many studies state that training should be given to ensure effective integration of mental health services at PHC level (Alfredsson *et al*., 2017: online; Akpalu *et al*., 2010:110; Da Silva *et al*., 2014:113). The WHO developed specific programs to assist sub-district and district offices with regard to mental health training e.g. Mental Health Action Plan and the mhGAP Intervention Guide. These guidelines assisted countries to develop tailor made mental health in-service training and programs for continuous service delivery (WHO, 2016: online). A training strategy was implemented as an in-service training program which entailed one-hour training sessions weekly by local psychiatry staff to 20 primary care nurses for over 5 months. The Practical Approach to Care Kit (PACK) guidelines were used which was developed by the University of Cape Town and tested in South Africa and Brazil. Within the Practical Approach to Care Kit (PACK) guidelines, primary care nurses were guided through first-line treatments for depression, substance misuse, psychosis and dementia. A training manual as well as logbook for recording MHCUs consultations, was used for case-based discussions, with space to record feedback and agreed development points. The format of the hour training sessions consisted of group work, discussions of MHCUs cases seen at the PHC facilities and sometimes role play. The course was evaluated after completion and found to be sound and relevant, equipping primary care nurses with knowledge and skills to integrate mental health care in PHC services (Maconick *et al*., 2018: online). The mental health policy formulated the following guidelines regarding training:

*An in-service training package should be developed for non-specialist workers (non-trained professional nurses, community health workers, social workers) to render evidence based psychological interventions.

*Mental health training programmes for all staff at PHC level (South Africa, 2013:23-24).

The conclusion can be made that in-service training should be provided to all staff members employed at PHC facilities.

- ***Collaboration between stakeholders***

Communication between stakeholders in this research means, specific liaison meetings between the MHCE, sub-district offices, district office and local area managers responsible for overseeing duties of PHC facilities. These meetings will be too big to be fruitful if also attended by all operational managers rendering services within the MHCE catchment area. The following quotes elicit the need for such meetings, followed by literature findings.

"…there has to be communication between us and the primary healthcare units, clinics…"

"….to meet so that what we did it has to be continued in the primary healthcare. They should know that when the patients are being referred to them they need also to make a follow-up on those patients because the patients are being referred to them…"

"…we have to meet, sit down and then know that patients that are being referred, they need to be followed up… they need to be followed up…"

According to Richards and Suckling (2009:379) a collaboration strategy is essential to assure quality mental services. Collaboration means professional communication by means of meetings and telephonic feedback. The MHCE in this research is a specialist level service and implementation, at PHC level, needs to be addressed by means of a step-down referral which can be followed and it can be used as a step-up referral in case of relapses. The mental health policy formulated guidelines to be in place by 2015 for mental health services, however according to quotes this did not realise. One guideline states:

"Early screening to diagnose mental disorders and a stepped approach for immediate management of depression and anxiety disorders at PHC level and referral to next level of treatment (South Africa, 2013:24).

More requirements are outlined in the mental health policy framework, but it is not applicable to this specific section and therefore not discussed (South Africa, 2013:23-24). No specifications are outlined with reference to collaboration and communication except for the step approach which needs to be followed.

- ***Stigma reduction strategies***

Stigma was identified as a sub-theme as a reason why MHCUs do not visit PHC facilities for mental health services. The multidisciplinary team discussion raised valid questions as indicated in the following quotes:

"…So those are the things and then every time without fail ah, the community must be educated about assorted mental illnesses also acceptable just like high blood…"

"… how can they provide privacy for patients, you understand. Jah. Because I mean if I'm depressed, how am I going to talk if there's only a curtain between us that is separating us? How am I going to talk?..."

"…Stigma, we should deal with stigma. You know we should make this patients feel like they're a human being also…"

"…you apply for jobs, people won't receive a mental illness. You getting… you understand, its stigma against you, discrimination against you already that you'll be taking time out of work…"

The establishment of credible strategies to reduce the stigma of mental disorders are essential, as PHC staff and communities need to be educated to accommodate the mentally ill (Akpalu *et al*., 2010:111). A study conducted in Cambodia revealed that stigma against mental disorders correlate to high numbers of treatment defaulters and relapses in MHCUs. Stigma under professional staff leads to unwillingness to specialize in psychiatry and contributes towards poor mental health services. The abovementioned factors are barriers towards the integration of mental health services at PHC level (Alfredsson *et al*., 2017: online). An unwelcoming and/or stigmatizing service denounces accessibility barriers in mental health services (Da Silva *et al*., 2014:115). Stigma reduction strategies includes awareness campaigns, direct social contact with MHCUs e.g. visits by community health workers, rigorous education of mental health professionals through undergraduate, postgraduate and in-services training about the damage stigma causes in MHCUs. Stigma can lead to a lack of confidence, hope and can influence recovery from a mental health disorder or have a negative impact on disorders that can be controlled with treatment (Horsfall *et al*., 2010:452). A conclusion can be made that the implementation of strategies to reduce stigma in the MHCU self, PHC staff and in communities are of utmost importance to ensure integration of mental health care services at PHC level.

- ***Establishment of an effective support system***

The support system was identified as a sub-theme with the question regarding what could be the reason for re-admissions within three months after discharge. The support system was a crucial requirement to ensure the successful integration of mental health care services at PHC level. The following quotes confirm the necessity of an effective support system.

"…I don't know if that is possible, for (clearing throat) for us to have people who do something like support groups…"

"…just have a statistics or data about make an example maybe extension 7. Say extension 7, we know that in this region we have this many mental healthcare users and this ones need to be visited by people who are involved in support group …"

"…to involve the family more, to make sure that when the patient is discharged she is discharged to a family member who's going to make sure that the patient actually follows up at her… even if it's at the clinic.

"…the other ways is that we do have the… what do you call those people? The door to door giver. The door to door giver they can also help. They can collect their treatment from the clinic and then they can give it straight to the patients where they stay…"

"…Uhmm… A lot of our patients they have poor ah, social support. The family themselves, you understand, they, for lack of better word, they fail our patients…"

According to Acharya *et al.* (2017: online) the support should start by empowering the MHCUs to participate in decision, promoting and assisting themselves to set and reach their life goals and not only focus on symptom control or stabilizing of conditions. A study conducted in Zambia revealed very low psychosocial support for MHCUs, in their respective communities. When MHCUs were admitted for long periods, they lost their occupational skills and became a burden to family members or care givers (Akpalu *et al*., 2010:11). The understanding of the nature of mental health illness and social acceptance in the community is negative. MHCUs with less psychosocial support are less satisfied with mental health care services rendered at PHC level (Sadik *et al*., 2010: online; Yimer *et al*., 2016:1848). There is therefore a great need for community education to ensure integration of MHCUs at community level (Sadik *et al*., 2010: online). A study was conducted to identify the specific needs of the MHCUs in South Africa. The specific needs identified in this study were: support with taking of medication, -with basic needs, -with handling of relapses, financial support and assistance to obtain employment (Maluleke *et al*., 2015:125). The community should be educated on these needs as a neighbour or friend could occasionally visit the household and identify a problem. This is one way of addressing negativity and stigma from the community side. A family member or caregiver should be familiarised with the treatment, follow up dates, side effects, and what to do if symptoms of a relapse surface. Information should be given through that a mental disorder can sometimes not be cured but can be effectively controlled just as diabetes and hypertension. Not all MHCUs qualify for a disability grant especially if the mental disorder is associated with substance abuse. Those who did qualify for a disability grant indicated dissatisfaction as their family often squandered the money. The community social worker deals with these grants and if a community member or health care provider has a suspicion that this is the case it can be

reported at the social worker for further investigation. Employment in South Africa is problematic but if a MHCU is prepared to do "piece" work it can lead to full time employment. It is essential for MHCUs to function within a structured program during the day, however these programs are currently not easy to sustain (Maluleke *et al*., 2015:125). Another way to support MHCUs in the community is by means of support groups. A support group can provide emotional support, assist MHCUs to manage and deal with risk factors, alleviated feelings of loneliness and social isolation. These support groups can share experiences and feelings with other members of the group (Da Silva *et al.*, 2014:2013-2014). To integrate mental health care services at PHC level the establishment of an effective support system is essential. This includes support groups which are facilitated in such a way that each MHCUs felt his/her opinion is important. The MHCU should have support in overseeing treatment as well as basic and financial needs. A family member or caregiver should be part of the MHCUs treatment plan and an understanding of the condition, side effects as well as the identification of relapses should be reinforced.

- ***Deficiencies at PHC facilities***

The multidisciplinary team members identified deficiencies at PHC level as one of the reasons why MHCUs did not want to attend PHC facilities for mental health services. The following quotes identifies the deficiencies.

"…need to equip the primary healthcare settings with other infra-structure, adequate infra-structure where we can provide privacy for patients, you understand. Jah. Because I mean if I'm depressed, I'm coming here there's next door, my neighbour is there, my friends are there, I'm not going to be open because a depressed person needs to talk about their problems. How am I going to talk if there's only a curtain between us that is separating us? How am I going to talk?..."

"…They need to be equipped, you know, with infra-structure, they need to be equipped with medication necessary to provide for this patient because what is the use of down referring patients there and then there is no medication you understand…"

"…and access to mediation I have to go back to as well because if the medications are available in a place that is right next to you, then you know it… it… it… it eliminates a lot of problems. It eliminate the problem of transport, it eliminate the problem of taking time off from work and all of those things…"

"…So its ether the treatment is not ordered in time so that when the patients come to collect they have their treatment. They usually come back to the hospital saying the same thing, there is no treatment…"

"…Well for psychology I have indicated that they don't have psychologists at primary healthcare, so they should actually appoint those services in primary healthcare. So I don't know how they think services should be rendered without the necessary resources and skills are one of those resources. So if there is no skill…"

"…I think there needs be a psychia… psychiatrist and psychologist at the clinics. And also… they need to make sure that the medications… they stock psychiatry medication and they give health education regularly about mental health care…"

"…there is supposed to be a mental health person as well but there… I really don't think it's being done…"

Medication related issues were discussed before and will not be discussed again. The South African scenario with regard to PHC Standard Treatment Guidelines and Essential Drug List for level 1 PHC facilities were outlined in detail. Non-Governmental Organizations which specialises in the rendering of mental health care service may have the infrastructure to render mental health care services but lack the expertise such as multidisciplinary team members which are not available at PHC facilities. If these Non-Governmental Organizations are utilised it may aggravate stigma (Acharya *et al*., 2017: online). One of the reasons for poor mental health service delivery is lack of infrastructure to provide privacy to MHCUs (Mosaku, & Wallymahmed, 2017:177). The National mental health policy framework and strategic plan for South Africa of 2013-2020 elicited to equip PHC faculties with psychology infrastructures which includes private consultation rooms and group facility rooms where psychologist can render services and facilitate group sessions (South Africa, 2013:37). A study conducted in Limpopo showed that the majority of the nurses did not have psychiatric training and that the absence of multidisciplinary team members which include a psychiatrist, psychologist, occupational therapist and social worker contributed to the breakdown in service delivery (Shilubane & Khoza, 2014:383). Human resources is a challenge in lower and middle income countries, therefore task shifting is used and professional nurses and community care workers are trained to do some of the functions such as counselling and facilitation.

A concrete next step will be to roll out mental health training for PHC facility staff, specific training for untrained psychiatric professional nurses to do basic psychiatric counselling e.g. supportive interview, assess a MHCUs general and mental health, identify side effects of psychotropic medication and adherence before given treatment. A MHCU should also be referred, if needed, to a councillor trained to do psychology sessions (Cognitive Behaviour Therapy) and group facilitations. Commitment from government is essential to extend PHC facilities in order to accommodate mental health and to ensure the availability of psychotropic

medicine at PHC level. Professional nurses rendering mental health care services at PHC facilities should re-order psychotropic medicine to ensure availability if the MHCU attends the facility.

3.3 SUMMARY

In this chapter the data analysis was discussed. Five main themes with sub-themes were discussed. All findings were embedded with literature. In chapter 4 an evaluation of the research, recommendations (derived from research questions), limitations and further research will follow.

CHAPTER 4: EVALUATION OF STUDY

4.1 INTRODUCTION

In chapter 3 the finding of the empirical research embedded in literature findings were discussed. In this chapter, the study is to evaluate with reference the achievement of its objective. Multidisciplinary team members were interviewed for suggestions to integrate mental health services at PHC level and recommendations were derived based on the findings. The limitations were identified and recommendations for further research were made according to the findings in this study.

4.2 EVALUATION OF STUDY

The progress of the integration of mental health services at PHC level are very slow. The multidisciplinary team members were interviewed because they experienced an escalation in MHCU numbers as the down referral mechanism, which is in place, does not function. The down referred MHCUs kept coming back to the MHCE and there was also an increase in relapses within three months after discharge of the MHCE. The objective of the study was:

- To explore and describe suggestions from multidisciplinary team members working at the MHCE in a sub-district of the North West Province which could contribute to the successful integration of mental health care services in a sustainable and effective way at PHC level.

Content scrutiny was used for initial data analysis and themes and sub themes were derived from these codes. Recommendations were given according to the questions answered. Each question in the interview schedule assisted the researcher to derive recommendations to integrate mental health services at PHC level. The researcher can thus declare that the objective of this study were met.

4.2.1 Role of multidisciplinary team members in the mental health care establishment

The first question asked was to define the role of the multidisciplinary team members in the outpatient- or psychiatric department. This question was asked to obtain an overview of the multidisciplinary team members' role in rendering mental health services but however did not lead to the objective of the study. The aim of this question was to set the participant at ease and to obtain an overview of the specific disciplines role in the MHCE. The multidisciplinary team members who participated in this research were doctors, psychologist, different categories of nurses (auxiliary-, enrolled- and professional nurses), dietician and social workers. Participants

worked either in the psychiatric unit which dealt with relapses after admission or the outpatient department.

4.2.2 Experiences of multidisciplinary team members about the number of MHCU visiting the outpatient department

With question two participants were asked how they experienced the number of MHCUs that visited the outpatient department. The first main theme derived from this question indicated that there was an escalation in the number of MHCUs that visit the outpatient department. Statistics revealed an increase of 323 visits more in one year. The sub-themes identified concluded that the waiting time increased, it was time-consuming tracing defaulters, the effect of increased MHCU numbers on staff and the high bed occupancy rate left no space for new or re-admission of MHCUs. These findings revealed information that could be used with the integration of mental health services at PHC level:

- MHCUs do not want to wait long for mental health services at public health services.
- There should be a system in place to trace defaulters and it should be practical and not time-consuming.
- With effective integration, emotional burnout on staff rendering mental health care services could be managed.
- Integration of mental health services at PHC level could ensure more open beds at the MHC establishment.

4.2.3 Experiences of multidisciplinary team members about rendering of mental health services at PHC level

These questions were asked to reveal multidisciplinary team members' opinion about mental health care services at PHC services at PHC level. One main theme and four sub-themes were derived with content data analysis. The main theme indicated that a down referral mechanism is available and multidisciplinary team members do refer MHCUs to PHC facilities. The sub-themes identified included unavailability of psychotropic medication, stigma, that patient assistance at PHC facility was a tedious process and that there was a negative attitude of PHC staff with regard to mental illness. The embedded research as discussed in chapter 3 could assist the researcher to formulate the following recommendations:

- Certain psychotropic medication to treat emergency mental health conditions is available in the drug cupboard of the PHC facility. The rest of the psychotropic medication needs to be ordered from the nearest District level 1 hospital. There is often a delay in the

reordering of MHCUs medication and this could lead to unavailability of psychotropic medication with the MHCUs next visit. A proper and timely reordering system should be implemented to ensure that psychotropic medications are available to MHCUs on follow up visits.

- Stigma is a sub-theme as some MHCUs do not want to receive treatment at their nearest PHC facility. The MHCE should give the MHCU and the family member or caretaker the option to visit a PHC facility of their choice for mental health services. Unsuitable consultation areas at facilities also contribute to aggravating stigma.
- Mental health care is part of the Integrated Chronic Disease Management Program. PHC facility staff should be aware that a MHCU may became agitated and need assistance earlier but if the MHCU is stable the ward-based outreach team can give his/her medication with the other chronic disease patients. There should be a strong follow up system in place to identify relapses, non-compliance, family problems, side effects and defaulters. The team leader of the ward-based outreach team should after conducting a home visit report back in writing to the PHC professional nurse who is responsible for chronic diseases. This could assist him/her to get the MHCU back to the PHC facility for follow up as soon as possible and if necessary transport and a referral to the MHCE could be arranged.
- Negative attitude of PHC staff includes all staff but it is the responsibility of the operational manager to create a warm welcoming atmosphere in the PHC facility. A negative attitude was confirmed by literature and there was a direct correlation between mental health care knowledge and attitude. All PHC staff needs to be trained specifically on how to deal with MHCUs so that they can develop a sense of belonging, feel welcome and accepted within the PHC facility.

4.2.4 Multidisciplinary team members' experiences with regard to relapses within three months of discharge

This question led to the identification of one main theme and three sub-themes. The main theme identified was psychosocial and PHC facility contributory factors. The sub-themes identified was that the MHCUs go back to the same environment which initially led to his/her admission or treatment at the MHCE. The second sub-theme related to medication-related factors such as side effects, feeling better and no transport to fetch medication. The last sub-theme referred to the lack of an effective support system (community, family, employers and PHC level). The following can be done at PHC facilities to incorporate mental health care services effectively:

- Medication related factors could lead to non-compliance or the stopping of their psychotropic drugs. If the MHCUs are not educated that medication controls their mental health disorder and makes them feel better, they tend to cease taking their medications leading to relapses. Education, which should be reinforced with each visit, can reduce the number of relapses. Side effects such as serious weight gain also contributes to MHCUs stopping their medication. Professional nurses consulting MHCUs at PHC facilities should explain the weight gain as a side effect and refer to a dietitian if the service is available. There is no solution to the transport problem and will need tactical planning and innovation to resolve.
- An effective support system is not available at PHC level. Communities need to be educated that mental a disorder is a chronic condition which can be controlled but it is not curable, like diabetes and hypertension. Families need to be educated on the limitations of the MHCUs, understand certain behaviour patterns and how they can reduce unacceptable behaviour. Co-operation from certain employers could be difficult, but the professional nurse at PHC level could write a letter and state that the MHCUs needs to attend the clinic on a monthly base for chronic treatment, not stating the condition. Staff needs to be flexible and refer the client to a 24-hour facility if it is not possible for the MHCU to attend a PHC facility that is only open till 19H00. The supermarket approach is needed to integrate mental health services at PHC level. Without an effective support system MHCUs will keep on relapsing.

4.2.5 Suggestions on how to integrate mental health services at PHC level

Suggestions were asked from multidisciplinary team members to see how mental health services could be integrated at PHC level. To make PHC facilities accessible for MHCUs (which was the main theme), five sub-themes were derived. There is training for professional nurses, team leaders of ward-based outreach teams, community health workers and other staff working at PHC level, as well as, collaboration between stakeholders, stigma reduction strategies and establishment of effective support system at PHC facilities. From these sub-themes the following recommendations can be derived:

- Training of all staff members regarding attitude towards MHCUs. Further in-service training is given to doctors rotating between PHC facilities and all professional nurses without psychiatry training regarding the emergency management of an aggressive patient (MHCU), what MHCUs specific needs are when attending PHC facilities, general mental health disorders and the management thereof and the role of the ward-based team leaders in assisting with assessment before providing medication and the follow-up of

defaulters. Professional nurses need to go back and provide in-service training to all specific staff e.g. the clerk at reception should know that he/she needs to treat the MHCU with respect and let him/her feel welcome. The clerk should report to the professional nurse managing chronic conditions if he/she observes agitation and arrange for the MHCU to be seen earlier rather than wait in a long queue. Every staff member at PHC facilities should know that MHCUs just as other clients have the right to respect and privacy. Training should be provided to fulfil the role of the psychologist and occupational therapist if needed. South Africa is a middle-income country and a full multidisciplinary team at each PHC facility is unfortunately not feasible. If a psychiatric nurse can be allocated full-time study leave to become a specialist psychiatric nurse, this specialist nurse could train and implement these roles.

- Collaboration between stakeholders need to receive urgent attention. The stakeholders in the case of MHCUs involve members of the multidisciplinary team from the MHCE, sub-district offices (coordinator of integrated chronic diseases), PHC facility team leaders and staff from district office (manager of integrated chronic diseases for the district) as well as district specialist team leaders. Unfortunately, a specialist psychiatric nurse is not part of these specialist teams yet, however for successful implementation it should be considered. The stakeholders should firstly determine the function of these stakeholder meetings e.g. discuss which patients were down referred, establish a system to identify if these MHCUs were followed up and how. Formulation of a district and sub-district policy, regarding feasible mental health care services, which could be implemented. Assistance required with regard to training of professional nurses. Multidisciplinary team leaders from the MHCE can give certain sessions training.
- Stigma reduction strategies include firstly to identify the knowledge and attitudes of mental health care providers at PHC level. The knowledge about mental health care correlates with the attitude of the provider e.g. professional nurses were very negative towards MHCUs and had very little knowledge about mental health conditions and treatment. Training should be done to ensure understanding the needs and behaviour of the MHCU. The PHC facility atmosphere should be warm, welcoming and accommodative.
- Establishment of an effective support system was reported on earlier but was re-emphasised again with this question. Communities should be educated nationally that mental disorders are controllable and not curable. PHC facilities should utilise opportunities to talk to community members about mental disorders and how they can assist these members of the community. Families should take responsibility and oversee psychotropic medication treatment intake. It is important that they swallow the medication to control their mental disorder. It is essential that the MHCU continues with the

medication even if they feel better. Assistance is required to help them feel constructive and worthwhile as this reduces the inclination to go back to drugs and alcohol. Ensure that the MHCU goes to the point of treatment on the specific return date or to PHC facility if side effects or signs of relapses became visible. Families do not have the right to take the disability grant from the MHCU for their perusal.

- Deficiencies at PHC facilities were identified in this research. PHC facilities do not have enough space to incorporate mental health care services. They do not have enough consultation rooms or a room to facilitate a group session with MHCUs even if they received the training to do so. MHCUs should be consulted in private rooms as they will not be willing to speak about the problems they experience with only a curtain between clients. MHCUs should not only be given their medication but should be observed for other physical problems, side effects, non-compliance, signs of relapse, stressors or abuse towards them as they are a vulnerable group.

4.3 RECOMMENDATIONS DERIVED FROM THE THEORETICAL DEPARTURE POINT: INTEGRATION STEPS TO ENSURE EFFECTIVE MENTAL HEALTH SERVICES AT PHC LEVEL

According to the steps that need to be taken into account to ensure integration at PHC level (WHO, 2008) the following recommendations and comments were made:

- The National mental health policy framework and strategic plan for South Africa 2013 – 2020 was developed however governmental commitment to implement the plan was lacking as the focus is fragmented. Currently, a questionnaire is used to screen household members for mental health care disorders and are then referred to the clinic if necessary. A collaborative system to follow up MHCUs in the community is not in place.
- Advocacy to MHCUs is still lacking as a lot of education, campaigns, group education for patients waiting for services in the outpatient department and PHC facility waiting rooms can be used to educate the community that a mental disorder can be controlled just like hypertension and diabetes. The key issue is the need to support them to take medications as prescribed and the need to feel part of the community. Advocacy for mental health care should be done at different levels of governance e.g. national, provincial, district and sub-district level. The people near to the MHCUs includes the community, family, employers, religious institutions and staff working at PHC facilities. The aim of advocacy is to use information strategically to influence behaviour change in people with a mental disorder.

- Training of all PHC facility staff was mentioned before but the WHO emphasises step three in their 10 point plan. Due to the fact that South Africa is a Middle Income Country, we cannot provide all areas with the service of all multidisciplinary teams. We need to use task shifting and continuous in-service training to ensure integrated mental health services at PHC level.
- It is essential to collaborate with stakeholders to limit PHC facility staff functions with regards to mental health services as it needs to be doable and the health care service delivery needs to be acceptable to the MHCU.
- At district and sub-district level a specialist psychiatry nurse, psychologist and social worker must be available to support PHC facility staff. There needs to be a step-down and step-up approach in place and in particular, professional nurses working with the integrated chronic disease management program, should know exactly how these steps work and train all professional nurses working in PHC facilities.
- Availability of psychotropic drugs as identified in the essential drug list should be available at PHC level in order to manage these MHCUs at PHC level. Professional nurses who received training and know the protocols as set out in the EDL can then prescribed the appropriate psychotropic drugs. Management of acute mental health disorders should be treated before referral to MHCE.
- Integration of mental health services is a process that takes time and can lead to a series of meetings, clarifying corrections and development. This should be emphasized while giving training to PHC staff members.
- The appointment of a psychiatry specialist nurse at sub-district level is essential to co-coordinate the mental health integration process. This person can serve as a liaison officer between the MHCE and PHC services.
- Interdisciplinary collaboration is needed between the health sector, non-governmental organisations and retired people of other related fields who can contribute with the assistance of MHC workers, even if it is only an hour or two per week. A creative person can give a session on how to make something and this contribution can help the MHCU become more functional and prevent relapses.
- Financial and human resources are required to integrate and maintain mental health care services at PHC level.

4.4 LIMITATIONS OF THE RESEARCH

The limitations of this study were as follows:

- There was no psychiatrist available for a voluntary interview. A Psychiatrist is a physician who specializes in psychiatry and could give accurate suggestions to integrate mental health care at PHC level.
- The study was conducted in one MHCE and therefore findings were contextual and could not be generalized to other contexts.
- Some of the participants did not understand the questions and even though the questions were rephrased these particular participants could not answer the questions.

4.5 RECOMMENDATIONS FOR FURTHER RESEARCH

- Further research to explore the perceptions of health professionals rendering mental health services to MHCUs at PHC facilities.
- Research to explore the experiences of MHCUs about the services rendered at PHC level.
- Participatory action research on how to establish a support group for MHCUs and evaluation of the experiences of role-players who developed the support group.
- Research to explore the insight of family members, caretakers and neighbours pertaining to insight into the mental disorders and compliance of psychotropic medications.
- Research to determine the needs of family members who care for a person with a mental disorder.
- Research with the focus on strategies to reduce stigma related to persons with mental health disorders.

4.6 SUMMARY

Chapter 4 started with an evaluation of the research, followed by the recommendations derived from each question asked and also included the theoretical departure of the study. The limitations were outlined followed by recommendations for further research based on the theoretical model of study.

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ADDENDUM A: HREC APPROVAL

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Fax: 018 299-4910
Web: http://www.nwu.ac.za

Research Ethics Regulatory Committee
Tel: 018 299-4849
Email: nkosinathi.machine@nwu.ac.za

11 April 2019

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North West University Health Research Ethics Committee (NWU-HREC) on 11/04/2019, the NWU Health Research Ethics Committee hereby approves your study as indicated below. This implies that the North-West University Research Ethics Regulatory Committee (NWU-RERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Suggestions from multidisciplinary team members at a mental health care establishment to integrate mental health services at primary level.
Study Leader/Supervisor (Principal Investigator)/Researcher: Dr CE Muller
Student: LC Ellie

Ethics number:

N	W	U	-	0	0	0	5	0	-	1	8	-	A	1
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single Study
Commencement date: 11/04/2019 **Risk:** Minimal
Expiry date: 30/04/2020
Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.

Special in process conditions of the research for approval (if applicable):

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The study leader/supervisor (principle investigator)/researcher must report in the prescribed format to the NWU-HREC:*
  - *annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for an external audit.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility the NWU-RERC and NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected;*

- *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
- *submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or*
- *new institutional rules, national legislation or international conventions deem it necessary.*

- *NWU-HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The NWU-HREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the NWU-HREC or the NWU-RERC for any further enquiries or requests for assistance.

Yours sincerely

Prof Wayne Towers
Chairperson NWU Health Research Ethics Committee

Original details: (22351930) C:\Users\22351930\Desktop\ETHICS APPROVAL LETTER OF STUDY.docm
6 November 2018

Current details: (22351930) M:\DSS\18533\Monitoring and Reporting Cluster\Ethics\Certificates\Templates\Research Ethics Approval Letters\9.1.5.4.1 HREC Ethical Approval Letter.docm
3 December 2018

File reference: 9.1.5.4.2

ADDENDUM B: PERMISSION FROM NORTH WEST PROVINCE DEPARTMENT OF HEALTH

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

Dr Sekame & First Street
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2030 NDP

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Dr. C. E. Muller
North West University
Supervisor

Physical Address
(Work/ Institution)
Researcher: Miss L.C Ellis
NWU-00050-18-51

Subject : **Research Approval Letter – Suggestions from multidisciplinary team members at a mental health care establishment for integrating mental health services at primary level.**

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards.

Dr. FRM Reichel
Director: PPRM&E

LEPAPHA LA BOITEKANELO
DEPARTMENT OF HEALTH
Kgetsona Poso /Private Bag X2068
Mmabatho.2735
05 NOV 2018

Date 05/11/2018

C E Muller
Researcher

NORTH WEST PROVINCE
REPUBLIC OF SOUTH AFRICA

Date 29/01/2019
29/01/2019

Healthy Living for All

ADDENDUM C: EXAMPLE OF INFORMED CONSENT

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INFORMED CONSENT DOCUMENTATION FOR MULTI-DISCIPLINARY TEAM MEMBERS OF A MENTAL HEALTH CARE ESTABLISHMENT

TITLE OF THE RESEARCH STUDY: Suggestions from multidisciplinary team members at a mental health care establishment to integrate mental health services at primary level

ETHICS REFERENCE NUMBERS: NWU-00050-18-S1

PRINCIPAL INVESTIGATOR: Dr CE Muller & Prof E du Plessis

POST GRADUATE STUDENT: Miss Leona Ellie

ADDRESS: Jenkins 4A, Potchefstroom, 2531

CONTACT NUMBER: 0825843672

You are being invited to take part in a **research study** that forms part of a Master degree in Nursing Science with the above mentioned title. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00050-18-S1) and the North-West Department as well as from the CEO: Witrand Hospital** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1 What is this research study all about?

- *This study will be conducted at Witrand Hospital in Potchefstroom in a private, convenient and interruption free venue which will be provided by the operational manager of the out-patient or psychiatric wards. This study will involve a face to face interview with an experienced health researcher qualified in advanced psychiatric nursing and trained in conducting interviews. A minimum of 15 participants will be included in this study.*

- *The research plan to derive suggestions from multidisciplinary staff members at a mental health facility on how mental health care services can be rendered at clinic level to improve or to make it easier for persons with a mental health condition to receive treatment at the nearest clinic*

2 Why have you been invited to participate?

- *You have been invited to be part of this research because you are a member of the multidisciplinary team at the outpatient department or psychiatric unit who fulfil a role in providing services to patients suffering from a mental health condition for at least six (6) months. You have been invited to be part of this research because you are able to communicate in English and/or Afrikaans.*

- *You will unfortunately not be able to take part in this research if you are a newly appointed staff member of the multidisciplinary team with less than six (6) months or a student conducting clinical practice under supervision of a multidisciplinary team member.*

3 What will be expected of you?

- *All members of the multidisciplinary team will be invited to attend an information session about the research project provided by the researcher. This will be done by means of a Power-Point presentation to provide you with all the details of the research project at two different occasions. After the presentation, time will be given to ask questions about the research project. Two informed consent forms will be hand out to each interested participant. You will have 24 hours to decide whether you would like to participate in the study or not. If you would like to participate in the study you take the consent forms to the independent person's office and sign both of them and she will co-sign with you, keep one form in a non-transparent container and give the other form back to you for your own perusal. The researcher will obtain informed consent forms from the independent person and will phone you for an appointment if you are chosen to participate in the study.*

- *You will be expected to be available for a 45 minutes face-to-face individual interview that includes five (5) questions. The interview will be done in private*

room, away from disturbances at a time scheduled when you are on duty. This will be arranged with your operational manager at a time when the unit is not busy. Each participant will be informed about the date and time beforehand. Interviews will also be digitally recorded to assist the researcher with the data collected by signing this consent form you give permission to the researcher to digitally record the interview. The interviews will be conducted during October to November 2018. A follow up interview might be requested only if necessary to clarify misunderstandings.

4 Will you gain anything from taking part in this research?

- *There will be no direct or indirect gains for you to participate in the study.*
- *The other gains of the study is the suggestions which can be derived from the interview data on how mental health services can be rendered at clinic level. These suggestions will be categorised and a final research report will be submitted to the Health research Ethics Committee and the North West Department of Health. In these reports no information will be used that could identify you in any way.*

5 Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study are minimal as you can experience emotional discomfort during interview.*
- *If emotional discomfort occur the researcher will ensure the participant that there is no right or wrong answers and that each participant's contribution is important. A psychiatric trained nurse will be arranged beforehand and will be available after interviews for counselling if needed.*
- *Your contribution can help to assist mental health patients to receive their treatment at a clinic near them or a clinic of their preference. You contribution can assist with suggestions on how to reduce the rate of relapses and readmissions after down referral to PHC level and relieve the workload at the outpatient department or psychiatric unit.*

6 How will we protect your confidentiality and who will see your findings?

- *Anonymity of your findings will be protected by using an independent person when obtaining of informed consent. All interested participants will receive two informed consent forms after the research project was explained to them. The independent person will keep all informed consents in a non-transparent sealed box and the researcher will collect the informed consents at the hospital.*
- *Your privacy will be respected by conducting the face to face interview in a private room. A do not disturb sign will be posted on the door to prevent interruptions. After all the interviews of the day is completed, the digital voice recordings will be loaded on a computer and password protected. The digital voice recording will be send to the transcriber. The transcriber will sign a confidentiality agreement and will remove any identifiable measures that was mentioned. The voice recording will also be send to the researcher's*

supervisors. All e-mail sending of voice recordings and transcriptions are done with password protection. All members that require access to data will sign a confidentially agreement such as the transcriber and co-coder. After completion of the study the informed consent forms, transcribed interviews and diary will be kept in locked cupboard in the locked office of the principle investigator and all electronic data will be stored on a password protected computer for a period of five years only for audit purposes and thereafter destroyed.

What will happen with the findings or samples?

- *The findings of this study will only be used for this study. The findings of this study will be given to the operational manager of each department by means of a research report. The North West Department of Health, the Health Research Ethics Committee of the North West University and the Manger of the Mental Health Care Establishment will also receive a research report.*

How will you know about the results of this research?

- *The results of the study will be given to you by means of a research report that will be given to the operational manager marked for your attention in a sealed envelope of each department. The researcher will send in an abstract for the district research day to present the research. If the abstract is accepted all participants will be informed about the opportunity to attend the research day.*

Will you be paid to take part in this study and are there any costs for you?

- *This study is not funded. No you will not be paid to take part in the study because the interview will take place at the facility with no traveling costs for you. Interviews will be conducted at a time convenient for your department and when you are on duty. Refreshments will be provided after the interview. There will thus be no costs involved for you, if you do take part in this study.*

Is there anything else that you should know or do?

- You can contact Miss Leona Ellie during office hours at 0825843672 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I ..... agree to take part in the research study titled: ***Suggestions from multidisciplinary team members at a mental health care establishment to integrate mental health services at primary level.***

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.
- I give permission to the researcher that the findings of this study may be disseminated to the Mental Health Care Establishment, the Health Research Ethics Committee of the North West University and the North West Department of Health.

Signed at (*Ward 2 or OPD*) ..... on (*date*) ..... 20....

....

Signature of participant **Occupation**

Declaration by person obtaining consent

I *(name)* ..... declare that:

- I clearly and in detail explained the information in this document to .....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*Ward 2 or OPD*) ..... on (*date*) ..... 20....

.....
Signature of independent person

Declaration by researcher

I Miss Leona Ellie declare that:

- I had it explained by ..... who I trained for this purpose.
- I did not use an interpreter
- I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) 2019

.....
Signature of researcher

ADDENDUM D: EXAMPLE OF TRANSCRIPT

INTERVIEW 11

(noise in the background)

(ping

I: This is interview 11. Its five questions. I'll be starting off with the first one.

P: OK.

I: Can you elaborate on your role in the out-patient psychiatric department when uhm, rendering services to mental healthcare users? What do you do on a day to day basis here at outpatients? Uhm, the services that you give to a mental healthcare user.

P: So usually then, uhm, I'd see patients uhm, coming in for their follow-ups. Uhm, primarily I try to establish how they are coping at home, how they are coping on their medication, are there any side-effects or any uhm, or any uhm, questions that they have regarding their medication, if it need to be adjusted or things like that. Uhm, and just seeing how the condition has stabilized over time or if it has, uhm, sort of like regressed dramatically while they're at home. Uhm, so it's trying to determine that it's safe to still keep them at home and that they can still function at their best. Uhm, so in a nutshell that's... that's what I do, jah.

I: So uhm, follow-up after how long when they have been discharges? How long are they being followed up?

P: Uhm, well, given that our setting is such that multiple people are working uhm, I don't get to follow up the same patient uhm, throughout. However as a general rule we would see patients about four weeks after they have been discharged. Uhm, so they will come in for their first visit after they've been discharged and uhm, continue following them up and then depending on how well they respond on treatment and if they don't have any like disabling features and things like that then at times you might increase the length in which you would see them. So already decrease it like that. So instead of seeing them every month then you could change to see them every three months or every six months. Uhm, and then over the other months then they can just come take their medication and then you check in on them when they come in every six months or few month follow up to make sure that everything is still OK.

I: Yes. So when they are stable they are being seen over three months or six months?

P: Yes, yes.

I: Oh. Do you also uhm, work at ward 2?

P: Yes I do.

I: Do you see patients there? So uhm, what do you do on a day to day basis, what is the services that you render to the patients at ward 2?

P: OK. Uhm, our (inaudible) part is establishing the reason why they have been admitted. Uhm, so, was it because of a substance use, is it a new uhm, condition that is coming out that was previously unrecognised. Is it a known patient that was discharged and then something could have precipitated them and brought them back into... into the hospital and then establishing that they are safe. Uhm, so safety being safety, integrity of like body uhm, psychologically uhm, safe and in terms of medication, that the medication that they are taking has not exacerbated anything so they don't get serious side-effects from their medication. Uhm, then after that try to establish... well rather formulate a working diagnosis and a working plan from which then different treatment mentalities would then be implemented. So from the medical side primarily uhm, I would then be dealing with the prescribing of medications, seeing response to medication and then uhm, working with other members of the team. So the nurses who will be with the patient most of the time then also might give us an idea of how they are coping. Uhm, the psychologist would come in and offer some psychotherapy for the patient. Occupational therapist, also I'm assisting and also psychotherapy and dynamics and all those things. And also work-up then also uhm, in terms of circum... social circumstances and making sure that they are living in a conducive environment. So that's my jobs. So every day, whenever they are scheduled I check in to make sure that whichever symptoms that were a problem on the previous time I saw them are not a problem anymore. I then try to see what can be adjusted to help alleviate.

I: Jah. So except just for the medical part of treating a mental healthcare user, when you observe or you identify and establish other problems then you refer to other members of the multi-professional team.

P: Yes.

I: What is your experiences about the number of mental healthcare users you need to provide mental healthcare for... services for here at the outpatients seeing that there is an

increased number of mental healthcare users coming to the OPD services?

P: Uhm, yeah, the number is significant. The number is significant, uhm, I would imagine it's obviously slightly different given that we're of a tertiary hospital compared to what primary entry level hospitals would have to deal with but we… there is still a significant number of people that come in on a daily basis uhm, so it can be seen as a good and a bad thing. Good in the sense that not a lot of people are then being admitted so it is that a lot of people with identified mental health problems are stable and taking their medication and they can function in society. So that's a good thing. Bad in terms of the number of healthcare professionals to patient ratio so it becomes slightly overburdening in that sense having to deal with a large number of patients by yourself but unfortunately (laugh) that's the system in general, jah.

I: Jah. What is your opinion about mental healthcare services which are rendered at a primary healthcare level?

P: Uhm, its… it's a… sjo, it's a difficult thing in one, uhm, the facilities are not always available uhm, trained professionals are not always available and uhm, and a large uhm, problem that I think I've noticed a lot is then uhm, medication will not be available. There is not enough psychologists, it's those kind of things, so it becomes very difficult to then have uhm, people being seen at places that are close to them that are easily accessible because the things that I required to keep them functioning in the community and being themselves are not always present. Uhm, then there's issues of stigma. Uhm, stigma coming from the community, stigma coming from the health profession as well. So I have noticed how whenever someone would come in say in a general clinic uhm, as soon as it is noted that there is a mental health diagnoses, uhm, peoples attitude change and more for the negative than they do for the positive, you know. Patients are seen as being irritating uhm, they don't listen to you. So you will have instances where a patient coming in with a problem that is not related to the mental illness being sent to the mental healthcare provider because they have the diagnoses. So people are not willing to sit down and listen to patients and that really becomes quite distur… uhm, destabilizing for the system because now you have to… as a mental health provider have to see cases that are outside of your scope so to say and its creating a system of accessibility for patients to just… to just be destabilized because patients don't trust mental healthcare…I'm sorry… they can't trust general… generally the

healthcare system to take care of them adequately. So then it becomes a huge problem. So those are the things that I've noticed at the primary healthcare level, (sigh) jah. Mental healthcare pro…uhm, users have a bad experience.

I: Re-admissions within three months of discharge are a problem according to stastistics and research. Uhm, except for stigma and the way people are being treated even by our own healthcare professionals, what are… can contributing factors be to relapse and readmissions?

P: …and readmissions. Uhm, one is looking at patient's insight, uhm, into their condition aause unfortunately we can't buy them into believing that this mental uhm, illness that we can't really and quickly buy them into continue on their medication. Uhm, you'll see that a lot especially with substance related conditions, where they will think or… jah, they will think various things are attribute but what happened to them to a lot of things but never to the substance. Uhm, and that becomes a problem because then you discharge them, then they go back to their community, back to the uhm, environment that led them back… that led them here in the first place, and they come back. Uhm, so that's the one thing. Two is uhm, side-effects. Uhm, and I suppose there's this… there's generally this idea that uhm, patients believe that: no, healthcare professionals know better, so if this medication was given then surely this medication was given to make me feel better and they might not always voice the fact that there was side-effects till they get unbearable and then they just stop taking the medication. Uhm, another one is, they felt feeling… I mean, they left feeling OK and they thought they were well. Uhm, not understanding that the medication were meant to be continued for a certain period of time. And so there's a lot of things that I get to hear actually when patients come back. Like I felt better and now I'm back because I never thought that… related that the medication is the reason why I feel better. And I guess the other issues can be problems that need to be uhm, factored in… issues that people might not have access to uhm, transport to get them to places and I think one of the big issues for those who are employed is trying to get the time off to go and get your medication. Not all employers are so forthcoming and offering for that period of time, even if it is for a few hours for you to go, have your follow-up, get your medication because you, probably you will find that people stop working way before only to get to work way before like six o'clock, seven o'clock so the transport can get there. By the time they leave work a lot of places are closed so then it becomes inevitable for them to relapse their medication

and that is not out of their own choosing but of a set of circumstances have made it very difficult for them to continue taking their medication, to even get access to them in the first place. Jah, so those are the main things that I picked up over time.

I: Jah, so can you provide me suggestions on how mental healthcare services can be integrated at primary healthcare level?

P: Uhm, I suppose education uhm, is a very big... is a very big thing to start off with. Uhm, education in the sense that it's happening with the aim of changing people's behaviour and people's thinking. Uhm, so that's the one thing.

I: So what of people's minds and thinking you want to... their behaviour and thinking you want to change?

P: So uhm, firstly viewing mental health problems as any other medical problem, right. We don't have problems with people being diabetic; we don't have problems with people being hypertensive. So we shouldn't necessarily come in and have problems with mental health diagnoses. Uhm, so excepting that spectrum of illnesses. It happens and we need to cater for people who have mental illness. Uhm, and then having things that are welcoming, so attitude no. To watch patients comes in...

I: So who do you want to have the welcoming attitude, who do you want to have... to be educated?

P: It has to start with the healthcare professionals. It really has to start there. So uhm, our own internalised stigmas, it need to be addressed and once those are overcome, its... I think it will be easier them for people to have a more open uhm, attitude towards patients, you know. Uhm, cause most of the time we uhm, we would think mental health patients are difficult, uhm, that, you know. Uhm, at times the suggestion is that they got themselves there, if say maybe it's a substance related condition. So such thinkings to be tackled, so it needs to start with us, that take care of that level. Uhm, and then I think increasing uhm, access to psychologists uhm, would really help because I'll be saying to my patients that medication alone won't get you better. But if we are not empowering patients with those skills uhm, you know to get better and to cope in those environments that they are in, then it's a total lose-lose situation. So I think that... that... that area also needs to be... to be... to be noted importantly. And access to mediation I have to go back to as well because if the medications are available in a place that is right next to you, then

you know it… it… it… it eliminates a lot of problems. It eliminate the problem of transport, it eliminate the problem of taking time off from work and all of those things. Uhm, and you know like other… I think it was in Cape Town. Uhm, they had this chronic thing where uhm, they had started delivering chronic medication to patients. Uhm, and those things were done by people who lived in the community. So you got that entire idea of having like healthcare community workers being engaged. So bringing those things in and putting mental health as well, as part of the thing, I say this because I am not particularly familiar as to the extent of the training that happens where mental health is related uhm, but I have seen it in action especially in oncology patients where you know, they would come in, make sure that ah, medication was taken. Identifying any problems that are happening and that was done by healthcare prof… community healthcare professionals who live in the community. People who come in with an approach that is empathic and understanding and people who come in from the same place as where you feel like I can speak to that person. So I think that if such things also happen for our sector as well, it really will help uhm, decentralise… decentralise mental healthcare and not being seen as things or institutions that are far away but instead be seen as a community problem and the community involved in addressing itself.

I: Maybe making the mental healthcare user feeling more accepted.

P: Yes, it's definitely.

I: Do you have any comments? Maybe something I didn't ask you?

P: Uhm… Jah, I think we've covered all. Well at least from my side (laugh) I think I've covered most of the things that I really wanted to say. Uhm. but jah, I guess the main thing is mainstreaming mental health just as we have with other conditions and other fields of medicine uhm, put in a healthy approach.

I: OK. I thank you for your time.

P: Not a problem. Best of luck with the rest of the…

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