Perceptions of Primary Health Care Facility Managers towards the Integration of Mental Health into Primary Health Care: A Study of the Tshwane District, Gauteng Province

by

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DEDICATION

This dissertation is dedicated to my parents, Nonceba and Sithembele Mtshengu; my sisters Sintro, Zingisa and Ntando; and, my daughter Lumnene “Fefe” Mtshengu. Thank you for your love and support through this journey.

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ABSTRACT

The integration of mental health care (MHC) into primary health care (PHC) has been identified as a practical intervention to: increase accessibility to mental health care; reduce stigma and discrimination against people living with mental illnesses; improve the management of chronic mental illness; and, to reduce the burden of comorbidity of mental illnesses with other chronic illnesses. In the South African context, integrating MHC into PHC also seeks to respond to numerous legislative reforms, with the aim of providing comprehensive health care, particularly to previously disadvantaged populations. The aim of the present study was to explore the perceptions of facility managers in the Tshwane District (Gauteng Province) towards the integration of mental health into PHC.

Fifteen participants from the Tshwane district facilities participated in the study. The participants were selected through a non-probability purposive sampling method. Data was collected through in-depth interviews using a semi-structured questionnaire, and analysed using the thematic coding approach. Significant findings suggested that the major hindrances to the realisation of the policy objectives may be due to: the lack of rehabilitation and psychotherapeutic services; insufficient skill and knowledge of mental health on the part of staff; insufficient or unsuitable practice space in the facilities; and, poor cooperation between South African Police Services, Emergency Medical Services and Primary Health Care. Inter-facility communication, district implementation support and policy knowledge has notably increased over the years and were deemed to be amongst the biggest enablers.

DECLARATION

I, Vuyolwethu B.R. Mtshengu declare that PERCEPTIONS OF PRIMARY HEALTH CARE FACILITY MANAGERS TOWARDS THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE: A STUDY OF THE TSHWANE DISTRICT, GAUTENG PROVINCE is the result of my independent work and that all sources used herein have been acknowledged by means of complete references and that this work has not been submitted before for any other degree at this or any other institution.

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Mtshengu Vuyolwethu B R Date

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LIST OF ABBREVIATIONS AND ACRONYMS

CFIR	Consolidated Framework for Implementation Research
DALY	Disability Adjusted Life Years
MDD	Major Depressive Disorder
MHC	Mental Health Care
MHPF	Mental Health Care Policy Framework
NHI	National Health Insurance
PHC	Primary Health Care
WHO	World Health Organisation
YLD	Years Lived with Disability

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CHAPTER 1

INTRODUCTION

1.1 Background to the study

Researchers, international health policy documents and advocacy bodies have made numerous calls to address mental health concerns globally. Much of the focus has been on the disproportionate burden that mental health places on developing countries in terms of stunted development in health, education, and economic growth, as highlighted by the United Nations (UN) Millennium Goals (Miranda & Patel, 2005; Sachs & McArthur, 2005). Proposed solutions include, among others, integrating mental health into primary health care and developing clear national mental health policies (Alem, Jacobsson, & Hanlon, 2008).

The South African National Department of Health has recently adopted the Mental Health Care Policy Framework (MHPF) 2013-2020. This framework provides guidelines for the provision of mental health care services in the country. It sets out eight key objectives, which include amongst others: the strengthening of governance and information sharing systems; the provision of comprehensive, integrated and responsive services in community-based settings; the implementation of preventative strategies; and, the integration of research in mental health care (Stein, 2014). The primary aim of the MHPF is to improve access to mental health services to the majority of South Africans, particularly the previously marginalised communities. Primary Health Care (PHC) serves as the cornerstone for the inclusive provision of health care.

Thus, the MHPF seeks to make PHC the first contact for mental health care within the health system. The ultimate goal is to promote and deepen the integration of MHC into the general health services while simultaneously developing community-based services (Schneider, Baron, Breuer, Docrat, Honikman, Onah, Sorsdahl, Van Der Westhuizen, Lund & Kagee, 2016; Stein, 2014).

The MHPF was primarily designed to redress the legacy of apartheid, particularly legislated racial disparities in the provision of health services, including mental health delivery (MHPF 2013-2030). Additionally, the framework was developed in line with the World Health Organization's (WHO) recommendations that called for member states to integrate mental health services into primary health centres (WHO, 2008).

Despite this critically important innovative reform policy framework, challenges still persist that plague MHC services in South Africa. These include poor accessibility to MHC services at community level, and a flawed governance system that causes confusion at implementation level (Marais & Petersen, 2015; Schneider, Baron, Breuer, Docrat, Honikman, Onah & Kagee, 2016; MHPF 2013-2020).

1.2 Research problem

The national legislative framework proposed several health reforms to deal with mental health-related challenges in South Africa. These reforms provide directives towards the provision of an integrated, decentralised and inclusive approach, thus allowing previously disadvantaged South Africans to access comprehensive health care (Padarath, King, Mackie, & Casciola, 2016).

Despite the increasing need for MHC service provision, challenges in integrating mental health services at PHC level persist, leaving a majority of South Africans who suffer from some form of mental illness excluded. Untreated mental illnesses, may result to loss of healthy relationships, disabilities, loss of income for the sufferers and their family members. This perpetuates the vulnerability of a significant proportion of South Africans suffering from mental illness. Recognising this, it becomes important to explore impeding barriers, while also identifying enablers that can improve the delivery of mental health services in response to the related legislative framework. This study, therefore, seeks to explore the perceptions of primary health care facility managers in the City of Tshwane towards the integration of mental health into PHC.

1.3 Aim of the study

The aim of the study is to explore the perceptions of facility managers in the Tshwane District (Gauteng Province) towards the integration of mental health into PHC.

1.4 Significance of the study

The study will add knowledge in the area of primary health care service delivery in South Africa. More specifically, the study will contribute or provide useful insights for

primary healthcare managers and policy bearers into the barriers and/or enablers to the successful integration of mental health into PHC.

Furthermore, the study will shed some light on the provision of a more holistic and comprehensive approach to MHC in South Africa.

1.5 Operational definition of concepts

- **Integration:** Integration refers to the inclusion process of services between same level service providers and different levels of care aimed at improving the management of patients (Maruthappu, Hasan, & Zeltner, 2015). Strandberg-Larsen and Krasnik (2009) defined integrated health care as an organised, harmonious and coordinated mode of health care delivery aimed at enhancing clinical outcomes for the patient. In the context of this study, integration is understood to be activities towards merging MHC services into PHC services.
- **Primary health care:** PHC refers to the integrated essential health care services accessible through clinic and community health services, as stipulated in the Primary Health Care Package for South Africa: a set of norms and standards (Department of Health, 2001). The same definition is adopted in this study.
- **Mental health:** Mental health refers to the ability to cope with mental, emotional and psychological stresses as well as the absence of clinically significant disturbances manifested in behaviour, emotion regulation, and cognitive functioning (American Psychiatric Association, 2013; WHO, 2017). The same definition is adopted in this study.
- **Barrier:** A barrier is a phenomenon or variable that hinders the achievement of the policy's intended outcome (Nilsen, 2015). In the context of this study, barriers are understood as obstructions that impede the mental health legislative objective.
- **Enablers:** A strategy or a catalyst that facilitates the accomplishment of the desired outcome (Gibson et al., 2015). In relation to the study, an enabler is understood to be a resource, programme, and/or project that

facilitates the achievement of legislative objectives.

1.6 Outline of the dissertation

This dissertation is divided into six chapters. Chapter one outlines the background to the study. Chapter two presents the literature review. Chapter three describes the research methodology followed in the study. Chapter four details the results. Chapter five discusses and interprets the results. Chapter six provides the conclusion and recommendations.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In this chapter, the literature on the subject of mental health challenges will be presented. This will be done by relating the study to existing theory on the subject. This chapter thus provides a review of literature in relation to integrating MHC services into PHC in the global and local context. In this regard, the review primarily explores MHC integration reforms, implementation efforts towards integration, enablers, barriers and other issues related to integration.

2.2 The global prevalence of mental health disorders

The prevalence of mental disorders is a major public health problem globally. In 2016, it was found that over 1.1 billion people were living with mental illnesses and substance use disorders, globally (Matlala, Maponya, Chigome, & Meyer, 2018). Between 1990 and 2016, mental and substance use disorders have risen to be the largest cause of disability in early adulthood (Vos et al., 2017). In 2004, the WHO mental health survey initiative (WMH), estimated that 18% of the global population suffered from anxiety disorders followed by mood and substance use disorders affecting between 0.1% to 9.6%. These disorders were also found to be the most common mental disorders (Demyttenaere et al., 2004; Kessler et al., 2009). Currently statistics show that the number of people living with depression has increased by 18.4%, thus making it the most common mental illness followed by anxiety disorders (World Health Organization, 2017).

Epidemiological studies of mental illness indicate that the most affected areas appear to be the American region followed by East Mediterranean region, then African and Western Pacific region (Vos et al., 2017; World Health Organization, 2017). The concern with this data is that, a majority of individuals living in middle to low income countries will not have access to treatment and a large number of African states fall into this category (Matlala, Maponya, Chigome, & Meyer, 2018).

Global health estimates also show that depressive disorder accounted for 7.5% of Years Lived with Disability (YLD), while anxiety disorders were estimated at 3.4%.

There is also a rising concern at the increase in deaths due to suicide, which contributed 1.5% of deaths worldwide (Vos et al., 2017). WHO further projected that, in the year 2030, depression would be amongst the top three global high-risk diseases and illnesses leading to mortality (Mathers & Loncar, 2006; WHO, 2003).

Similar to the WHO findings, Jenkins et al., (2012) found that in Kenya, depression and anxiety were the most prevalent mental illnesses in the country with an estimated 6.1% of the population affected. Panic disorders contributed 2.6%, with no indicative gender differences. These estimates were found to be higher when compared to the common mental illnesses in Nigeria (5.8%) and Tanzania (3.1%) (Hamid, Abanilla, Bauta, & Huang, 2008; Jenkins, Njenga, Okinji, Kiwamwa, Baraza, Ayuyo, Singleton, Manus, & Kiima., 2012). Recent studies conducted in the African region show that the highest prevalence of depressive disorders is seen in Cape Verde with 4.9%, followed by Ethiopia and Botswana with 4,7%, respectively (World Health Organization, 2017).

Jenkins et al. (2012), suggested that a significant risk factor to increasing mental illness, was the comorbidity of physical illness and increased risk was seen between the ages of 30 to 35 years on average. Literature also suggests that the risk of developing a mental disorder may be amplified in countries beset by conflict and gun violence such as Sudan. This is assumed to be a direct impact of trauma, poverty and a lack of accessibility to MHC services (Ayazi, Lien, Eide, Swartz, & Hauff, 2014).

Okasha (2002) indicated that Africa also faces an increased risk of developing neurocognitive disorders due to HIV, epilepsy, inadequate care at childbirth and/or malnutrition. Though literature is limited on estimated prevalence of mental disorders due to epilepsy in Africa, there is evidence that at least 19% of people diagnosed with HIV are at risk of developing mental illnesses (Breuer, Myer, Struthers, & Joska, 2011). Thus, given the 4.2% prevalence rate of HIV in Africa, mental illness may exceed the documented estimates (World Health Organization, 2016).

The South African Journal of Psychology indicated that mental disorders are experienced by at least 16.5% of South Africans and only 25% of those people received treatment on a 12 months interval as MHC access is limited to a mere 5% of the population (Kaminer, Owen, & Schwartz, 2018). The most common mental

disorders are anxiety disorders estimated at 8.1%, followed by substance use disorders at 5.8% and mood disorders at 4.5%. Major Depressive Disorder (MDD) (4.9%) and agoraphobia (4.8%) seemed to have mild prevalence when compared to the abovementioned African countries (Herman, Stein, Seedat, Heeringa, Moomal & William., 2009). The lifetime prevalence and risks of developing mental disorders in adults increased to an estimated 47.5%, from 30.3% in 2003 (Herman et al.; 2009).

Similar to other African countries, in South Africa, the risks of developing a mental illness is further perpetuated by the impoverished socioeconomic status, exposure to crime, violence against women and children and lower education levels (Mungai, 2016; Mayosi, Lawn, Van Niekerk, Bradshaw, Karim, Coovadia & Lancet, 2012; Surender, Van Niekerk & Alfers, 2016). Yet, mental health programmes remain inferior when compared to other health programmes in the country. Thus, it would ideal to put efforts towards integrating mental health care services at the most primary level to increase accessibility to treatment.

2.3 The burden of mental disorder

According to Funk (2012), the third leading cause of death globally is depression accounting for 4.3% of deaths. Major Depressive Disorder (MDD) carries an increased burden and accounts for 85% of Years Lived with Disability (YLD) and Disability Adjusted Life Years (DALY), globally. This presents an increased risk of developing other diseases such as dysthymia and substance abuse (Ferrari, Charlson, Norman, Patten, Freedman, Murray & Whiteford, 2013). Moreover, the increased risk of suicide associated with depression, increases the rates of mortality (Burns, 2011). In addition, the presence of mental disorder symptoms tends to have significant undesirable outcomes on people diagnosed with chronic illnesses, due to the high probability of non-adherence to treatment prescribed. (Coventry et al., 2015; Lund, Tomlinson, & Patel, 2016; Zewdu & Abebe, 2015).

Mental illness presents consequences in cognitive functionality for day to day living and disrupts sufferers' ability to work (American Psychiatric Association, 2013). As the wellbeing of productive personnel becomes compromised, the country's economic growth is threatened and the cost burden in its healthcare system is increased (Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015; Shen, Arkes, & Williams,

2012). The loss in health experienced by productive personnel further increases the burden of years lived with disability (YLD) and disability-adjusted life years (DALY), as reflected by the Global Burden of Disease (GBD) index (Ferrari et al., 2013; Mathers & Loncar, 2006).

According to Olesen, Gustavsson, Svensson, Wittchen, and Jönsson (2012), brain-related disorders can have direct and indirect costs on the country's health budget. In the United Kingdom, it was found that the cost burden of autism and intellectual disability further increased the unemployment rate, added to the cost of special school's infrastructure and increased the development of psychological disorders for the caregiver (Buescher, Cidav, Knapp, & Mandell, 2014).

In Africa, mental illnesses contribute an estimated 5% to the total burden of diseases and account for 19% of the causes of disability on the continent (Monteiro, 2015). The burden of mental disorders is further exacerbated by the poor socioeconomic status of a large proportion of the population, the lack of effective mental health policies, the prevalence of psychosocial stressors and the comorbidity of mental illnesses with non-communicable and HIV related illnesses (Kapungwe et al., 2011; Monteiro, 2015). South Africa also experiences similar issues, despite its politically sound environment and approved MHC legislation. The scarcity of mental health resources and lack of service integration increases the burden on health care and social welfare costs through increased provision of disability grants. This puts pressure on the national fiscus (Mall, Lund, Vilagut, Alonso, Williams & Stein, 2015).

The economic burden is also transferred to families and societies as a whole. Communities and families experience disruptions in their lives due to undesired conduct exhibited by people with mood, personality and psychotic related disorders (Jacob & Coetzee, 2018; Winkler & Theron, 2009; World Health Organization, 2017). Moreover, the stress of coping with disturbances in behaviour disrupts household routine and restricts social relationships. Caregivers lose employment opportunities, social relationships come under pressure and some legal implications associated with aggression of the mentally ill individual can arise. It further predisposes the family members to the risk of developing further debilitating psychological illnesses (Burns, 2014; Burns, 2011). Generally, the burden of mental illness on humans is difficult to

assess and quantify, as it ranges from economic to personal health consequences (WHO, 2003).

2.4 Mental health integration reforms in the global perspective

In 1978, the WHO called for transformation in the provision of primary health care through the Alma-Ata Declaration document (Fendall, 1978). The document proposed primary health care reforms and called for a person-centered and holistic approach to service offered at a community level. This document provides a guide to incorporating MHC into PHC (Fendall, 1978). However, while it explains how other primary health services may be implemented, it seldom articulates practical ways to integrate MHC into PHC.

Research shows that countries only began to show progress towards integrating MHC services in PHC institutions in the ’90s (Funk, 2012; Saxena, Funk, & Chisholm, 2013; WHO, 2001). These included Argentina, the Philippines, Australia, Belize, and South Africa. Their efforts mostly began with policy reforms, obtaining political buy-in, with a focus on big cities and having physician-led mental health programmes (Bhana et al., 2010; World Health Organization, 2001; World Health Organization, World Organization of National Colleges, Academies, & Academic Associations of General Practitioners/Family Physicians, 2008).

Despite the integration efforts made, trends show that mental health remains inferior compared to other health programmes. High-income countries were spending 5% of their health budget on the generic provision of mental health care while middle to low-income countries were spending 1% on average (Hamid, Abanilla, Bauta, & Huang, 2008). Concerns with budget constraints continued to mount, driving international institutions, such as the Lancet Global mental health group to continually urge countries to recognize mental health care services as a primary need and prioritise its provision (Group, 2007).

Literature also suggests that constraints on mental health care may not be limited to its integration in PHC but are spread throughout its generic provision at other levels of healthcare (Group, 2007; Hamid et al., 2008). Moreover, the Lancet Global mental health group 2007 report indicates that budget limitations may be one, but it is not the only barrier to the integration of mental health services. Other barriers include: a lack

of advocacy or political will; MHC services remaining centralised in tertiary hospitals with limited links to community-based facilities; and, limited capacity, knowledge, and skills of staff to render and lead the delivery of these services (Group, 2007). Generally, implementation falls short of contextual suitability strategies, regardless of the evidently unique environmental influences (Collins, Insel, Chockalingam, Daar, & Maddox, 2013).

Evidently, at an implementation level, integration does not conform to the ideal procedure which requires planning, budgeting, programme monitoring, training at different levels of implementation and supervision (Schierhout & Fonn, 1999). Moreover, the attitude of the healthcare worker has been found to perpetuate stigma and is assumed to cause barriers in rendering MHC services at PHC. A study conducted by Vistorte et al. (2018) in Latin American countries, indicated that healthcare workers have contributed to the observed stigma and PHC physicians were identified as being the principal perpetrators. Vistorte et al. (2018), associated the negative attitude of implementers with their limited knowledge of mental health.

The concern with the unreceptive attitude of healthcare workers is that they may repel people from accessing MHC services and further perpetuate stigma (Alfredsson, San Sebastian, & Jeghannathan, 2017). In Asia, Alfredsson et al. (2017) found that practitioners with more extensive training in mental health, namely medical practitioners, showed a more positive attitude towards rendering the respective services, even though they recognised that people with mental illnesses may be unpredictable and could harm others. This suggests that increasing knowledge on mental health can contribute to effective service provision and further decrease stigma.

An unreceptive attitude has also been seen in the criminal justice system. Literature shows that at a community level, people living with mental illnesses experience increased psychological, emotional and physical abuse. They are often exposed to rape or used to conduct criminal activities, yet when they report cases, they are often dismissed as they are deemed to be unreliable and thus neglected or ignored (Ellison, Munro, Hohl, & Wallang, 2015; J. Read, Sampson, & Critchley, 2016).

The barriers shown in literature seem to be common across countries, despite their economic status. High income countries, such as United States of American and the

United Kingdom, seemed to also experience financial constraints in MHC services provision with comparable variances between the public and private healthcare institutions. There is also an absence of an evaluation system to give feedback on the progress of implementation (Collins et al., 2013; Patel et al., 2013; Zeiss & Karlin, 2008). Additionally, challenges for middle- and low-income countries include limited infrastructure to offer services and users' inaccessibility to care due to their socio-economic status (Alfredsson et al., 2017). This tends to result in non-treatment of about 5% to 50% of people with serious mental disorders, annually (Chisholm et al., 2000)

Observing these challenges, the WHO developed guidelines informed by global lessons and perspectives on integration. This was meant to simplify the process through learning best practice. The document sets out the following principles for successful integration: policy and planning; advocacy; training PHC workers; specialists' availability; accessibility; coordination; financial and human resources; and, collaboration of health care facilities at different levels (World Health Organization et al., 2008).

However, this document has been observed to be suitable in more stable environments where there are minimal wars and conflicts, where there is political buy-in and where a comprehensive health care model is affordable. Yet some parts of the world do not have such liberty (Engela & Ajam, 2010; Group, 2007). Conversely, the available studies contribute insightful knowledge regarding barriers to integration and possible reasons for these challenges. However, their focus seems to be on the extent to which countries have aligned and adopted the WHO-proposed implementation principles and seldom investigate or evaluate the challenges facing such strategies. This seems to imply that certain international principles can be applicable universally, which may not be the case.

2.5 Mental health integration reforms in the African context

Global projections on mortality show that in the year 2030, high risk diseases and illnesses leading to death will be HIV and AIDS, depression and ischaemic heart disease (Mathers & Loncar, 2006). In 2010, mental illnesses contributed at least 10% to the global burden of diseases. This indicated that the provision and accessibility to

mental health care had become urgent. Yet despite this information, the level and effort to reform and execute mental health policies in low and middle income countries remains minimal (Mugisha et al., 2017).

In Africa, the treatment gap of mental disorders such as MDD is estimated at 67%. This is perceived to be a consequence of failures in the PHC facilities to detect mental disorders and limited accessibility to treatment which seems to worsens stigma and discrimination surrounding mental illnesses (Bhana et al., 2010; Chisholm et al., 2000).Though efforts are being made towards mental health care reforms on the continent, in 2007, 53% of the continent was reported to be without MHC policies (Flisher et al., 2007). This figure improved marginally to 43.5% in 2010. The increase in policy development and other noticeable efforts were laudable, however, the majority of them fell short in reaching their objectives as barriers to implementation persist (Hanlon et al., 2010).

Similar to trends in the rest of the world, people with mental illnesses in Africa also experience stigma and are discriminated against. For instance, in Zambia, Kapungwe et al. (2011) found a positive correlation between low levels of knowledge and increased stigma by healthcare workers. The majority of their study population deemed people with mental illnesses as unpredictable with a tendency to exhibit strange behaviour including a high probability of posing danger to others. Their findings were similar to studies conducted in Nigeria, South Africa and Ethiopia (Ahmed et al., 2019; Dube & Uys, 2016; Kapungwe et al., 2011).

Evidence demonstrates that contextually based methods seem to enable the integration of MHC services into PHC facilities. For instance, in rural Nigeria, involving families in the assessment and treatment of patients enabled a reduction in stigma and discrimination, when compared to utilizing community care workers. Ghana saw better outcomes in rendering community-based resources through assimilating families and traditional healers in the treatment plan (Read, Adiibokah, & Nyame, 2009). In Uganda, shifting mental health care services to non-specialists enabled adherence to drug treatment (Mendenhall et al., 2014).

Policy developers attribute integration failures to limited financial investments in the programme, political conflicts, natural disasters and the perpetual loss of mental health professionals in public healthcare institutions (Hanlon, Wondimagegn, & Alem, 2010;

Kigozi, 2007). Implementation research assumes that knowledge, perceptions and attitudes of implementers hinder effective implementation at PHC level and should be equally considered (Ahmed et al., 2019). In addition, challenges to integration are also attributed to resistance to change, but rarely explore the frustration and burnout that such changes can have on implementers (Antoniazzi, 2011; Friedberg et al., 2014).

African studies acknowledge the importance of legislation, policy reforms and increasing knowledge as proposed by international institutions. They also propose practical contextual enablers and implementation methods for such reforms. However, evidence on the integration of therapeutic intervention in basic drug-treatment services remains neglected (Kigozi, 2007; Mendenhall et al., 2014). The concern with the available literature is that the information gathered seldom records the perceptions of the implementers at PHC levels and their efforts to respond to the policy frameworks and legislative reforms. Nor does it analyse the usefulness of training offered, if any. Thus, conducting a yardstick study, similar to Read, Adiibokah and Nyame, is admirable as it may provide recommendations that are informed by implementers' experiences, local norms and practices.

2.6 Mental health care integration in South Africa

Along with other countries, the South African (SA) government made commitments to lessen the possible burdens on mortality and other illnesses posed by poor mental health. In 1997, the government presented a White Paper which set out the provision of comprehensive health services including the principles to provide mental health services in PHC. This was meant to be carried out through the Primary Health Care Package for South Africa: a set of norms and standards adopted in 2001 (Department of Health, 2001).

Following committee and parliamentary discussions, the Mental Health Care Act (No 17 of 2002) was approved in 2004. To operationalise this policy, the National Department of Health provided Standard Treatment Guidelines for Common Mental conditions with set principles to standardise the management and treatment of mental disorders at PHC level. Conversely, the National Mental Health Policy Framework and Strategic Plan (MHPF) 2013-2020 came into existence. The objective was to create, improve and guide the provision of an integrated, decentralised and inclusive approach to care and to allow previously disadvantaged South Africans to access

comprehensive health care through the PHC (Padarath, King, Mackie, & Casciola, 2016).

Implementation of the MHPF objectives required nurses to acquire history, manage the treatment dosages, monitor side effects and consult when needed (Department of Health, 2006; Dube & Uys, 2015). However, staff shortages and the lack of skills meant that services were unavailable, particularly in rural areas, resulting in poor management of psychiatric patients. In addition, high numbers of patients at PHC level seemed to increase the workload and hindered the realisation of the policy objectives (Dube & Uys, 2016; Petersen, Bhana, & Swartz, 2012). Consistently, Schneider et al. (2016), also found that the limited integration and implementation of the legislative framework is further hindered by budget constraints and human capacity to deliver services.

Another hindrance to comprehensive mental health care is attributed to the drug treatment-based focus of care for those with severe mental disorders and the frequent neglect on assessing and diagnosing of other mental disorders (National mental health policy framework and strategic plan, 2013-2020; Schneider et al., 2016). The existing practice is inconsistent with the ideal PHC system. Challenges to integrating mental health services at PHC level persist and this perpetuates discrimination and vulnerability of mentally ill individuals (Burns, 2011; National mental health policy framework and strategic plan, 2013-2020).

In addition, MHC orientated programmes, such as community education campaigns and lay counselling, focused on HIV testing and counselling and often neglected other mental health illnesses and disorders (Kemp, 2014). The country seems to have given priority to HIV and AIDS treatment and other infectious diseases. This is also evident in the department of Health's (DOH) annual report, which shows that an estimated 12.26% of its budget was spent on HIV-related intervention, while only about 5% was spent on MHC (National Department of Health: Annual Report, 2015/16). Even so, knowledge on the impact of HIV-focused mental health interventions on individuals remains limited.

A local study conducted by Petersen et al. in 2015, proposed a collaborative care package that would integrate MHC services into other chronic care services at PHC level. This meant that mental health patients would be supported and kept on

treatment with the strategy used to follow up chronic medication defaulters by using community care worker services (Petersen et al., 2015). This trial was based on the process map strategy designed by the Programme for Improving Mental Health Care (PRIME), which was aimed at intensifying research outcomes to improve implementation (Programme for Improving Mental Health Care, 2013).

Petersen et al. (2015), also revealed that nurses at PHC level referred small numbers to MHC units, which implied that mental illnesses and disorders were still unidentified and undiagnosed and thus under-treated. Additionally, poor follow-ups in counselling and rehabilitation programmes, with a high default rate by those on treatment, were evident. Upon further enquiry through qualitative interviews, nurses indicated a lack of confidence in rendering MHC services and at times did not trust non-specialist MHC workers, such as lay counsellors, with the mental well-being of their patients. Yet, they viewed integration as an efficient and effective method of delivery for a variety of services as it enhanced confidentiality through queuing in one line (Petersen et al., 2015; Sibiya, 2009). These findings give an impression that, nurses at PHC level do not necessarily accept the use of non-mental health care trained staff, hence they become sceptical in making referrals, which then questions if such a strategy is “feasible”.

Contrary to Petersen’s findings, Chowdhary et al. (2014) and Mendenhall et al. (2014) stated that the provision of mental health care by non-mental health care trained staff at PHC level was acceptable and feasible. They conducted studies in low and middle-income countries which included South Africa. They found that training non-specialists to provide MHC can effectively deliver the needed services to the community. However, even with such intervention there were challenges encountered in the provision of these services. They highlighted the following challenges: cultural barriers; poor adherence to treatment; minimised home visits due to lack of funds; increased work load on PHC workers; and, unfavourable clinic settings to render these services (Chowdhary et al., 2014; Mendenhall et al., 2014).

A study conducted in KwaZulu Natal (KZN) indicated that the provision of MHC services at PHC level included screening, making appropriate referrals, providing management for chronic psychiatric patients through dispensing medication and upholding adherence to medication. The implementers perceived this to be enabled

through the availability of nurses with a psychiatric nursing science qualification, an environment with adequate space for private consultations and an effective referral network. Yet, hindrances such as unavailability of medication for specific mental disorders, lack of trained staff on MHC, stigma, resistance to change by staff members and lack of communication between managers and staff persisted (Hlongwa & Sibiya, 2019).

The locally conducted studies seem to agree on the limitations of providing MHC services through non-MHC skilled personnel. In addition, there is limited exploration on the level of MHC policy knowledge and its effects on implementation. Yet, the South African Health Review (2018), perceives poor policy knowledge to be a barrier to policy execution in general. Thus, an exploration focusing mainly on the MHC-related framework may provide insight into other barriers.

2.7 South African legislative disparities in the provision of mental health

The South African government introduced an integrated decentralised provision for MHC at PHC levels through the Primary Health Care Package for South Africa (Department of Health, 2013; MHPF, 2013-2020). This package details the elements of an ideal PHC: good infrastructure; appropriate staffing levels; sufficient quantities of medicines and supplies; implementable clinical policies and guidelines; and, the provision of quality health services (Department of Health, 2001). This was aligned with the human rights framework, which calls for the decentralised, accessible and coordinated health care delivery system (South African Human Rights Commission, 2008).

According to Robertson and Szabo (2017), the current MHC implementation system, has not shown significant alignment to the current legislation, nor reorientation to redress historical injustices. Historically, the provision of MHC services was available for severe psychiatric conditions and relied on the availability of psychiatric hospitals. Unfortunately, these were mostly restricted to white people (MHPF, 2013-2020). This kept the majority of South Africans, mainly black people, marginalised and unable to access MHC services. Yet, most of these people were exposed to violent trauma and stress, which predisposed them to developing mental and psychological disorders (Mayosi et al., 2012; Van Niekerk & Alfers, 2016).

The relationship between poverty and mental illness is significant: patterns of poverty and violent neighbourhoods exacerbated by apartheid policies are still present (Jacob & Coetzee, 2018; Stein, 2014; Surender, Van Niekerk, & Alfers, 2016). Poor people remain vulnerable to traumatic events, such as crime, rape, physical illnesses, which can also give rise to the development of mental illnesses. Yet, accessibility to assessment, treatment and social support is limited, which further exposes the next generation of children to psychological traumas (Jacob & Coetzee, 2018).

Accessibility to mental care is worsened for people living with disabilities. This is attributed to the lack of resources and competent capacity to render tailor-made services (Burns, 2011). For people living with intellectual disabilities, access to care is further heightened by the glitches in poor partnerships and unreceptive role players. Hlongwa (2017) conducted a study in KZN which highlighted nurses' concerns regarding the minimal response of the South African Police Services (SAPS) in transporting users with perceptual disturbances. Their minimal response was attributed to poor knowledge and skills in handling people with severe mental disorders. This challenge was also observed with Emergency Medical Service (EMS) personnel and a MHC-orientated training was deemed a necessity to minimise these challenges (Petersen et al., 2009). Yet, there is lack of evidence that this recommendation has been implemented.

Currently, the South African government seeks to roll-out the National Health Insurance (NHI). This strategy is being piloted in numerous districts across the country, with Tshwane district as one of the sites. It seeks to integrate MHC services in generic service provision, promote accuracy in assessment of mental health disorders and reduce the disparities of the past (Surender et al., 2016). However, progress with such developments is under investigated.

2.8 The need for a coordinated management strategy for inclusive mental health care services in South Africa

Evidence shows that coordination and communication strategies at national and provincial levels harmonise policy development and implementation (Marais & Petersen, 2015). It is also assumed that decentralisation and integration of MHC into PHC may promote access to comprehensive health care to redress the health

inequalities of the past and further reduce the burden of the comorbidity of mental illness in patients diagnosed with HIV and other chronic illnesses (Petersen et al., 2015; MHPF, 2013-2020).

Harmonisation also fosters collaboration and planning which enables sharing of resources and enhanced communication (MHPF 2013-2020). However, mental health policy implementation towards integration at PHC level appears to be poorly coordinated, monitored and less-prioritised by the government. Integration hindrances seem to be further perpetuated by poor planning, limited staff and the inability of national and provincial authorities to accept responsibility for its implementation (Lund at al., 2010; Stein, 2014).

Integrated care evidently improves the quality of services, cost-effectiveness, reduces duplication, eliminates barriers to MHC services and creates a coordinated response to the patients' needs (Maruthappu et al., 2015; Petersen, 2000). This information highlights the need for national and provincial leadership to develop communication strategies to enhance coordination in policy development and implementation.

Additionally, the gap between researchers, policy developers, implementers and monitors can be minimised as it further perpetuates the observed disproportions between 'what is done' and 'what should be done' (Flisher et al., 2007). The implementation support strategy seems to be a dominant method used to facilitate integration, promote communication between policy maker and implementers and minimise execution glitches and resistance (Bogopane, 2012). Yet its use in attaining its intended goals in different settings in the country, remains minimal.

2.9 Theoretical framework

The study is guided by the Consolidated Framework for Implementation Research (CFIR) model. This model originates from the classical Everett Roger's Diffusion of Innovations theory in social sciences. The theory of diffusion pursues knowledge on 'why' and 'how' methods, technologies and innovation of new ideas and how much time it takes for them to be adopted within a social system (Wejnert, 2002).

The CFIR model is also used to explain, investigate and evaluate barriers and enablers in implementation studies. It guides the process of data collection and analysis in diverse settings. Moreover, evidence research details the usefulness of the CFIR model in measuring implementation efforts and outcomes, influencing factors and their complexity, as well as the process of refining implementation, among other things (Keith., 2017; Kirk et al., 2015).

According to Damschroder et al. (2009), the CFIR provides five theory-based domains, which practically guide the systematic assessment of potential barriers and enablers for context specific implementation. The composition of the five domains includes:

- **Characteristics of the intervention**: Adaptability, complexity, cost and origination.
- **Inner setting:** Structural composition, internal policies, network and communication, culture and implementation climate.
- **Outer setting:** Patient needs and resources, diversity, external policies and benefits.
- **Individuals involved**: Knowledge and beliefs on the intervention, self-efficacy, individual stages of change, other personal attributes.
- **Implementation process:** Planning, engaging, execution, reflection and evaluation.

Using this model, the researcher assesses the gaps, barriers and enablers of interventions in each domain. This is done through an interactive process that considers the contextual needs, implementers, recipients, and resources and therefore makes thoughtful reflections on the execution-system (Keith et al., 2017). This theoretical framework was deemed relevant to the present study based on its ability to identity structural and practical barriers, processes and enablers in implementation. The model is contextually adaptable, and integrates probing on diverse areas of implementation to allow in-depth investigation. However, further investigation and tests are still required for it to be generalised as an integration model.

2.10 Summary of the chapter

The literature review demonstrates that the prevalence of mental illness is widespread and continues to present a global challenge. The global burden of mental illness represents a worrisome concern in both the developed, developing and underdeveloped countries. The WHO has proposed an urgent strategy for countries to explore avenues to integrate mental health care services into primary health care with a view to tackling the prevalence of mental illness. The literature gives global evidence of the varying research findings with regard to the efforts made, the gaps, as well as feasible and non-feasible methods towards integration.

Generally, there is a high prevalence of mental disorders in South Africa and around the world, which makes the issue important. Yet as shown by the review MHC has not been integrated adequately at PHC level as required by the South African legislation. This is viewed as a worsening factor due to the inaccessibility of comprehensive health care for people in rural communities and those living with disabilities. Therefore, the aim of the study is to explore experience-based enablers and hindrances towards the attainment of the integration objective of the MHPH & SP, from the view of PHC facility managers. This will be explored using the CFIR model to allow for a comprehensive enquiry.

Chapter three will detail the research methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This section describes the research methodology used to conduct the study. The chapter begins by outlining the research design followed in the study. This is followed by a description of the sampling method used in the collection of data for the study. It also presents the data sources and procedures for ensuring ethical research considerations in the study.

3.2 Research design

The study used a qualitative research approach and adopted a case study design. Qualitative research is a non-numerical approach that investigates concrete views, subjective realities and shared meanings within a certain context. It seeks to describe the fundamental constructs of evident cultural, practical and uniqueness of phenomena to specific environments (Lewis & Ritchie, 2003). The case study design involves the exploration of social units, such as institutions, on the implemented processes and their interrelationships. Its primary objective is to comprehensively understand factors that constitute a certain behaviour-pattern for a specific unit (Merriam, 2002). Data is predominantly collected using semi-structured interviews, observations, interactions and content analysis from available documents (Creswell, 2013; Kothari, 2004).

Methods of research are selected in relation to the research question, with contextuality being a guiding principle. Therefore, a qualitative approach was assumed to be appropriate as it seeks to gather in-depth insight and multiple contextual interpretations that shape behavioural patterns through exploratory and explanatory strategies (Wagner, Kawulich, & Garner, 2012). This study seeks to understand the Tshwane district PHC Facility Managers' social and practical experiences in integrating MHC, based on the assumption that specific findings emerge from social perceptions and context (Ulin, Robinson, & Tolley, 2004).

3.3 Sampling and setting

Fifteen participants were chosen to participate in the study using the non-probability purposive sampling method. Purposive sampling refers to the selection of specific units, settings and/or individuals considered to be suitable for the study (Kothari, 2004). The homogenous sample of participants with set characteristics was selected because it reflected a particular view, knowledge and features for the study. This was in line with recommendations by Teddlie and Yu (2007) who suggested that sampling should involve a combination of methods and populations suitable to respond to the research question. The same sentiment was expressed by Wagner et al. (2012) who suggested that sampled individuals should represent a unit of analysis in a specific population which appears suitable for the study.

The researcher targeted primary health care (PHC) facility managers as they were considered suitable to respond to the central theme and data required for the study (Lewis & Ritchie, 2003; Wagner et al., 2012). The characteristics of the participants included a prerequisite of a minimum of five years at PHC, and who were tasked with the duty of MHC integration.

The study's participants were drawn from the National Health Insurance (NHI) Tshwane pilot site in Gauteng. This site represents a re-engineered PHC system whose key role is to provide integrated, specialised and comprehensive care. This sample appears to be aligned with the aim of the study and provides diverse views of programme integration at implementation levels. The diversity seeks to ensure that a full range of knowledge is acquired, and it allows probing of similarities and differences in the researched settings (Gentles et al., 2015).

3.4 Data Collection

Data collection is a systematic method used to collect relevant data to respond to the primary research question. Data is collected from primary and/or secondary sources. Primary sources include surveys, experiments, observations and direct interviews with respondents. Secondary data is obtained from publications, journals, compiled reports, institutional documents and books (Merriam, 2002). In this study, data was collected from primary sources through semi-structured interviews (see Appendix D). This allowed the researcher to obtain in-depth experiences around the objectives of

the study (Ulin et al., 2004). The interviews were recorded on audio with supportive note taking.

Participants were invited using emails which detailed the nature and the study's intended purpose. The primary language used was English and those that were comfortable to elaborate in their native language could do so. Each interview was conducted in a selected space to minimise disturbances and ensure accurate audio recording. The interviews took approximately 40-50 minutes on average. Prior to the interview, the researcher clarified the ethical obligations and the participant's rights as outlined in section 3.6 of this chapter. Secondly, available material detailing the integration of MHC into PHC was studied to obtain insight into the ideologies of the programme implementation. The documented information comprised departmental reports and strategic frameworks (Wagner et al., 2012).

3.5 Data analysis

Data analysis refers to techniques used to interpret the collected data to give a meaningful explanation to the research question. This process involves the capturing, transcribing and organising of data to minimise inconsistencies and to ensure validity of the results (Ulin et al., 2004; Wegner et al, 2012). In this study, the obtained data was transcribed using Microsoft word and excel. Thereafter, data was coded into themes using a thematic coding approach to identify, compare, and contrast possible information. This analysis method unified the detailed experiences of the respondents to obtain common origins and combine common threads in the data (Braun & Clarke, 2006).

It further assisted in recognising common knowledge on practical approaches and lessons around integration. According to Anderson (2007) and Neuendorf (2016), data should be detailed, coded, interpreted following a series of six steps. Similarly, the researcher in the present study followed these steps as reflected below:

- **Transcribing:** Obtained information which was transcribed using Microsoft word and excel.
- **Textual description:** Common barriers and enablers of integration were highlighted in the text.
- **Reduction and elimination:** Abstract, vague and uncategorised

information was eliminated in the analysis process

- **Thematisation:** A thematic coding approach was applied to identify, compare, and contrast commonly shared experiences.
- **Structural description:** Dimensions to be considered included the nature of services offered, resources, innovation strategies and outcomes in accordance with the CFIR model discussed in section 2.9.
- **Synthesise the essence of the experiences**: Bringing together themes allowed the researcher to explore correlations and synthesise experiences on the barriers and enablers of implementation and their variations across the research participants.

In addition to these steps, data interpreted was rechecked to minimise incorrect information and errors.

3.6 Quality assurance

Research findings in qualitative data are to bring out meaning within the specified context. It is thus imperative for the researcher to address the data credibility, transferability, dependability and confirmability. This was done in accordance with the following:

- **Credibility**: This represents truth according to reality to establish trustworthiness (Wagner et al., 2012). This was achieved using research methods accepted in qualitative research; getting familiar with the culture of the contextual practice through available documentation; reflecting the respondent's response during the interviews and verifying the findings following the data interpretation process and continuous scrutiny of the research project by the supervisor (Shenton, 2004).
- **Transferability**: This quality criterion refers to the possibility of identifying and obtaining similar findings to other similar settings, without generalising the results (Cope, 2014). Therefore, the researcher conducted a thorough description of the context, meanings and assumptions of the study, to increase this possibility.
- **Dependability**: This refers to selecting, justifying and applying theoretically accepted research methods to produce dependable results (Yilmaz, 2013). This

was achieved through detailing the research design and its implementation; using a standardised questionnaire and analysing data through noting quality and identifying patterns and themes relevant to the research (Shenton, 2004).

- **Confirmability**: This refers to the extent to which results can be verified for correctness by other researchers (Ritchie et al., 2013). The researcher executed this process through using a standardised questionnaire; checking and rechecking the data to uphold correctness and objectivity; sharing audio and transcripts of data with the assigned Supervisor to minimise bias.

3.7 Ethical considerations

Accordance to Ramos (1989), there are three main ethical issues that qualitative researchers need to be careful of: the researcher's objectivity in data interpretation; the research design; as well as the relationship between researchers and participants. Therefore, the researcher should be able to recognise important subjects and the possible conflict of interest; balance the researcher/participant's relations and be aware that information volunteered by participants may be specific to their view (Orb, Eisenhauer, & Wynaden, 2001; Ramos, 1989).

To uphold ethical obligations, the researcher followed the steps detailed below;

- **Permission for the study:** Before conducting the study, ethical clearance was obtained from the University of Limpopo's Turfloop Research Ethics Committee (TREC). In addition, gatekeeper permission was sought and obtained from the Gauteng Provincial Health Department in order to interview the potential participants (see Appendix B: Tshwane Research Committee Clearance Certificate and Appendix C: Declaration of intent from PHC Manager for Tshwane Provincial Clinics).
- **Voluntary participation and informed consent:** Before conducting the interviews, participants were informed about the purpose of the study and the nature in which privacy, confidentiality and anonymity were maintained. They were further advised that participation is voluntary, and that they could withdraw at any stage should they wish to do so (Wagner et al., 2012). Furthermore, the researcher explained the research recruitment criteria by reading the consent forms and allowing them to ask for clarity (see Appendix E: Informed consent).

This informed the participants to make an informed decision prior to partaking in the study.

- **Anonymity and confidentiality**: The study did not require any personal identifying information that could be traced back to the participants. The taped interviews were accessed by the researcher and the Supervisor. Confidentiality, privacy and anonymity were assured to the participants and maintained throughout the study.
- **Respect and dignity:** Every participant was treated with respect and dignity; their rights to confidentiality, anonymity and to withdraw from participating were not to be compromised. The study did not misrepresent their views or impose any physical and/or psychological harm to them (Richards & Schwartz, 2002).

3.8 Concluding remarks

This chapter provided a description of the research methodology, methods and their implementation in executing the study. These were informed by the theoretical assumptions underpinning qualitative research. The sample of the study comprised PHC facility managers from 15 clinics in the Tshwane district, which is an NHI pilot site. Participants reflected subjective views of the phenomenological experience and data was analysed using thematic analysis method. The researcher upheld ethical principles and quality measures were well thought out.

The next chapter provides a presentation of results obtained from data collection methods, detailed in this chapter.

CHAPTER 4

PRESENTATION OF RESULTS

4.1 Introduction

This chapter presents findings of data gathered from the in-depth interviews conducted with PHC facility and programme managers in the Tshwane district. The findings are organised in a thematic structure and provide verbatim quotes to present a narrative perspective to allow the reader to understand and create links to the presented findings. Moreover, the themes are presented in a manner that responds to the objectives of the study (Bryman & Burgess, 2002).

The aim of the study was to explore the perceptions of PHC facility managers towards the integration of mental health into PHC, through;

- Exploring the implementation process and support within the facilities
- Presenting the nature of interventions rendered in respective PHC facilities
- Identifying the enablers and barriers that hinder service delivery internally and externally
- Exploring human resources regarding skills and knowledge to render MHC services

4.2 Profile of participants

The Department of Health together with the Tshwane research committee had approved 13 facilities to partake in the study and all were invited to participate. However, only 11 were able to take part. There were 15 participants in total, with 11 facility managers and four programme managers who were interviewed jointly with their facility managers.

Participants were made up of facility managers in the NHI pilot sites and their respective programme managers. Each participant had a minimum of five-years of experience working in the facility, overseeing the mental health programme. The interviewed participants possessed an understanding of the implementation of the integration of MHC services into PHC, in order to contribute the desired views on the MHC provision in their facilities and the concept of integration.

Certain categories were grouped so as to minimise the risks of bridging confidentiality as some participants may be easily identified.

Table 1: Participants profile

Participants	Facility managers	11	
	Programme managers	4	
Facility profiles	Urban clinics	2	
	Peri-urban Clinics	4	
	Outlying suburbia Clinics	5	
			Facility profile
Facilities and number of participants	Mandisa Shiceka Clinic	1	Peri-urban
	Adelaide Tambo	1	Peri-urban
	Skinner Street Clinic	3	Urban
	Jubilee Gateway Clinic	1	Urban
	Refentse Clinic	1	Outlying suburbia
	Kekana Gardens Clinic	1	Peri-urban
	Ramotse Clinic	1	Outlying suburbia
	Suurman Clinic	2	Outlying suburbia
	Bophelong Clinic	1	Peri-urban
	Kekanastad Clinic	1	Outlying suburbia
	Dilopye Clinic	2	Outlying suburbia

4.3 Main findings

The following findings from participants are grouped into themes and sub-themes to show mutual ideas and differences thereof, as per the themes identified.

Table 2: Themes and sub-themes

Main theme	Sub-themes
Integration of Mental Health Care (MHC) to Primary Health Care (PHC)	The concept of integration at the facility level
	Perceptions on the concept of integration
	Approaches to integration
The nature of intervention	Implemented services and interventions
	Cultural differences and impact on interventions
Inner setting	Context based implementation procedures and guidelines
	Policy knowledge and application
	Availability, relevant skill and knowledge
	Inter-relation within facilities and referral
	Practice environment
Outer setting	National and provincial legislative frameworks
	District Implementation support
	Monitoring and Evaluating the implementation process
	Stakeholder networks and relationships
	Patients' vulnerabilities and resources for help
Individual characteristics	Individual Capacity, Attitude and Motivation
	Adjustment to change
	Individual skills and knowledge

4.4 Presentation of results

The results discussion is split into five primary themes that emerged from the responses and seeks to respond to the aims of the study as pre-identified. The findings were further broken down into sub-themes, to provide more clarity and understanding of the content.

4.4.1 Integration of Mental Health Care (MHC) into Primary Health Care (PHC)

The responses given in this theme gave the understanding that integration is the provision of comprehensive MHC services to the community, families, and individuals

through the PHC facilities. The understanding of the concept seemed to be similar across all facilities. Yet different opinions were expressed on how integration could be implemented given the differences in facilities.

4.4.1.1 The concept of integration at the facility level

The majority of participants appeared to share a similar understanding on the concept of integration. Some of the descriptions are shown below:

> ***…****in my view they have done the integration, yes it's nice, it is serving its purpose eh everybody is…is in the one queue and then no one knows who's who and then they're not stigmatized, everybody's just going to this one room and getting everything they want in this one room* (Facility Manager: Outlying suburbia facility)

> *…it's integration, it means I should come as a patient who is coming with whatever… that could be mental health case, at the primary health care site first entry. The sister can see me there as a curative patient if I have symptoms that could say that I …I might be a mental health patient I should be managed there. If it needs medical treatment, like drugs, then the doctor at the primary health care, should also see me, manage me for a month or investigate me for a month or so. If she is comfortable that I can remain there then it's fine I can remain there, but then if it's something that needs then secondary then she comes in, with the psychiatrist* (Facility manager: Urban Clinic)

> *…we've integrated the services, chronic, it's everybody, including mental health, HIV, and hypertension…all these chronic conditions. Our services are like…I'm saying chronic services are everyday eh and at first, we used to come only on Fridays then we felt for integration, they must come on every day* (Facility manager: Peri-urban clinic

Integration at PHC levels seems to be understood as merging MHC services with the provision of other chronic health care services in the facility. Respondents mentioned that health care practitioners, primarily nurses, equally have the responsibility to provide comprehensive services to all individuals on all days to meet the needs of each patient in one setting.

4.4.1.2 Perceptions on the concept of integration

Most participants referred to the current system as more challenging to implement, giving examples of where offering services to MHC users would be delayed due to long queues. Moreover, respondents perceive integration to have given less priority to mental health services when compared with the previous system. Some of the views were:

> *Integration. …And then the...the mental health care users need to queue with the chronic, with everyone who is on chronic medication. So it happens that they they… they stay in the queue until they go away* (Programme manager: Outlying suburbia)

> *My personal view is that the old system used to work better where you have to have where a mental health user stays, they know on Monday and on Tuesday or whatever day 'it's our day to go to the clinic'. And then when they come, they are prioritised and then…because now they say if we may prioritise mental health patients but if I have to prioritise the…the…the sick and the frail, the weak, the old and now who am I prioritizing? Because I'm prioritizing so many people. So, if mental health eh clients are clients for that day, to that specific sister at that specific place* (Facility manager: Peri-urban)

> *We were giving it a special attention, that's why now after the integration we are feeling that…we feel like you know, it has diluted that attention. But I think it is being given the…the attention that it needs. … the integration I think we lost many of them because even the…the…the sisters, you're not able to follow, the sisters are not able to follow them like if they've got this one sister or there's two sisters looking after them, you are able to follow, to know 'but this one didn't come today'. But if they're just coming randomly, we are not even able to know if they're defaulting, we see it after a long time that this patient has not been coming. Yah, so it's a problem* (Facility manager: Outlying suburbia)

Participants gave different views on the ideal clinic and integrated model, comparing it to the previously implemented model of care. The opinions gave a sense that separating mental health care users from other chronic patients had the advantage of

minimising stigma. However, implementers were unable to manage defaulters nor speed-up MHC services through fast queues. Moreover, the MHC-designated nursing practitioners were able to increase their level of knowledge in MHC through continuous practice.

4.4.1.3 Approaches to integration

The approaches to integration within the Tshwane facilities seem to differ in their delivery and coordination. This seemed to be dependent on the setting and services available. The differences in opinions are attested by the views below:

> *She pre-retrieved the files because she booked them, pre-retrieving the medication, because they are packs nhe, and she agrees with the pharmacist they get some extra for pain, for anything, for headaches all those for primary medication. They no longer go to the pharmacy…what… and they …when it is time for the blood, then she gets somebody there, when it's time for HCT she gets… she does everything for them. And they don't have to go to this room, go there and do this. She does everything for them. So, it's really an integrated service* (Facility Manager: Outlying suburbia facility)

> *They know most of the time after they see who is the dedicated sister for mental health so they will usually send the patient to her to say go to sister so and so and she knows. She attends to the patient* (Facility manager: Peri-urban clinic)

> *For the mental health, we are having, everybody is doing mental health but we've got a sister who is assigned for mental health management and then a sister who is assigned for mental health room, that is mental health room where the medication are kept and everything for mental health for registers and files and policies, yes* (Facility Manager: Urban clinic)

> *Including school health…everyone. So, we are…we…that's why we try to push with that mental health project. Everyone is just… doing their best to make sure that there is an improvement. Let me try out before I push it to the next person…then it goes to the psychiatrist* (Programme manager: Urban facility)

The findings give an impression that facilities in peri-urban and outlying suburban areas have a similar approach to implementation: all nurses screen and refer to a specialising nurse to provide integrated services in a specific room. However in urban areas all their facility nurses provide MHC services. From the views above, facilities outside the urban areas appear to have a lower sense of confidence and knowledge of MHC to render services, when compared to their counterparts in urban areas.

4.4.2 The nature of intervention

This theme identifies the type of services rendered by facilities as well as challenges and enablers that may foster the desired outcomes.

4.4.2.1 Implemented services and interventions

There seems to be uniformity in the services that are rendered across the district. Participants stated that their facilities offer screening for mental health conditions, continuation of medication, identifying symptoms for referral, education on mental health and management of defaulters through follow-ups. In addition, mental health care users also have access to be screened for other health conditions.

> *We screen them, then we refer so that they can be controlled on treatment and then when they are referred down is then that we take them as our chronics… Eh, we offer medication, we…uhm what else…we screen them for anything that eh is necessary for each patient like we screen them for TB, we screen them for HIV, we screen them for eh bloods for maybe their medication that they are taking for drinking, yah* (Facility Manager: Outlying Suburbia).

> *Related to mental health it's referral of identified cases to psychologist because the clinic does not have a full-time psychologist* (Facility Manager: Urban Facility)

> *You educate them on their rights and what they need to do with their medication… eh defaulters we use, we utilise WBOT (Ward-Based Outreach Teams) and then...eh we've got forms akere (isn't) …for WBOT to to be able to go to the...the specific house to follow that ..that lost patient* (Facility Manager: Outlying Suburbia).

This sub-theme also added participants' views on services that are lacking and that could be useful to support patients to adhere to medication and enforce better care.

> *If we can have a structure that will assist us in the formation of support groups specifically for mental health. If there are support groups that are being supported not only by the clinic, also by the district whereby we know that these people neh we are going to support them on these issues and whatever and then the increase in health promoters* (Facility Manager: Peri-urban).

> *Rehabilitation services is zero because we don't have them we wanted a support group but then it's not well-established and we wanted the gardening equipment because even the clinic does not have their equipment for gardening…you know* (Facility Manager: Urban Facility)

Overall, the facilities sampled in the district appear to be rendering similar interventions. It also appeared that the ward-based outreach teams are deemed useful in terms of conducting follow-ups on defaulters. However, some participants seemed to be of the opinion that the offered services are not sufficient and are not sustainable without extended support services in communities.

4.4.2.2 Cultural differences and impact on interventions

The participants shared that, due to the diverse population they serve, at times they are required to respond to misinformed cultural beliefs regarding mental illness. Some of the comments were;

> *I am seeing things, I am hearing things, NO! ke badomi (it's ancestors) like they are trying to tell you something...you see. And first it was a white people thing and the…until it started happening at home. So, people, our culture, I think that's another reason why they are not aware. They know that it's not there but to them it's a white people thing, it's like cancer* (Programme Manager: Outlying Suburbia).

> *Actually this is a cultural area, the one that we are servicing. And people around this area they believe a lot in ancestral calling..eh. They believe that if someone is saying things that are not making sense to us, he is speaking to the ancestors*

and then when eh… you want to start treatment because you feel that this person is maybe is hallucinating and they will say that person go to intwaso, this other challenge (Facility Manager: Outlying Suburbia).

I think cultural belief also…also…also takes part because most of them before they come to the…to the clinic neh, they…they will believe that it's…it's either the person has to go through ritual things before or it's not sickness. Those things, cultural belief it's a very…very difficult thing to deal with neh but with education because we do have this eh…eh Dingaka association around here (Facility Manager: Peri-Urban facility)

No, with us around here…culturally, I don't think there is any. Mostly white, especially our mental health care…. mental health care users yes, they are mostly white (Facility Manager: Peri-Urban).

The responses given suggest that certain facilities have recognised the restrictions imposed by cultural beliefs and practices pertaining to mental health and resort to Traditional healers' associations to handle cultural misinformation. Moreover, there seems to be a perception that the white population possesses more information and is more receptive to diagnosis and medical treatment than their black counterparts.

4.4.3 Inner setting

The inner setting theme essentially explores the perceived enablers and barriers towards successful implementation within facilities. The participants shared approaches used in implementing the legislative frameworks, organisational structures and the availability of resources.

4.4.3.1 Context-based implementation procedures and guidelines

In this sub-theme, participants gave dissimilar views. Facilities seem to have adopted specific methods that suit their contexts better. Some participants indicated that they utilise the national and provincial operational plans and no challenges have been faced in implementing them. Others preferred to use a facility integrated operational plan to reinforce integration. In addition, several had developed context-based

implementation guidelines with the intention of making the integration process comprehensible and uniform.

> *Concerning the SOP, no, we don't have any internal policies we are using the provisional and the national ones* (Facility Manager: Urban Facility)

> *As ehh…no, we fall under the clinics operational plan. Specifically for… akere (isn't that) now we are integrated. We cannot stand alone to say we as mental health…we have this operational plan* (Facility Manager: Urban Facility).

> *Yah, we do have…we do have uhmm…we do have a file with policies, I don't know whether you want to see that file? We do have…how to handle an aggressive patients, how to screen in new patients, how to deal with that patient…Uhm* (Facility Manager: Peri-Urban Facility).

> *The internal policy that we have, is that after I came from studying for primary health care, with the agreement from the office akere (isn't), gore (that) they don't go in to queue that side…Yes, it can be our internal policy because then we were avoiding this thing with defaulters, because they were starting to default. It's more like an implementation procedure* (Programme Manager: Outlying Suburbia).

Overall, participants seemed to have common knowledge on the overarching implementation procedures and guidelines provided by the province. Yet, there were noticeable differences on how these procedures are adopted. It appeared that other facilities have designed operational procedures to guide implementation, while others deemed the over-arching plans as sufficient.

4.4.3.2 Policy knowledge and application

Participants in the study, perceived the implementers' policy knowledge as an enabling factor to rendering interventions that seek to integrate MHC into PHC facilities. However, there where observable inconsistencies amongst facilities at the level of policy knowledge and efforts made to enhance the MHC-related aspect. Respondents shared that:

> *hmmm…Normally when the new policy comes, we eh…we we we…eh we sit down in the morning, report and then we read the policy. That is when inputs and debates come in. And then at the end when it is finished, it is then that*

everybody eh acknowledges that I know about this policy (Facility Manager: Outlying Suburbia).

I wouldn't say know …means they will have to know every detail of it, uhm I can say that they are aware of the mental health care policies but they know the PC101 because that one they have been trained in. Mhm yah, it's fair but…but…but the guideline that they are using it's good, the guideline, the PC101 is good (Facility Manager: Outlying Suburbia).

Those who are willing. And currently we just went for a in-service training. Actually, I'm just saying know but because…it means I know. So, people who are working there, they know about the policy (Facility manager: Peri-Urban area)

From the information gathered, it can be deduced that the level of policy knowledge remains low in most facilities, though it is regarded as important by participants. It was also evident that this pattern is perpetuated by personal interests of implementers.

4.4.3.3 Availability of relevant skills and knowledge

A number of facilities highlighted the need to have a diverse range of skills available to render quality services. Significant inconsistences between facilities outside the urban areas and those within the urban areas were noted. Outlying suburban and peri-urban areas highlighted concerns regarding the provision of psychotherapeutic services and treatment reviews for patients who are currently on medication. They shared that:

I feel that we do need psychiatrists sometimes, because if the person is at some stage needs to go to be reviewed by the psychiatrist, remember we are referring and based on the income issues that I have stated, it is not all of them who can go there (Facility manager- Outlying Suburbia)

yah you know especially the psychologist because it's…it…it…it impacts them. It's physical but it impacts them mentally so, as a result you find…you'll find that this patient at the end of the day they default from their treatments, they're angry, they commit suicide all those things (Facility Manager: outlying suburbia).

If I was falling short, then talk to the psychiatrist at Weskoppies and ask…but Doc do you have …the registrars, that are interested and want to learn, that would actually come and be…and render services. And support …yes and like even if they come for like 3…eh some of them would just come for 2 hours or 3 hours before they start working (Programme manager: Urban Facility)

The sampled responses further highlighted the differences in the availability of skills to render MHC services. Respondents in non-urban areas also mentioned the unavailability of skills as a hindrance in getting the required services for users in lower-socio economic backgrounds. Some of the views were:

Most of them..are are… they don't go to a psychologist and they remain with the problem and until again next time when someone again goes to that household and then check if the person did went to the psychologist to find out that..only…to find that the person did not go because of unavailability of fare… fares to…to to can take a taxi to go there (Facility Manager: Outlying suburbia).

… as a challenge, we've found out that maybe let's say we have sent the client to Jubilee maybe last month and then this month the person comes back and then if you ask hore (that) what did they say? Did they give you anything that we can refer from maybe to continue where they have left of? And then the patient says that I didn't go because I didn't have money to go there (Programme Manager: Outlying suburbia)

We are in the middle so there is nowhere where we belong. Maybe she can be…she can go…they can go to Mandisa Shiceka clinic? And the problem was transport, who was going to transport them? Yah, so it best if they come to the facility and the psychiatrist or the psychologist or whoever to come and see them on an appointment system. But we don't have a psychologist, at least a psychologist…(Facility Manager: Peri-urban)

The opinions shared by the respondents give an impression that the availability of necessary skills and practitioners outside urban areas remains a barrier to the provision of MHC services. The perception is that accessibility of services for those from poor socio-economic backgrounds, especially in non-urban areas, remains a challenge. Facility managers seem to believe that though the identification of

symptoms and early referrals are made, the majority of those in need of care, fall through the cracks due to services being centralised in developed areas.

4.4.3.4 Inter-relations within facilities and referral

Responses gathered indicated that facilities have formed inter-facility collaborations to support each other**.** This is done through formed networks, communication, flexibility between professionals and programme managers within the district that was perceived to enable better implementation and outcomes for users. Respondents mentioned the following:

> *I know the psychologist from Gabo and eehh DD clinic …I know… you call them and even ask…can you assist? Can you help us with 1 2 …they are able to actually see patients* (Programme Manager: Urban Facility).

> *And then she is the one who is checking if everyone has got medication or if there is a lack of something in terms of their medication. So that we can make a plan to ask from other clinics or to make other plans to ensure that nje (just) the patient does not default* (Facility Manager: Outlying Suburbia).

> *...whatever problem that I have, maybe let's say for example I have get eh medication which I don't get from the pharmacy and then so on and so forth, then is the person that I contact and tell* (Programme Manager: Outlying Suburbia).

Generally, respondents identified the quality of communication between facilities as significant enabling factors. The majority of participants seemed to have formed working relationships within the programme to foster implementation. It can be deduced that these relationships serve as enablers as implementers are able to share resources available.

4.4.3.5 Practice environment

The majority of respondents shared common ideas on the importance of consultation rooms that are suitable for the needs of mental health care users. However, it appeared that about half of the facilities in the district, are still challenged by the availability of practice space. Participants shared that:

Space is a big issue. It's a…it's a…it's a problem because we don't have enough space as it is when she comes, we have to shift some of the services, you know, to compromise. And she also…will also have to…to…to render those services still. It's a problem (Facility Manager: Peri-Urban area).

We need the services but the challenge is sharing of space… yes, we don't have enough consulting rooms (Facility Manager: Per-urban area).

I can see that they are busy extending and with the Kekana gardens, they have already moved into the space. And, that one at Kekana is the ideal clinic. We are supposed to have that type. So, we here, because we don't have space so you are left behind (Facility Manager: Outlying suburbia).

I think it's…it's one of the requirements according to the ideal clinic. All the services must be in but when we were still in the old clinic neh it was because of space and whatever we couldn't have social workers coming in we were referring them to Jubilee. Yah, now we do have space for all the services (Peri-urban area).

Respondents believe that the unavailability of practice space hinders the provision of mental health care services. It also seems that this goes against the requirements of the ideal clinic framework and further questions the readiness of the facilities to render the services.

4.4.4 Outer setting

This theme seeks to give insight into the wider influences affecting implementation. This is done by identifying external barriers and enablers affecting policy execution at facilities.

4.4.4.1 National and provincial legislative frameworks

According to participants the implementation process towards integration is guided by national and provincial operational procedures as well as continuous consultation with the district programme coordinator. The guiding legislative and policy documents mentioned by a majority of participants included the Mental Health Care Act, the Ideal

Clinic Realisation and Maintenance: Primary Health Care Package as well as provincial Standard Operating Procedures (SOP). Participants mentioned that:

> *Okay, we use the mental health care act and then we also follow the…we prescribe according to the EDL akere…*(Programme Manager: Urban Facility)

> *Yes. Its eh…its policies …it's a protocol. It's part of the Ideal clinic akere (isn't that). So according to the ideal clinic, chronic patients are supposed to be managed under one, it's no longer, we no longer we having an ARV clinic or a hypertension and diabetes clinic* (Programme Manager: Urban Facility)

> *We've got policies and the SOPs that we follow. When they design the SOPs, they engaged us like at the meetings, when we attended the meetings they will ask for the challenges and then even the coordinator when she comes to the clinic for support visit, she identifies the problems and then she asks us the challenges and everything and when they draft that SOPs they…they draft it depending on the challenges that we have encountered* (Programme Manager: Outlying suburbia facility).

The extracts above show commonalities and standard methods that guide integration. The responses give an impression that the national and provincial document are used to benchmark and standardise implementation across the district. Moreover, a majority of participants recognised the increased consultation practices engaged by the district coordinators as an enabler.

4.4.4.2 District Implementation support

Most responses gathered made reference to implementation support provided by the district through the mental health programme coordinator and communication between facilities. There was a general agreement that the support provided by the district is helpful. These are some of the views shared:

> *Coordinators are the ones, because they meet with us monthly. Isn't it we've got the monthly meetings where we…we it's like the integration meeting yes. They're the one who take the challenges and …report them. Before we…we*

didn't have a coordinator for mental health, it was general coordinator so now we have this specific person (Facility Manager: Outlying Suburbia)

We didn't have a…a…a coordinator for a long time but now we do have a mental health care coordinator and she is supportive so we do have support for mental health (Facility Manager: Outlying Suburbia)

The most mentioned method of support by participants was the consultative meetings with the district MHC coordinator. Participants viewed the coordinator as a communication link between themselves at implementation level and non-implementers at the district and provincial level. This link was regarded as important for implementation and further promoted communication between facilities.

4.4.4.3 Monitoring and Evaluating the implementation process

Programme monitoring and evaluation practices mentioned by respondents were based on the number of chronic services users reached, with no specification on the type of chronic service that had been offered. The majority of participants perceived this practice to be not very helpful and further weakened the prioritisation of MHC when compared to other programmes.

Monitoring, we send stats on monthly basis. Yah, that's that. Through stats (Facility Manager: Peri-Urban Facility)

We have the register, through the statistic… Yah. So, every month, they count how many mental you have and how many attended (Facility Manager: Outlying Suburbia)

I still feel that it's not well monitored as compared to other programmes. As compared to other programmes because if you have something to compare with neh, it's so easy to say this one I mean I…I will tell you about the HAST programme. The HAST programme they monitor it, you know left and right (Facility Manager: Peri-urban Facility)

We don't even have…because I remember when I started here about nine years ago, they would expect us to, to submit stats of total number of patients that you've have seen. Eh the new that we have seen. It's not happening anymore. So, they are just treated like any other chronic patients just on

monthly basis to send the MDS. So, we don't know whether this MDS is enough for them, we don't know (Facility Manager: Outlying Suburbia Facility)

There seems to be an agreement amongst participants on the process of monitoring and evaluating the implementation process of the programme. The indicated monitoring is done through an administrative approach, with specific focus on the number of MHC users. Furthermore, participants commonly perceived the monitoring and evaluation practices used by the district and provincial officials as poor when compared with other programmes in the facilities.

4.4.4.4 Stakeholder networks and relationships

This theme explores the relationships and networks that facilities have with external organisations and entities who may be needed to support the MHC services in PHC facilities. All participants mentioned the importance of Emergency Medical services (EMS) as well as South African Police Services (SAPS) and further shared their experiences about them. Some of the comments were:

They will come here; they need our assistance and to get eh…eh an ambulance for a psychiatric patient in the community there are…the ambulance people will tell you that we need the police to be there as well. So, it's difficult to get them both at the same time coming to a…to…to a patient. Sometimes the ambulance will come, the police are not there. Sometimes the police come, the ambulance is not there. The patient is just left there. It's not attended (Facility Manager: Outlying Suburbia).

Mhm, I can say that there is a good relationship with the police neh, although…although…although you know sometimes like we don't have a memorandum of understanding, a written memorandum of understanding with SAPS and the…the…the…the…the…the department of health, do you understand what I mean neh? (Facility Manager: Peri-Urban Facility).

From external factors that problem that I have identified last year was that when we've got the… have the psychotic patients that is in the community and needs to be transported to the clinic or the hospital the challenge was that the police doesn't want to accompany EMS and then the EMS does not want to go to the

identified psychotic patients alone, so you find that at the end the patient is not collected (Facility Manager: Urban Facility)

We are supposed to work with SAPS and EMS but we take advantage of the fact that we are in the same facility as the hospital so if we have maybe a patient that we…we just walk (Programme Manager: Urban Facility)

The level of contact and information sharing with external role players in this regard seems to be minimal. From the views, it is inferred that this hampers services offering for MHC users due to minimal communication amongst stakeholders. This challenge seems to be further perpetuated by the lack of knowledge amongst EMS and SAPS members as well as the possible fear of handling patients with perceptual disturbances.

4.4.4.5 Patients' vulnerabilities and resources for help

Participants in the study deemed the available MHC services as only responding to patients who can be managed through treatment and neglected those who cannot be. The most highlighted patients were those with neurodevelopmental disorders as well as intellectual disabilities. The participants mentioned that:

But the thing is that…with…with mental retardation, they usually become the…the the…the…the members of the Clinic… eh family. Whereby, you see them today and then tomorrow maybe and then they just come to the clinic and comes to the clinic for no apparent reason and then mara (but) actually I don't think that it is not for no apparent reason, I think it's a cry for help actually (Programme Manager: Outlying Surburbia).

I think that they can do for mental health, I think ke yona…that is what is missing. If they can give us the services maybe tsa nthwena (for the) for mental retardation and go ba (to be) educated ka (about) …as they are being raped…the females…wa bona (you see). We see that they are not ok, so they must just have techniques and how to alert them if somebody is abusing them. To not agree to anybody that says…ok come I love you…ll buy spatlo (bread) and all those waybona (you see)…such things like that (Facility Manager: Outlying Suburbia)

In my opinion, they need to be institutionalised still to be in the institutions because they are a danger to themselves. There's one boy who is mentally confused, would go just around in the village breaking windows in houses. They'd beat him, and he cannot even talk. Yah, so you see and then if you want to take this child to Jubilee that they keep him there and do something because in the community he, that child was beaten almost every day (Facility manager: Outlying Suburbia).

There were significant differences in experiences between participants in the outlying suburbia and those in urban areas on the types of vulnerabilities that MHC users were exposed to. In the non-urban areas, MHC users seem to be exposed to criminal acts which affect them physically, emotionally and psychologically. Moreover, there are limited care institutions to place vulnerable users to prioritise their safety. In more urban areas the concerns were based on the suitability of the care institution in meeting the user's needs and their possible ill-treatment rather than their availability.

And other places they take their IDs, they take their SASSA cards and that's why he ran away…That's why he ran away. Now he doesn't have his ID or SASSA ey bona (them)…They will tell you that it is for safe keeping because then they say no, but the patient is mentally ill, he cannot keep his own things (Programme Manager: Urban Area)

From the opinions provided, it appears that facilities know the specific needs of the users and their vulnerabilities in the wider community. Moreover, they deem these needs as crucial in protecting the vulnerable members in the communities, yet these needs are not met due to the unavailability of resources. There was a sense of helplessness exhibited by facility participants in this regard. They perceive mental health services to be falling short in providing protective care for vulnerable MHC users.

4.4.5 Individual characteristics

The research participants deemed personal enthusiasm, attitude, motivation and skill as successful determinants to carry out MHC interventions in the respective facilities. There was a general perception amongst participants of the importance of individual interest towards mental health in general. This perception also seemed to be the

motivating factor in referring MHC users to a specific nurse following screening in other consultation rooms.

4.4.5.1 Individual capacity, self-efficacy and motivation

The responses gathered from participants identified individual beliefs, skill, attitude, self-efficacy and past experiences in rendering mental health care as an overlapping enabler and/or barrier. The respondents mentioned that:

> *…cause you know when…when you come with something that is new to… to implement you need the people's attitude to be positive for it to happen, it's not 100% but the percentage we get at least it's picking up somewhere…we see results* (Facility Manager: Urban Facility)

> *Yes, akere (isn't) it used to be like those...eh volunteers, like nurses who are interested in doing mental health. So now if you are saying that we need to integrate mental health, some feel, like confidence, not confident enough to render the…the mental health* (Facility Manager: Outlying Suburbia)

> *That are interested and want to learn, that would actually come and be…and support …yes and…eh some of them would just come for 2 hours or 3 hours before they start working, just so that they get that…experience nhe wabona (you see). So because I …like..ehhh I I I made the …I made them aware gore (that) we have the…they are more than welcome. Sometimes we have an overflow of Doctors, we don't even have rooms* (Programme Manager: Urban Facility).

> *Some of the staff, they don't like it because of that. At times it becomes an area of trauma that, they think of certain incidents and then they develop resistance…not assaulted but threatening and all those things (Facility manager: Peri-urban facility).*

The extracts above, emphasize the importance of individual characteristics in executing implementations plans and rendering quality services. In addition, individual characteristics were perceived to be an additional reason for designating a specific nursing practitioner to render MHC services. Moreover, it appeared that practitioners who have had negative experiences in working with mental health users were most

likely to develop a level of resistance and negative attitude which may hinder service offering.

4.4.5.2 Adjustment to change

Most respondents expressed difficulties with adjusting to the proposed change. They indicated that this challenge had been experienced by users, implementers and policy makers. Some of the views were:

> *From both patients and staff. Because you know patients are used this type of…of of …doing things and now you saying they must turn the the the …the the way they have been used to doing things to something else. Then it's a bit of a challenge because they are used to that system* (Facility Manager: Urban Facility).

> *Let me just say this, our services are like I'm saying chronic services are everyday eh and at first, you know especially psychiatric patients, they are, they are sometimes reluctant to change. We used to, at first, we used to come only on Fridays then we felt for integration, they must come on every day, we gave them different…different days so but we had difficulties with that* (Facility Manager: Peri-urban area).

> *Eh yah still in the queue. But I'm not seeing any change, I'm just seeing myself being more frustrated because they want certain standards that we don't have resources and the patients come with more expectations* (Facility Manager: Peri-Urban Facility)

From the responses it can be inferred that the process of change and difficulties in adjustment has affected every person concerned with the programme. Furthermore, it appears that, though changes in legislation have been introduced, resources to execute the change remain scarce.

4.4.5.3 Individual skills and knowledge

The individual skill, knowledge and experience through continued professional training are perceived to be enablers towards rendering quality services. The responses gathered referred to refresher courses on MHC through training and workshops as skill and knowledge enhancers. Below are some of the views:

Even now there's a…a…a training going on regarding mental health. Uhmm, I think in case of any other thing even if it's not mental we need continuous refresher courses, just to remind you that this is done like this and then even if there are new policies and new SOP's that need to be communicated to us to keep us up to date (Facility Manager: Peri-Urban)

…and also, there's a course that they've introduced of capacitating the PHC nurses on mental health. Mhmm. So, I think if we've got…we can add that capacity, things will maybe advance (Facility Manager: Outlying Suburbia)

It's now that at least they..they see the interest ela ya gore (in that) they even do workshops and training, tse gore (that) have never been done, wabona nhe (you see) (Programme Manager: Outlying Suburbia)

For the programme to be well implemented, continuous training and updates on recent trends are required. All facility respondents perceived the recently offered trainings for their staff members as useful. They further mentioned that, though most of their professional nurses have been trained in psychiatry as part of their formal training, refresher courses remain a necessity.

4.5 Summary of results

This chapter organised the research findings into themes and sub-themes. The data was gathered from 15 participants in 11 primary health clinics in the Tshwane District. This district is one of the 11 identified NHI pilot sites in the country. Data was collected through individual interviews with facility managers and in some instances, their respective programme managers also participated.

The purpose of the study was to explore the perceptions of facility managers on the integration of MHC into PHC facilities. Explorations reviewed: implementation processes and support available to facilities; the nature of interventions rendered in the PHC facilities; the enablers and barriers to service delivery from the internal and external settings; as well as, the availability of human resources in terms of skills and knowledge.

The findings suggest that facility managers in the Tshwane district understand integration as the assimilation of MHC services into the generic provision of health care services in the PHC context. Participants perceived the current concept of

integration as giving less priority to MHC users. They also deemed it as posing challenges on managing defaulters and risked having less knowledgeable nurses on MHC providing such services. This suggests a possibility of poor screening methods and an increase in defaulter rate due to possibilities of poor follow-ups.

Approaches to integration, within the district, seemed to be common. The majority of facilities preferred having a designated nurse to manage and implement the programme, whilst other nurses were trusted with screening symptoms for referral. This practice was common in facilities outside the urban area and prompted an interrogation on the level of confidence that facilities have to provide the services, should the MHC trained nurses be unavailable.

It was found that facilities primarily screened; identified symptoms for further management and care; conducted follow-ups through ward-based outreach teams to educate on mental health and the continuation of medication. This practice appeared to be common in most of the sampled facilities. However, participants perceived these services as inadequate for the overall care of the mental health care user. They indicated that rehabilitation services and psychosocial support in the form of support groups are needed if the user is to adhere to medication and become equipped to manage triggers, such as drug use.

Findings show that white users are deemed more accepting and understanding of their mental health status when compared with black users. It was also highlighted that there is a need to generate understanding of cultural beliefs and their influence on interventions, whilst being sensitive to the user's belief system.

In the inner setting, it was found that facilities individually adopted context-based implementation procedures in the form of implementation plans and SOPs. These were adopted from the provincial and national frameworks. This indicated the presence of sound knowledge of the legislative frameworks and was perceived to be an enabling factor to rendering services by facility managers. However, it was not clear how the outcomes of this practice are reviewed to inform better practices. In addition, the participants raised concerns around the levels of policy knowledge possessed by the nurses, who are primarily entrusted with service delivery.

The availability of relevant skills and level of knowledge in PHC facility was highlighted as a barrier. The findings indicated that there is a slight positive change in this regard,

in facilities around urban areas when compared to their counterparts on the outskirts. Moreover, psychotherapeutic services and treatment reviews for those on medication remain a challenge in underprivileged areas. This seems to have prompted facilities to form better working relationships with one another to the benefit of the users, which was regarded as an enabler.

The majority of participants indicated that MHC services should ideally go beyond the provision of medication and require an enabling environment with suitable consulting rooms that allows for therapeutic services to take place. However, the majority of facilities indicated that they do not have suitable environments and were of the opinion that this undermines the requirement of the ideal clinic as stipulated by the ideal framework. Generally, findings indicated that there have been minimal positive changes within facilities and this seemed to be creating frustration and helplessness amongst managers as they were aware of their responsibilities in their respective communities but were limited in their delivery.

The outer setting reviewed wider aspects which tend to affect service delivery in facilities. Findings show that in the context of Tshwane, participants regarded the Mental Health Care Act; the ideal Clinic Realisation and Maintenance: Primary Health Care Package as well as Provincial SOPs as the core external influencers of implementation. They regarded these documents as enablers that sought to guide implementation across facilities. The adoption of these frameworks seemed to be enabled by the implementation support provided by the district MHC coordinator, through increased communication. However, the monitoring and evaluation practices by the districts were limited and regarded as not useful to implementers.

Findings highlighted the lack of coordination in service delivery between the Department of Health and the Emergency Medical services as well as the South African Police Services. Participants shared their frustration over the possible limited knowledge possessed by personnel within these departments. This was also viewed as increasing the vulnerability of mental health care users to neglect and increasing their inaccessibility to treatment. Additionally, the unavailability of placement facilities for users who need further support and care perpetuated such challenges.

The human aspects namely: interest, self-efficacy, motivation and attitude in this instance were deemed as both enablers and barriers to service delivery and impacted

on the quality of service delivery. Findings suggest that MHC services are delegated to certain nursing staff based on such human aspects, seemingly for the benefit of the user. Moreover, workshops and refresher training were perceived to be presenting a potential for increasing individual knowledge and skill on MHC for nurses. However, it appeared that both users and implementers have not fully engaged the process of change. The challenges in adjusting to change may threaten the attainment of policy objectives.

4.6 Concluding remarks

This chapter focused on presenting findings gathered in relation to the purpose of the study. Overall, the findings suggest that the adoption of MHC services in PHC facilities has presented practical implementation challenges in PHC facilities within the Tshwane District. Participants view change as occurring on a minute level and seemed to be falling short in meeting the demands which the facilities tend to be faced with. It was identified that collaboration with other facilities; implementation support; external stakeholder engagement and individual attributes had greater potential to foster service delivery while the lack of these hindered service delivery.

The following chapter discusses and analyses the findings, relating them to the theoretical knowledge provided through literature.

CHAPTER FIVE
DISCUSSION OF RESULTS

5.1 Introduction

This chapter analyses and interprets the research findings presented in the previous chapter in relation to the literature review discussed in chapter two. This is done through synthesising and comparing the study's findings with available literature (Bryman & Burgess, 2002). The discussion of the results is guided by the Framework for Implementation Research (CFIR) theoretical model discussed in section 2.9, and further considers public sector implementation practices.

In the South Africa context, providing comprehensive health care services through a decentralised and integrative approach remains a challenge, despite the numerous legislative reforms, as discussed in chapter four. The challenges were observed to be perpetuating discrimination, vulnerability and inaccessibility of an all-inclusive health care service, primarily for those in disadvantaged areas (Padarath et al., 2016). Based on this, the study therefore explored the perceptions of PHC facility managers in the Tshwane District. The research explored the integration of MHC into PHC focusing on what enables and what hinders implementation.

The discussions around key findings are arranged in the same sequence as the main themes outlined in chapter four.

5.2 Integration of mental health care into primary health care

In the data analysed, participants understood integration as the assimilation of MHC services into the generic provision of other chronic illness in PHC facilities. Ideally, the services are meant to be provided by all nurses, on all days of the week. The participants' understanding of integration is regarded as valid in accordance with the definitions provided by Schierhout and Fonn (1999). They state that integration practices infer an all-encompassing service provision, run by adaptable health care workers. They further add that effective integration should include programme planning, budgeting, monitoring systems, training of non-specialist health care workers and supervisory visits. Maruthappu, Hasan and Zeltner (2015) defined integration as the inclusion process of services between same level service providers

and different levels of care aimed at improving the management of patients. Both definitions regard the well-being of the individual as of primary importance.

Similarly, Strandberg-Larsen and Krasnik (2009) defined integrated health care as an organised, harmonious and coordinated mode of health care delivery aimed at enhancing clinical outcomes for the patient. They also encompass coordination and organisation concepts in their description. These concepts also form part of the 10 key principles for successful integration detailed by the World Health Organization et al. (2008). Therefore, in accordance with the provided definitions, integration in the Tshwane district appears to be partially understood and partially practised. In both the inner and outer setting, integration has not been extended to include implementation supervision and monitoring systems.

Implementers perceived integration to have minimised stigmatisation of MHC users, as all patients are attended to in a similar manner. This is consistent with Sibiya (2009) who found that in KZN, integration was perceived as an efficient and effective method of delivering a variety of services to users as it enhanced confidentiality through queuing in one line. However, this study highlights challenges with this concept. Findings suggested that integration has resulted in service delays and this was interpreted as giving less priority to MHC users when compared to the past model of care. Moreover, it seemed to heighten difficulties in tracking treatment defaulters. These challenges are corroborated by Petersen & Lund (2011), who found that issues with extended queues resulted in longer waiting periods and led to an increased number of defaulters.

Though service provision was similar in most facilities, services delivery approaches appeared to differ. Findings show that most facilities delegated MHC service provision to specific nurses, based on their experience and knowledge. Less experienced nurses were entrusted with the responsibility of identifying symptoms and screening for further management and care. According to Petersen et al. (2015) such practices can be attributed to a lack of confidence on the part of non-specialist MHC workers in rendering MHC services. He further found that this resulted in minimal referrals which led to limited access to services. However, urban-based facilities seemed to be cultivating the culture of having all nurses render MHC in its entirety.

These findings are consistent with Chowdhary et al. (2014) and Mendenhall et al. (2014) who stated that the provision of mental health care by non-mental health care trained staff at PHC level was acceptable and feasible. It seems that the lack of confidence in having general nurses rendering MHC services is contextually based. Some settings seem to be more receptive while others still experience challenges in having non-specialist MHC practitioners providing the services.

5.3 Nature of interventions

The services provided in the sampled facilities consisted of screening for mental health conditions, continuation of medication, identifying symptoms for referral, management of defaulters through follow-ups and education on mental health. The nature of services provided were similar to findings made in KZN by Sibiya (2009) & Hlongwa (2017). These services are also prioritised in the Primary Health Care Package: Ideal Clinic Realisation and Maintenance (Department of Health, 2001), which implies that the clinics are adhering to contextually based requirements.

The participants described how they make use of Ward-Based Outreach Teams (WBOT) consisting of community care workers. This team's responsibility seemed to be limited to tracking users who had defaulted on their chronic medication and was deemed to be useful in that regard. This practice follows a strategy proposed by the Programme for Improving Mental Health Care (2013) and Petersen et al. (2015), whereby MHC users are listed on the chronic care list and monitored accordingly. It appears that the use of community care workers in MHC is a favoured approach, though it is often met with criticism as they lack knowledge on MHC and their lack of confidence impacts negatively on their contribution to the programme (Inge Petersen, Lund, Bhana, & Flisher, 2011).

The majority of participants also highlighted the lack of preventative and rehabilitation measures. They perceived that medical treatment is a necessity, however it should be combined with rehabilitation services to offer psychosocial support to the community and to prevent relapses. These findings are consistent with the gaps identified by Marais and Petersen (2015). They state that rehabilitation services facilitate recovery and minimise re-admission. The need for rehabilitation services to continue care have

also been identified in Primary Health Care Package: Ideal Clinic Realisation and Maintenance (Department of Health, 2015), yet it remains a gap in integrated care.

Participants further expressed challenges in assimilating diverse meanings and beliefs around mental illness. These were observed to interfere with adherence to treatment. A study conducted in Gert Sibande district by Chowdhary et al. (2014) echoed by Mendenhall et al. (2014) found cultural beliefs can be another factor that contributes to poor adherence to treatment. According to Hlongwa & Sibiya (2019), cultural perceptions are important factors in treatment, thus there is a need to consider culturally sensitive methods in the adopted treatment model.

5.4 Inner setting

The inner setting theme explores contextual enablers and barriers that exist within facilities. Participants identified five primary measures that affected service delivery within facilities. These were: context-based implementation procedures and guidelines; policy knowledge and application; availability of relevant skills and knowledge; inter-relations within facilities; and, the practice environment.

The findings suggest that implementation of MHC services is facilitated by national and provincial plans. Thus, based on the context of the facility, the documents are translated into facility-based operational plans to suit the needs of the respective facility. It was also evident that other facilities found it acceptable to implement the national and provincial guidelines in their original state. Wehrens (2014) is in agreement with this. He states that implementation may be guided by relevant contextual aspects that consider culture, social, economic and political norms of the given population. Moreover, Sibiya (2009) found that in KwaZulu Natal, the implementation approach in PHC facilities also followed the provided legislation, but contextual factors such as the facility size, available staff members and their competencies, as well as practice space still influenced their implementation practices.

Participants perceived the knowledge of policy to be an important enabling factor for service delivery. Yet, the level of policy knowledge seemed inadequate in most facilities in the district. The concern is that poor policy knowledge may perpetuate a variety of barriers to policy application (South African Health Review, 2018). In addition, in Zambia, Kapungwe et al. (2011) found that low levels of mental health

knowledge have the probability to increase stigma on the part of healthcare workers, which consequently hinders service delivery.

In the Tshwane district, the lack of mental health care knowledge extended beyond policy and further included the non-availability of relevant skills to implement services. Findings showed that facilities outside urban areas had increased challenges with the availability of skills and the capacity to render services as required by the Department of Health. This challenge was observed to be similar to local findings made by Dube and Uys (2015). They found that rural areas experienced staff shortages and poor management of psychiatric patients, when compared to their counterparts in more developed areas.

In the South African context, people who live in less developed areas, are perceived to have been excluded from the provision of comprehensive health care despite the legislative requirement that calls for inclusion (Padarath et al., 2016). Yet, it appears that in the Tshwane district this challenge remains and increases the vulnerability of mentally ill individuals as stated by Burns (2011). Participants indicated that to mitigate challenges of accessibility, often patients would be referred to the nearest facility which was frequently visited by mental health care specialists such as psychiatrists, psychologists, occupational therapists. Yet, individuals from poor backgrounds could not afford these trips, and thus remained untreated.

These findings are consistent with Mungai (2016) and Jacob & Coetzee (2018). They found that individuals from poor socio-economic backgrounds have increased risks of developing mentally-related disorders posed by their environments. Jacob & Coetzee (2018), further state that, locally, poor people are exposed to trauma, crime and rape amongst other things, yet their accessibility to MHC remains limited.

Though challenges exist in the district, facilities seem to have developed a working relationship amongst each other. Participants in this study highlighted the importance of the link between facilities and the flexibility of practitioners within these facilities. This collaborative approach seems to enable facilities to share resources such as medication and to access scarce skills practitioners. This practice supports the MHPF 2013-2020 collaborative approach to foster planning and service delivery. Increased collaboration of health care facilities with multidisciplinary professionals at different levels effect positive outcomes (World Health Organization et al., 2008).

Findings also highlighted the challenges caused by limited practice space. Participants stated that small clinic settings and rooms are not conducive to therapeutic services and restrict service delivery. Consistent with prior findings, a practice environment and its variables are important enablers to render efficient services. According to Hlongwa & Sibiya (2019), implementers perceived an environment with adequate space for private consultations as an enabler for good practice. This aspect further challenges the attainment of the ideal clinic elements concerning adequate space to accommodate all service disciplines in the facilities (Department of Health, 2015).

5.5 Outer setting

This theme explored wider influences on implementation in the Tshwane district. Participants recognised that the following external factors influenced service integration and delivery in different ways: the legislative framework; district implementation support; monitoring and evaluation of the implementation process; stakeholder networks and relationships; patient vulnerabilities and available resources.

Findings showed that the legislative framework provided by national and provincial departments is regarded as a guidance tool to standardise the integration and implementation of the MHC into PHC. This suggests that, despite the identified limits on human capacity and budget constraints, facilities still follow legislative framework to integrate and implement. Marais and Petersen (2015) view this as the principle of responsiveness to policy implementation and integration of services at facility level. Moreover, it highlights the absence of resistance by implementers.

Importantly, participants emphasized the use of the legislative framework to benchmark and contextualise their implementation plans. This also indicates efforts made by the Tshwane districts to attain an integrated care model through planning for a more practical and contextual-based method of delivery (Read, Adiibokah, & Nyame, 2009).

Policy implementation support offered by the district also seems to have fostered the planning and contextualisation of implementation plans. Findings revealed that recently the district had increased its level of mentoring support towards integration. Participants regarded this as an implementation enabler, as it had elevated

communication between policy monitors and implementers. Similarly, a study conducted in the North West on MHC integration and governance, illustrated that policy support offered by the provincial and district representatives facilitates integration, increases recognition of the programme and minimises resistance (Marais & Petersen, 2015).

Though there is a perceived increased in implementation support, findings show that the programme remains poorly monitored thus rarely evaluated. According to participant opinions, the monitoring is based on numbers reached and often neglects service quality offered by facilities. Kirk et al. (2015) states that monitoring and evaluation gives feedback on the progress of implementation and further displays enablers and barriers to effective implementation. This data can be used to review implementation so as to improve it.

It was also found that monitoring and evaluation practices of MHC were worse than with other chronic health care services in the district. The absence of evaluation systems in mental health programmes seems to be a common oversight across countries. Studies conducted in the United States of America and the United Kingdom, obtained similar findings along with limitation in budget for MHC programmes (Collins et al., 2013; Patel et al., 2013; Zeiss & Karlin, 2008). Poor monitoring of MHC programmes is perceived to increase the risk of unethical practices and neglect of MHC users, which has been found to be a challenge (Marais & Petersen, 2015).

The neglect of MHC users is further perpetuated by poor stakeholder networks and relationships. As stipulated by the ideal clinic realisation and maintenance document (Department of Health, 2001), multi-sectoral partnerships between the Department of Health, South African Police Services (SAPS), Department of Social Development (DSD) and Department of Education (DOE) remain critical to the provision of MHC services. The document further states that a memorandum of understanding (MOU) is to be followed where these partnerships are concerned.

Contrary to this, participants indicated that the relevant implementing partners hardly offer support when an MHC user is involved. This was viewed to be exacerbated by their limited knowledge on how to handle patients who may experience perceptual disturbances. Similar to the Tshwane district, in KwaZulu Natal, Hlongwa (2017) found that stakeholder engagement and participation, particularly by the SAPS was minimal.

This study proposed training for SAPS members focusing on the management of MHC cases.

This proposal echoed the recommendations made by Petersen et al. (2009). They called for education on treatment protocols to be given to SAPS staff with regular MHC orientated training for emergency medical services personnel to minimise the experienced partnership challenges. Yet, currently it appeared that there is minimal response to such challenges. The risk to this is that service programmes that fail to create and maintain a diverse range of partnerships, renders the programme ineffective which negatively impacts on service delivery (Acharya et al., 2017).

Along with these challenges, the vulnerability of MHC users is further worsened by a limit on resources that are suitable for their diverse needs. Findings brought attention to the disparities of service focus, particularly where intellectual disability disorders were concerned. In most cases, there is limited treatment for people with intellectual disabilities, thus they are often neglected and exposed to sexual and physical abuse. Participants believed this to be a consequence of limitations in placement institutions for those that need assistance with day to day functioning, particularly in semi-urban and semi-rural areas.

This supports the findings made by Burns (2011). He stated that accessibility to mental care is worsened for people living with disabilities, due to the lack of resources and competent capacity to render suitable services. Moreover the situation was worse for people living with an intellectual disability, as they tended to experience repeated victimisation through increased exposure to physical abuse and sexual solicitation in their communities (Ellison et al., 2015).

Findings also highlighted the risks of human rights violations, abuse and neglect of MHC users, often carried out by communities and family members themselves. Participants believed that the availability of care centres has the potential to minimise such challenges. However, the abuse of MHC users continues to be a challenge. Petersen and Lund (2011) also found that the abuse and dehumanisation of MHC users is also seen in psychiatric institutions and perpetuates the poor quality of care. This presented concerns in the attainment of MHC-related legislative objective.

5.6 Individual characteristics

The role of the implementers in rendering services is influenced by their attitude, level of skill and motivation as well as their ability to adjust to change can either hinder or enable service delivery (Dube & Uys, 2016). Participants in the study made reference to the nurses' individual characteristics and perceived them to be determinants towards effective implementation.

Findings suggested that beliefs, attitude, self-efficacy and work experience are crucial to effective implementation. It was found that certain nurses were more interested and passionate when working with mentally related disorders when compared with others. It also appeared that those who have negative experiences working with MHC users, preferred to be removed from the programme. These aspects were also observed to be determining factors on the allocation of MHC work to specific nurses. Thus the designation technique is used to ensure efficient service execution. Similarly, Kirk et al. (2015) identified individual attributes as potential enablers or barriers to implementation. He assumes that, trusting individuals with responsibility that resonates with them maybe a risk. The lack of confidence, their belief systems and attitude have been found to worsen accessibility to care, increase discrimination and stigma towards MHC users (Vistorte et al., 2018).

In its nature, the health care sector policies, organisational structures and implementation methods are bound to be restructured given new discoveries. These may also bring changes in work responsibilities to the respective personnel. This therefore demands one to be flexible and adaptable to change (Marais & Petersen, 2015; Strandberg-Larsen & Krasnik, 2009). Findings in this study highlighted the difficulties experienced by both nursing practitioners and MHC users to adjust to integration changes. The challenges for patients were attributed to separation concern due to relationships formed and positive experiences with certain nurses. Whilst in practitioners, it was perceived to be a consequence of frustration given the standard of service required versus the resources available to achieve such standards.

Findings from KZN attributed challenges with change to resistance (Hlongwa & Sibiya, 2019). This study found that emotional difficulties had a predominant influence, where implementers appeared to be emotionally frustrated and uncomfortable in working with MHC users. On the other hand, MHC users seemed to be drawn towards

implementers, whom they regard as thoughtful and caring. Accordingly, implementation changes can cause frustration for implementers which in turn increased work stress and absenteeism. This was observed to worsen when changes brought increased expectation and workload (Antoniazzi, 2011). This seems to be an unintended policy consequence which seems to be less explored. Halldorsdotti, (2008), also states that, when patients perceive nurses as kind and wise, they tend to trust them, thus separation from those nurses can bring some level of anxiety.

The designation of MHC responsibilities also seemed to be motivated by the level of skill and experience one possesses. That said, findings indicated that the district and provincial coordinators have been offering training and workshops to close the knowledge gap. These are offered through in-service training and refresher courses which were perceived to be informative and skill enhancing. This practice is consistent with the requirements of the Mental Health Care Policy Framework (MHPF) 2013-2020, which is to impart skills on MHC at PHC level. This may also be viewed as a capacity building initiative which has been highlighted as a priority and a gap in the plans to integrate MHC into PHC (Marais & Petersen, 2015; Schneider et al., 2016; MHPF 2013-2020).

5.7 Concluding remarks

This chapter provided a detailed discussion of the research findings on the perceptions of PHC facility managers towards the integration of MHC into PHC, within the Tshwane District. The findings were also linked to comparable literature which provided insights on key aspects of the research question and exposed gaps that may exist in practice within the district.

The following chapter gives a summary, recommendations and conclusions which are based on information gathered and ideal practice provided in the literature.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The importance of integrating MHC into PHC has been a priority globally since its effectiveness is associated with better access to care for those who have been previously disadvantaged. Integration is further assumed to improve the overall outcome for patients. Despite this knowledge, the integration process has been met with unfavourable hindrances.

Thus, this study explored the existing enablers and hindrances viewed by the facility managers at an implementation level. The enquiry was carried out using semi-structured research questionnaires to obtain perceptions on the integration of MHC into PHC in the Tshwane District, Gauteng Province.

The findings were then compared with the available research and theoretical framework deliberated on in chapter two. This chapter summarises the subject matter and provides an overview of the insight into the findings. It also reflects on the limitations of the study as well as possible areas of future research.

6.2 Summary

The objective of the study was to explore the perceptions of primary Health Care facility managers towards the integration of mental health into PHC, through;

- Exploring the implementation process and support within the facilities
- Presenting the nature of interventions rendered in respective PHC facilities
- Identifying the enablers and barriers that hinder service delivery internally and externally; and,
- Exploring human resources regarding skills and knowledge to render MHC services.

Data was collected from 15 participants in 11 primary health care facilities within the Tshwane district. It was collected through individual interviews with facility managers and, in some instances, their respective programme managers also participated. The participants showed an adequate level of understanding of the concept of integration, which seemed to correspond to the available literature. However, the integration

practice within the Tshwane district seemed to fall short on its monitoring and evaluation practices as well as implementation supervision as proposed by literature. Similar to other provinces, the Tshwane district seems to have utilised available resources to track defaulters with aim of upholding adherence.

The services offering was also found to be similar to that offered in KwaZulu Natal, however, the unavailability of community-based rehabilitation services and limited access to psychosocial services seem to persist and present a challenge to the sustainability of services offered. Despite challenges experienced in the district, there seems to be adequate effort integrating MHC into PHC. The district's implementation process is guided by the stipulated framework and policy knowledge which is recognised as enabling integration.

The district also seems to be experiencing similar barriers to those discussed in literature. The findings indicated that there is a shortage of skilled personnel, with limited psychotherapeutic services. The individual's socio-economic status still determines access to care. In addition, a non-conducive environment for such service offering, the lack of placement centres and the unresponsiveness of the SAPS and EMS posed barriers to accessing care. This was observed to be increasing the burden on families and communities, particularly lower income and those from outlying areas, and further perpetuated violence against people living with mental disorders.

Facility managers in this district further made reference to individuals' characteristics and how these affected implementation. It appeared that these characteristics prevented them from designating MHC responsibilities to all nurses in the facility; instead they rather entrusted these responsibilities with those who seemed passionate about MHC. The highlight in this district, was observed to be the increased collaborative approach amongst facilities and implementation support offered by the district coordinating team.

6.3 Implications for theory and research

Research findings are made up of scientific system of enquiry, gathering contextual knowledge and facts aimed at increasing knowledge and understanding of a particular phenomenon or practice (Kusek & Rist, 2004). Thus, integrating theory and research into implementation is intended to improve implementation outcomes and create a

positive impact for the recipient. It also seeks to improve implementation practices to keep up with the needs of the public (Madon et al., 2007).

The theoretical assumption here is that integrating MHC services into PHC has the potential to increase accessibility to comprehensive care, decrease stigma, reduce the burden of mental disorders in the population, and ultimately improve the quality of life. Yet, the findings in this study suggest that there is a visible gap between the theoretical assumption of integrating MHC into PHC versus what is currently being practiced. The implications for such gaps are that the implementation practice of the programme may be misaligned and outdated thus risking accessibility and quality of care. Secondly, the misalignment also puts the integration theory at risk of failure thus rendering many South Africans without access to comprehensive, quality care.

As highlighted in section 5.6, the health care sector is guaranteed to be restructured given new discoveries. Yet, there is limited effort put into investigating the achievability of such discoveries both financially and operationally, given that MHC services seem to less pririotised during budget allocation. Thus, structural factors and implementers' readiness may need to be explored, if theoretical and research implications are to be taken into account.

6.4 Implication for policy

The MHPF sets out key priority areas with the ultimate aim to improve access to mental health services for the majority of South Africans, particularly the previously marginalised communities. In the local, public sector context, policies are deemed as significant tools used to enforce research and theory into implementation in numerous institutions (Cloete, 2009). Thus, when there are barriers to implementation, the policy objectives are almost guaranteed to fail.

Monitoring and evaluation systems can be used to gather evidence-based practical knowledge to inform policy monitors on progress and glitches thereof (Kusek & Rist, 2004). The findings show that the policies in MHC are deemed as enabling factors and inform best practice in implementation. Yet, the Tshwane district lacks an in-depth monitoring and evaluating implementation system that can be used to identify barriers and enablers to policy objectives. Moreover, the notable lack of cooperation between the relevant key stakeholders also poses a risk to the attainment of policy objectives.

Thus, the absence of this monitoring and evaluation tool in the district is worrisome as it implies that the district lacks the knowledge on the potential threats to the attainment of the policy objective.

6.5 Implications for practice

The changes and development in policy seemed to have had unintended consequences in practice in the Tshwane district. Firstly, the MHC services are to be offered by all nursing professionals in the PHC facility, regardless of their experience in MHC. Yet, findings show that in practice this has resulted in an increased level of defaulters due to poor monitoring. Secondly, MHC users are required to queue with all other patients in an attempt to increase confidentiality and reduce stigma. The implication of this as shown by results, is that MHC users feel less prioritised, resulting in them defaulting on their treatment.

Generally, it was observed that in practice, the attainment of MHPF objectives pose numerous challenges due to limited space, lack of skilled professionals, while patients are still required to travel to access specialised MHC professionals.

6.6 Strengths and limitations of the study

The study provided an understanding of the perception of facility managers on the proposed and implemented practice, the enablers and barriers to the integration of MHC in PHC. This may be used to inform policy reviews, future research and implementation changes to the identified barriers.

The identified limitations of the study are that:

- Findings are based on personal experiences and opinions of facility and programme managers within the Tshwane district. The opinions of MHC users and their families have not been explored.
- The study provides insightful information on the integration of MHC into PHC. However, its findings cannot be generalised to other settings due to its qualitative nature.

- Locally, literature on integrating MHC into PHC was also observed to be longstanding and limited. Moreover, it is limited to policy and research topics and seldom explores the implementation aspects.

6.7 Recommendations

Based on the findings, the following recommendations are proposed;

- A study review conducted by independent researchers, on the nature of training offered to implementers at PHC level as well as their level of usefulness with regard to implementation may be valuable.
- The Department of Health should strengthen monitoring and evaluation systems in the programme in order to understand the implementation challenges and inform implementation changes.
- Implementation supervision should be offered by policy bearers to implementers to foster effective quality services.
- Future research should measure emotional aspects imposed on implementers by policy changes and how these are hindrances to implementation.

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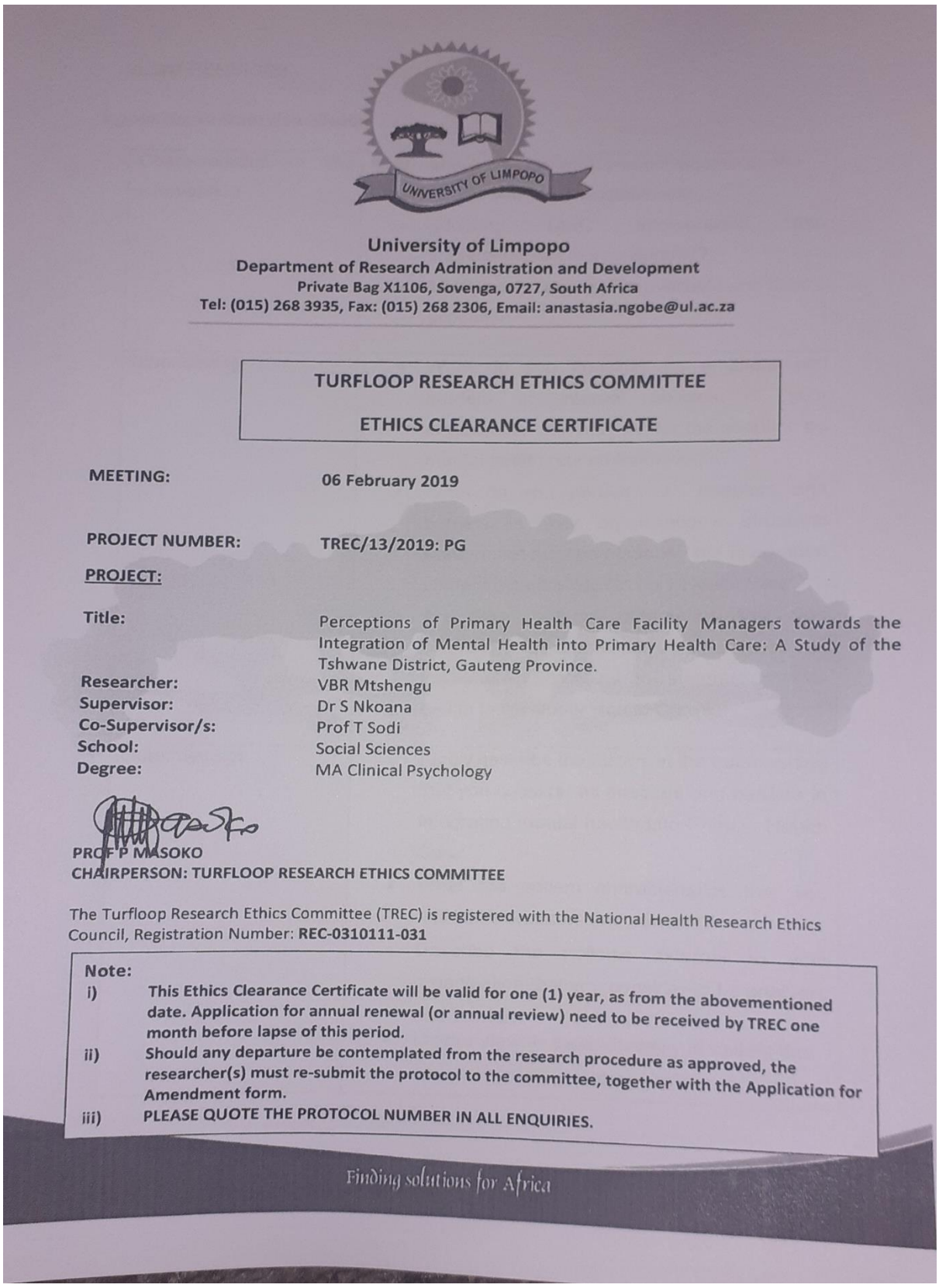
Appendices

Appendix A: Ethics Clearance Certificate



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TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 06 February 2019

PROJECT NUMBER: TREC/13/2019: PG

PROJECT:

Title: Perceptions of Primary Health Care Facility Managers towards the Integration of Mental Health into Primary Health Care: A Study of the Tshwane District, Gauteng Province.

Researcher: VBR Mtshengu
Supervisor: Dr S Nkoana
Co-Supervisor/s: Prof T Sodi
School: Social Sciences
Degree: MA Clinical Psychology

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix B: Tshwane Research Committee Clearance Certificate

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 02/04/2019
PROJECT NUMBER: 22/2019
NHRD REFERENCE NUMBER: GP_201903_010

TOPIC: Perceptions of Primary Health Care Facility Managers towards the Integration of Mental Health into Primary Health Care: A study of the Tshwane District, Gauteng Province

Name of the Researcher:	Ms. Vuyo Mtshengu
Name of the Supervisor:	Dr. S Nkoana Prof T Sodi
Facility:	Tshwane District Health Facilities
Name of the Department:	University of Limpopo

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: **APPROVED**

.....
Mr. Peter Silwimba
Deputy Chairperson: Tshwane Research Committee

Date: 2/4/19

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2019.04.03

Appendix C: Declaration of intent from PHC Manager for Tshwane Provincial Clinics

Annexure 1

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Ms Vuyo Mtshengu** to do his or her research on **"Perceptions of Primary Health Care Facility Managers towards the Integration of Mental Health into Primary Health Care: A study of the Tshwane District, Gauteng Province"** in

Adelaide Tambo
Mandisa Shiceka
Kekanastadt
Suurman
Dilopye
New Eersterus
Kekana Gardens
Ramotse
Jubilee Gateway
Themba CHC
Refentse
Skinner Street
Bophelong

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

The researcher to have an entry meeting with potential facilities before starting with the data collection.

DR SL PHOSHOKO
ACTING PRIMARY HEALTH CARE: TSHWANE
Date: 29/03/2019

Appendix D: Interview Guide

Characteristics of the intervention	Kindly share with me what you consider to be the enablers and barriers associated with: • adopting MHC interventions into implementation in your context? • MHC resources that are available and their allocation?
Inner setting	• What do you consider as enablers and barriers in internal policies of your organisation that may hinder the adoption on mental health related frameworks? • What do you perceive as enablers and barriers in your organisation's structural system that may be hindering the integration of mental health into Primary Health Care? • Are there cultural differences that you consider as enablers and barriers in implementing policies to integrate mental health into Primary Health Care?
Outer settings	• Kindly describe the factors in the outer setting that you consider as enablers and barriers in integrating mental health into Primary Health Care: • What are patient characteristics that you regard as enablers and barriers? • Describe the policies external to your organisation that you consider to be enablers and barriers. • In your view, is there diversity in beliefs that may be hindering integration?

Appendix E: Consent Form

Barriers and Enablers to Integrating Mental Health Care (MHC) Services into Primary Health Care (PHC) in the City of Tshwane, Gauteng Province

I, ……, hereby consent to participate in a study entitled: Perceptions of Primary Health Care Facility Managers towards the Integration of Mental Health into Primary Health Care: A Study of the Tshwane District, Gauteng Province. I also consent to the tape recording of the research interview conducted by Vuyolwethu Mtshengu. I understand that confidentiality will be maintained at all times and that tapes will be destroyed two years after the publication arising from the study or six years after completion of the study if there are no publications. I also allow my direct quotes to be incorporated into the study.

……..

Mtshengu Vuyolwethu B R (Miss)

MA Clinical Psychology Student / Researcher

University of Limpopo: Department of Psychology

Date:……

……..

Participant's signature

……

Name of the Facility Date

:……