UNIVERSITY OF THE WITWATERSRAND

INTEGRATION OF MENTAL HEALTH INTO PHCS IN JOHANNESBURG

Nonceba Sennelo

A research report submitted to the faculty of Commerce, Law and Management, University of the Witwatersrand, in 25% fulfillment of the requirements for the degree of Masters of Management (in the field of Public & Development Management).

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ABSTRACT

The South African (SA) government recognizes mental health as a serious public health and development concern that warrants the same status as general health. The current legislation of SA emphasizes accessibility of all services to all citizens, including mental health services. It is vital that Integration of mental health into primary health care services be viewed as a priority to address the past injustices brought about by institutional care. New mental health policies are formulated within the framework of the Constitution of the Republic of South Africa of 1996. The White Paper for the Transformation of the Health System in South Africa (1997) makes provision for the integration of mental health into primary health care services in order to improve access to mental health services to the majority of the citizens of the country.

The study looks at the factors leading to slow and no integration of mental health into Primary Health Care (PHC) services at Johannesburg Metro (JHB) Health district. The aim of the study was to explore the perceptions, attitudes, knowledge of the health professionals at JHB Metro re integration of mental health into PHC services, their experiences in working with mentally ill persons and problems experienced, as well as solutions. The exploratory study is qualitative in nature. Primary data was collected using in-depth interviews and strategic documents from the Gauteng Department of Health (GDOH).

The study describes the main challenges facing the health professionals in integrating mental health into primary health care services that include mainly shortages of trained mental health staff, negative attitudes of PHC staff, lack of support from senior management, shortage of skills in mental health care, poor supply of medicines and lack of family and community involvement. Recommendations to improve access to the mental health care services at the lowest level of care include gaining the support of senior management and addressing attitude issues of PHC staff as identified as the two main problems hindering integration of mental health into PHC services.

DECLARATION

I declare that this research report is my own work. It is submitted in fulfillment of the requirements of the degree of Masters of Management (in the field of Public and Development Management) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any University.

Signature: _____

Nonceba Sennelo

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DEDICATION

I wish to express my appreciation to my wonderful family; my husband, Sam Sennelo and my three children, Andiswa, Kagiso and Tebogo who supported me throughout my studies, you are pillars of my strength.

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LIST OF ABBREVIATIONS

ADHD	Attention deficit hyperactivity disorder
ANC	African National Congress
CHC	Community Health Center
DHS	District Health System
EDL	Expanded Drug List
EMS	Emergency Medical Services
GDOH	Gauteng Department of Health
GDOHSD	Gauteng Department of Health and Social Development
JHB	Johannesburg
KZN	Kwa Zulu Natal
MDT	Multi Disciplinary Team
MH	Mental Health
MHCA	Mental Health Care Act
MHD	Mental Health Directorate
MhGAP	Mental Health Gap Action Plan
MO	Medical Officer
NHCP	National Health Care Plan
NDoH	National Department of Health
NGO	Non-Governmental Organization
NMHP	National Mental Health Policy
PHC	Primary Health Care
OT	Occupational Therapist
R/N	Registered Nurse
SAPS	South African Police Services
SA	South Africa
S/W	Social Worker
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION

Integrating mental health into primary health care services facilitates person-centered and holistic services, and as such, is central to the values and principles of the Alma Ata Declaration (WHO, 2008). Mental health (MH) services have to be delivered in as equitable a way as the rest of the health services. Mental health services deserve the same status as other health services and need to be delivered in the same facilities as those for general health care. Integration of mental health into primary health care stresses the need to have mental health care as part of general health care in order to address the past injustices brought about by institutional care (WHO, 2008).

South Africa (SA) has witnessed political changes since the beginning of the 1990's and is emerging from the Apartheid regime to democracy. In order to address the injustices of the past there was a need for mental health policies to be formulated within the framework of the Constitution of the Republic of South Africa of 1996. The White Paper for the Transformation of the Health System in South Africa (1997) makes provision for the integration of mental health into primary health care (PHC) (Mohlaokane, 2003).

1.1 Background to the study

More than thirty years after the adoption of the Alma Ata Declaration on primary health care the vision of primary care for mental health has not yet been realized in most countries, especially not in South Africa. WHO publications aim to raise public and professional awareness of the real burden of mental disorders and their costs in human, social and economic terms and dismantle those barriers associated with mental illness, especially stigma, discrimination and inadequate services (WHO, 2001). One of the most important issues highlighted in the ten recommendations for action in the Alma Ata Declaration report (1978) was the provision of mental health treatment in primary care. The management and treatment of mental disorders in primary care is a fundamental step, thus enabling the largest number of people to get easier and faster access to all services (WHO, 2001).

District Mental Health system (DHS) is the vehicle by which effective intervention and management of mental illness is delivered. The services are structured to meet the aims of the National Mental Health Policy (NMHP), Strategic plan of Gauteng Department of Health (GDOH) and the Mental Health Care Act (MHCA) No 17 of 2002. There are very few health facilities in Gauteng that render mental health services in primary care despite significant training provided for primary care professionals such as doctors, nurses and community health workers. The district Mental Health managers submit monthly reports on the status of the integration of mental health into PHC of their respective districts and these are analyzed at the Provincial office by the Mental Health Directorate (MHD) staff. When analyzing these reports, it was revealed that only 44 % of all 367 PHC clinics in Gauteng provide mental health services at PHC, with Johannesburg Metro (JHB) only at 27% (MHD report, 2011/2012).

The study seeks to respond to research questions with specific reference to the health professionals at the JHB Metro district as a case study. The findings of this study may be used to improve service delivery and accessibility of mental health services at PHC level in this district. The detailed structure of the research report is outlined in section 1.12.

1.2 Key directives for the transformation of mental health services

According to the principles laid down by the United Nations, no individual will be discriminated against based on the grounds of mental illness, the importance of treating and taking care of the mentally ill in their own communities as much as possible is vital. It is also indicated that every patient shall have the right to be treated in the least restrictive environment, with the least restrictive or intrusive treatment (WHO, 2001).

Since the downfall of apartheid in SA, and the election of the first democratic government in 1994, important reforms have occurred in mental health policy and legislation. The Constitution of the Republic of South Africa of 1996, in its Bill of Rights, section 27, I (a) states that *"everyone has the right to have access to health care services".* Section 9 (1) further prohibits unfair discrimination of people with mental

disabilities. It is within the legislative framework of the Constitution that the old Mental Health Act No. 18 of 1973 was found to be unconstitutional and thus required to be changed.

The White Paper for the Transformation of the Health System was promulgated in 1997 and makes provisions for a mental health system that is based on primary health care (PHC) principles. This document was accompanied by Mental Health Policy Guidelines, which gave further details to this vision of a new mental health system. The White Paper for the Transformation of Health Systems in South Africa of 1997 indicated that historically mental health existed as a vertical service within the health care system, providing largely institutional curative care for individuals with severe mental illness. The importance of transforming the mental health care services is outlined and made provision for comprehensive and community based mental health services that are to be integrated with other health services.

It also emphasized the importance of human resource development for mental health services ensuring that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care. Personnel to be trained in planning, implementing, supervising, monitoring and evaluating mental health care programs and medicines required for the management of mental health conditions should be available at all levels of health care provision (The White Paper for the Transformation of Health Systems in South Africa, 1997).

Post 1994, the MHCA was one of the acts enacted to address the inequalities and discriminatory practices of the past; this act was promulgated and signed by the President of SA on the 15th December 2004. It replaced the previous Mental Health Act No 18 of 1973; this Act necessitated the development of policies and programmes like the SA NMHP, which was first drafted in 2006.

The MHCA promotes the human rights of people with mental illness and broadens the range of practitioners who can contribute to improving the mental health status of all

South Africans. The Act also emphasizes community care thus improves access, making primary health care the first contact of mental health care with the health system, and promotes the integration of mental health care into general health services and the development of community-based services (MHCA, 2002).

1.3 Importance of integrating Mental Health care into PHC

It must be understood that an individual's mental health is an integral aspect of overall health and wellbeing. Mental health care has usually been seen as a separate field, or a specialty alongside the general healthcare system. It is the treatment of disorders of the mind. Therefore integration of mental health into primary care raises the challenge to address the continuing need to make mental health a global priority, and stresses the all too often neglected fact that mental health is an integral element of every individual's overall health and well-being (WHO, 2001).

Most research conducted on this topic reveals that in SA, not all the clinics are able to attend to patients with mental illnesses, as a result patients have to travel far to get psychiatric assistance and this may impact negatively on them as they do not have the financial means to travel, therefore may not receive the much needed help. Availability of psychotropic drugs (treatment) is also a challenge; integration means that the clinics must make available the treatment for those people needing assistance (Mohlaokana, 2003; Ngunyen, 2004). These authors also posit that the absence of pyschiatrists at clinics forces patients to travel far to hospitals to get psychiatric asistance, integration in this case would mean psychiatrists visting the clinic maybe once or twice a week to see patients. Similar findings were revealed in a study conducted by Gharraee, Shariat and Mansouri (2007) in Iran and they identified some of the challenges which hindered the process of integration, including existing negative attitudes among health policy makers and program designers and limitation of financial resources dedicated to mental health as well as arguments of psychiatrists and staff members of large psychiatry hospitals.

In spite of the aforementioned limitations, through several evaluations, studies, and reports, the national mental health program of Iran has been proved to be a successful

one in decentralization of the services, case finding, and referral of the mentally ill patients to the higher level service providers (Gharraee et al., 2007)

Integrating mental health care into PHC services will yield good results because the burden of mental disorders is great. Mental disorders are prevalent in all societies. They create a substantial personal burden for affected individuals and their families, and they produce significant economic and social hardships that affect society as a whole (WHO, 2001).

Mental and physical health problems are interlinked**.** Many people suffer from both physical and mental health problems. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders (WHO, 2001).

Primary care for mental health enhances access**.** When mental health is integrated into primary care, people can access mental health services closer to their homes, thus keeping their families together and maintaining their daily activities. Primary care for mental health also facilitates community outreach and mental health promotion, as well as long-term monitoring and management of affected individuals (WHO, 2001).

Primary care for mental health promotes respect for human rights. Mental health services delivered in primary care minimize stigma and discrimination. They also remove the risk of human rights violations that can occur in psychiatric hospitals.
Primary care for mental health is affordable and cost effective**;** primary care services for mental health are less expensive than psychiatric hospitals, for patients, communities and governments alike (WHO, 2001).

Many physical health problems have a psychosocial component, for example several chronic and severe illnesses give rise to disabling psychological distress and may lead to depression. Preventive programs at the primary care level could substantially reduce

later impairment, for example, crisis intervention can assist in preventing long term, more intractable psychological disorder (WHO, 2008). Integration into primary health care is mandated by the Mental Health legislation and also the SA government mandate to reengineer the PHC services as announced by the Minister of Health, Dr. Aaron Motswaledi, in his speech in Parliament (May, 2011).

1.4 Principles of integration

Primary Health care is a health delivery strategy and is based upon some principles that include access to effective and efficient mental health care services, ensuring that services are equitable to all the people at an affordable cost. Access is defined in terms of the following aspects: geographic, financial, and functional access. Affordability refers to the fact that the cost of care should be affordable, the level of health care offered should be aligned to what the community and the country can afford, that people should not be denied health care based on inability to pay. Availability relates to sufficient and appropriate services to meet the particular health needs of each community. Effectiveness means that the services provided must do what they are intended to do for the specific community. Efficiency indicates that the results attained should be proportionate to the input, in terms of effort expended, money spent, resources used and time utilized (WHO, 2001 in Mohlaokane, 2003).

Given these principles, it was only appropriate that they also be applicable to mental health. It is vital to apply the principles of PHC to MH to improve access to mental health care like general health care. Commitment from the government to integrated mental health care, and a formal policy and legislation that ensures this commitment, are fundamental to success. Integration can be facilitated not only by a mental health policy, but also by a general health policy that emphasizes mental health services at primary care level. National directives can be fundamental in encouraging and shaping improvements (The White Paper for the Transformation of Health Systems in South Africa, 1997).

1.5 Mental Health services in Gauteng Province

Gauteng Province, which is mostly urban, consists of five (5) Districts namely; Johannesburg Metro (JHB), Sedibeng, Tshwane, West Rand and Ekurhuleni districts. The Gauteng Department of Health through the MHD renders acute and chronic mental health care services to children and adults through a system composed of the following: Primary level, secondary level, tertiary level, contracted chronic care and Non Governmental Organizations (NGO); residential and daycare services. The services are provided in inpatient and outpatient facilities and caters for children, adults and forensic patients (adults and children referred through the Criminal Procedures Act), with a range of mental disabilities and disorders.

For the purpose of this study, the focus is on the primary level. One of the strategic objectives of GDOH is to strengthen the DHS by improving health and wellbeing with an emphasis on vulnerable groups, including people with mental disorders (GDOHSD-strategic plan, 2009- 2014). The mission of MHD includes empowering PHC staff with skills which will enable them to identify, manage or appropriately transfer patients with mental health problems that present to their health facilities. It was important to build capacity among professional nurses who did not hold a qualification in mental health care through a ten (10) days short course in mental health care skills. More than thousand (1000) primary health care nurses, including community health care workers, were trained in mental health care skills during the period of 2003 -2012. The short course covered the following areas: promotion of mental health and prevention of mental illness, detection of mental health problems, history taking, interview skills, assessment, basic intervention skills, management, counselling, monitoring of medication, referral and crises intervention. It was envisaged that PHC staff would be sufficiently competent to take over the management of patients with chronic stable major mental illness (MHD, report 2011/12)**.**

The district training coordinators were trained and expected to train the PHC nurse generalists in their districts. For the financial year from 01/04/2011 to 31/03/2012, 298 PHC Nurses were trained by the district coordinators and it was difficult to train the

nurses from JHB Metro district because of lack of support from the district management to release the staff to attend the training. As a result this district dismally fails to integrate mental health into PHC services, with only 27% of clinics rendering mental health services at PHC level. MHD also participated in the development of “Guidelines for the management of mental illness for PHC doctors” and the Psychiatric Consultants are expected to conduct in-service training for the PHC medical officers (MHD, report 2011/12)**.**

Participation by mental health care specialists in terms of referral, supervision and support for PHC nurses to fully implement their skills and gain more experience on the job is important. This short course has contributed to a larger extent towards mental health services being delivered at PHC level in other districts but JHB Metro district is still lagging behind (MHD report, 2011/12).

According to Statistics SA in 2011, Gauteng remains the most populous province in South Africa, accounting for 21.5% of the population of South Africa. Gauteng population is at 12,272,264 – an increase of 14.8% between 2007 and 2011. In addition to being a densely populated province, Gauteng faces additional challenges around migration, including illegal immigrants, and cross-boundary transferred populations. The estimated population for the province is as follows:

Table 1: Distribution by municipal area

Municipal area	Population
Ekurhuleni	3,178,470
Johannesburg	4,434,827
Tshwane	2,921,488
Sedibeng	916,484
West Rand	820,995
Gauteng	12,272,264

Retrieved 17/08/2013 from

http://en.wikipedia.org/w/index.php?title=Districts_of_South_Africa&oldid=555193423

Balfour, Gilson and Goosen (1997, p. 5) argue that the main goal for District Health Development in South Africa is to have "*well-functioning health districts that contribute to sustained health status improvements through the provision of equitable, efficient, technically good quality, acceptable, appropriate and affordable health care"*. It is imperative to emphasize that DHS is indeed the main vehicle through which primary health care services are delivered. The clinics (fixed/mobile), CHCs and community hospitals form the basis for the delivery of primary health care services. MH services in the Gauteng Province are mostly run as a vertical program and lack a comprehensive approach according to the principles of primary health care. This results in mental health services being inaccessible to the majority of the people in the province (Gauteng Annual Performance Plan, 2008).

Based on MHD audits done in September 2011, it was evident that, patients with mental illness are referred straight to specialized hospitals; often geographically far from home and often to a more restrictive environment. PHC Professionals are reluctant to treat and manage mental health care users at the PHC level. Therefore this indicates that the mental health services are not accessible to all citizens, especially in JHB Metro health district being only at 27%; Percentage of facilities rendering MH Services: 163/367 x 100= 44% (MHD report, 2011/12).

Table 2: Status of Integration of MH into PHC in Gauteng Province

District	Number of facilities rendering mental health care/ Total number of facilities			
	Total Facilities/ Clinics	Provincial	Local Government	Total
(JHB) Metro	118	21	11	32
Sedibeng	38	11	17	28
Tshwane/	81	28	15	43
Ekurhuleni	85	26	15	41
West Rand	45	15	4	19

1.6 Mental Health Services in JHB Metro District

JHB Metro Health district comprises fixed 118 PHC clinics; some clinics are under management of the Provincial government and others are controlled by Local government. This poses a problem because it contributes to different management styles which might have implications on how integration of MH into PHC is viewed and managed. This district is divided into 7 regions (A- G) and there are 10 CHCs which provide 24 hr services with 8 Large PHC clinics offering 12 hour week day services and also operate from 07h00 to 13h00 during week- ends. Specialized community mental health services are supposed to be offered in CHCs, but in JHB Metro district not all CHCs offer this service due to the fact that they are not under the same management. Only 9 CHCs, with the exception of Alexander CHC, provide specialized MH services.

Inpatient mental health services are accessed through only one district hospital leading to overflow to the tertiary hospital. Most patients are referred straight to the designated psychiatric hospitals for 72 hour assessment. The district has 2 psychiatric specialists who are responsible to oversee, guide and supervise the Registrars in training. Registrars are allocated on rotational basis to all specialized psychiatric clinics within the province during their 4 year training period. These clinics are run by 2- 3 Registrars per clinic with the average of more than 1000 patients seen per month; 1- 2 Psychologists, 1 Social Worker not dedicated for MH, who is also responsible to see all patients attending the clinic, and 1 Occupational Therapist. There are 2- 3 Psychiatric trained nurses allocated at each clinic with sometimes 1 Auxiliary nurse assistant to help. Most of the nursing staff at these specialized MH clinics are appointed by the District MH programme and dedicated to provide MH services but few are employed by the facility and belong to the PHC staff. The dedicated MH staff reports to the MH manager at the district office and this sometimes poses problems as the facility managers are unable to account for the activities of these staff members even if they are operating within their facilities.

MH services provided at the specialized MH clinics are mainly responsible for management of more complex cases which cannot be managed at PHC level; these

patients are seen by the multi disciplinary team (MDT). The MDT is expected to mentor the PHC staff and offer guidance. Each CHC has a staff establishment of approximately 30 registered nurses, 10- 15 trained PHC nurses, 10 Medical Officers, who are mainly generalists, who are expected to focus on diagnosing, investigating and initiating outpatient management options of less complex and common problems. If expertise does not exist at the PHC, clinic staff will initiate emergency treatment and refer patients to a higher level of care. Clinic staff will also provide long term maintenance care of stable chronic patients (Information obtained from District Manager).

1.7 Research Problem

As defined by Badenhorst (2007), the problem statement is a well constructed statement that describes the actual problem. Leedy and Ormrod (2010) support Badenhorst and postulate that the research problem is the heart or the axis on which the study to be conducted is based.

Despite the adoption of the Alma Ata Declaration on primary health care and efforts made by national governments, the vision of primary care for mental health has not yet been realized in most countries, especially in SA. Mental health services are still not accessible to the majority of the citizens of Gauteng province. The majority of patients presenting with less severe mental health problems are totally missed. The number of patients referred unnecessarily to the secondary or tertiary mental health care facilities in Gauteng is escalating with high costs to the province. According to the findings of the MHD audits done in September 2011, only 27% of PHC clinics have integrated MH into PHC services in JHB Metro district. The main problem is that this district is lagging behind in integrating mental health into PHC services.

The study seeks to explore and understand why JHB Metro district is lagging behind in integrating mental health care into PHC services and health professionals not treating and managing mental health care users at PHC level as the entry level. PHC health professionals are at the front line in the delivery of comprehensive health care, and are

therefore the most suitable to provide information with regard to integration of mental health into PHC.

1.8 Purpose of the Research

The study seeks to explore and understand why JHB Metro district lags behind in integrating mental health care into PHC services and in not treating and managing mental health care users at PHC level as the entry level. Experiences of clinic nurses, family physicians and MDT will be used to obtain a broader view on integration. The purpose of the study is further to investigate factors leading to slow and no integration of mental health care into PHC services at JHB Metro district. The specific objectives of the study are to explore the views, knowledge of the health professionals at JHB Metro re integration of mental health into PHC services and identify the challenges of integrating mental health into primary health care in this district.

1.9 Research Questions

The research seeks to respond to the question of how integration of mental health into primary health care services is perceived by the health professionals.

What are the challenges facing the health care personnel with regard to the integration of Mental Health into primary health care and skills required to manage mentally ill patients?

Answers to these questions will be achieved by asking questions that will be included in the methodology section of this paper.

1.10 Significance of the Study

The study is aimed at looking at the factors that hinder the process of integration of MH into PHC in JHB Metro, seeking to understand the challenges of the PHC professionals who are an important component in the implementation of the policy on the integration of mental health into PHC. The study will also assist in identifying the gaps between the Gauteng Province Integration of MH into PHC services policy guidelines and the reality of the situation with regard to integration. The solutions and recommendations derived

from the study will contribute towards improving mental health services in JHB Metro district.

1.11 Limitations of the Study

The study was confined to the JHB Metro district at PHC settings. The other four (4) districts were excluded to avoid the scope being too cumbersome. While admitting that health professionals are busy people dealing with issues of life and death and dealing with the public directly, but with timely arrangements, the interviews were squeezed in between their busy schedule; some PHC trained nurses were not cooperative and not willing to allow the Researcher to interview them. The study is limited to soliciting responses from front line health workers and the importance of making prior arrangements for interviews was viewed as critical. Nevertheless, the facility managers at PHC clinics were considered as an alternative group of the respondents in this study. This might, or might not, compromise the quality of information that will be provided as they are accountable of the services.

1.12 Structure of the Report

Chapter 1

This chapter entails the background to the study, reasons underlying integration of MH into PHC services, the mental health services in Gauteng including the MH services in JHB Metro Health District, the research problem, the research purpose, the research questions, the study's significance and its limitations.

Chapter 2

This chapter discusses the integration of mental health care into primary health care as a policy issue both internationally and nationally. It deals with the literature reviewed relating to the integration of mental health into primary health care. The situations of integration of mental health into PHC in developed and developing countries, as well as in SA are discussed. Arguments on those supporting and those against the integration as presented by the various authors are indicated. The appropriate theoretical framework is also discussed.

Chapter 3

This chapter discusses the research methodology of the study. The research design and methodology described the sampling, designing of questions for interviews and how data was collected. It described the research approach and design, data collection, data analysis, validity and reliability. The researcher investigated the perceptions, attitudes and knowledge of the health professionals at JHB Metro re integration of mental health into PHC services.

Chapter 4

This chapter presents findings of the study.

Chapter 5

The findings of the study and the findings of the various authors in the literature are discussed fully. The applicable theoretical framework is applied to indicate the relevant policy and management gaps in the implementation of the integration policy.

Chapter 6

This chapter provides a conclusion to the study and describes recommendations to improve the integration of mental health into primary health care and areas for future research.

1.13 Summary of the Chapter

The rising realization of the need for the development of adequate and appropriate MH programmes, integration with general health has been well reflected in recent policies by WHO and national governments in the developing countries including SA and various strategies have been suggested to improve and extend mental health care in developing countries with limited resources. SA has taken an initiative and developed the National Mental Health Policy which is aligned to the MHCA of 2002. The Alma Ata declaration (1978) strongly reaffirms that health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity and is a fundamental human right and that the attainment of the highest possible level of health needs concerted effort by all stakeholders. Mental health care is a part, but is not apart from the total health care programme. Integration of MH into PHC is important to minimize the stigma associated with mental illness, thus the need to empower the PHC staff especially in the JHB Metro Health district.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

Badenhorst (2007:43) explains that the literature review sets the platform for discussing previous research done and locating the current research. Therefore, the literature review can be viewed as the existing relevant body of knowledge. It is vital to use the literature to inform the research. Reviewing literature on the topic helps the researcher to get insights and helps to determine the relevance of the research problem being investigated.

The literature review provides a theoretical background to the research. Neuman (2011) argues that the literature review aims at reflecting an understanding of major issues pertaining to the body of knowledge which the researcher intends to study and emphasizes that it is more about learning from past research efforts. Therefore, to help understand why integration of MH into PHC is a problem in JHB Metro district, the Researcher reviewed both international and national literature on integration of MH into PHCs.

According to Creswell (2009), definition of key concepts forms an important part of the literature review. This section is critical, especially when the researcher sometimes uses specific words that explains the subject matter well but which extend beyond common spoken language as well as when there is a likelihood for the readers not to immediately understand what is meant by the researcher due to potential ambiguity.

2.2 Mental Health (MH)

According to WHO (2008), MH is a state of complete mental wellness with the absence of both physical and mental illness when an individual is able to cope with the normal stresses of life. Mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience. Mental health can also be defined as an expression of emotions, and as signifying a successful

adaptation to a range of demands. To help individuals to work productively and be fruitful and contribute to their communities, the health professionals at PHC should be able to detect any deviations from normal early. Early detection of mental illness will only be possible if PHC health professionals are trained in MH.

2.3 Primary Health Care (PHC)

According to the National Health Care Plan (NHCP) of SA, PHC is based on practical, scientifically sound and socially acceptable methods and technology that is made universally accessible to individuals and families in the community through their full participation at a cost the community and country can afford to maintain at every stage of their development (ANC, 1994: 20). In the Alma Ata declaration report (1978), the term PHC is further explained in a similar manner and it is indicated that PHC is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

For the purpose of the study, it is imperative to operationally define the health professionals working in PHC settings who will be considered as the target population for the study.

PHC trained nurses; these are nurses registered in terms of the Nursing Act No 50 of 1978 as amended by section 56 of Nursing Act 2005 (South Africa, 1978; 2005). Some of these nurses do not have a psychiatric nursing qualification. These nurses are authorised to examine, diagnose and prescribe medicine only from schedule 1- 4, as covered by section 38 of the Nursing Act.

Registered nurse generalists; these are nurses registered as general nurses only, and are not trained in PHC or psychiatric nursing.

Medical officers/ Family Physicians; general doctors who are non- psychiatric specialists; these doctors are authorised to prescribe psychiatric treatment which is

available at the PHC level; therefore are able to commence treatment of mental disorders (GDOHSD, Circular 21, 2010).

Multi Disciplinary Team (MDT); refers to the group of professionals providing specialised MH services within the PHC setting, mostly provided in Community Health Services and bigger PHC centres. MDT comprises of trained psychiatric nurses, Social Workers, Psychiatrists, and Registrars who are on training as Psychiatrists, Psychologists and Occupational Therapists (MHD, 2011/12).

Integration of MH at all PHC facilities is expected to occur in accordance with the Primary Health Care Package by the National Department of Health (NDoH) that aims at guiding implementation of primary health care services in the provinces, including the integration of mental health. NDoH developed PHC guidelines in the form of 'A Comprehensive Primary Health Care Service Package for South Africa and The Primary Health Care Package for South Africa; A set of Norms and Standards' (September, 2001). The purpose of the package is to ensure equity and define primary health care services common to the whole country, within a five year time frame of implementation (Mohlaokane, 2003).

2.4 The Stance of the World Health Organization on Integration

World literature, as well as local experience indicates that a considerable number of people present to PHC clinics with mental health problems, especially depression and anxiety. It is evident from the literature that these conditions are not well detected at PHC level due to the inability to diagnose them early. These conditions later could lead to significant suffering and disability and some risk of mortality, whereas if identified and treated early, adverse consequences could have been prevented (WHO, 2001). Mohlaokane (2003) asserts that staff working at the PHC clinics can be trained to identify, manage and or appropriately refer patients with such mental health problems. Cook (1997) explains sustainable capacity building by explaining that empowerment of people is the prerequisite for development and enable people to take responsibility for their own lives and succeed, e.g. by training the PHC nurses, through their acquired

skills, the department as well as the country will benefit, as this will lead to effective service delivery and accessibility of services even to the under privileged communities. Internationally, a similar trend has been adopted for training of PHC nurses especially in the developing countries. Training programmes have been developed because of the realization that mental health services were mainly rendered at psychiatric hospitals and not easily accessible to the communities (Mental Health Policy, Republic of Sierra Leone, Ministry of Health and Sanitation, 2008).

On realization that mental disorders affect hundreds of millions of people and, if left untreated, create an enormous toll of suffering, disability and economic loss, WHO, in partnership with the World Organization of Family Doctors (WONCA), took the leadership in the initiative to transform health and mental health services. WHO (2008) asserts integrating mental health services into primary care as the most viable strategy of closing the treatment gap and ensuring that people get the mental health care they need. Primary care for mental health is affordable, and investments can bring important benefits.

In its search for appropriate and flexible ways of health care delivery, the WHO argued that existing systems for the delivery of health care, including mental health care, have largely failed to meet the needs of most of the world's population. It is believed that many of the systems are centralized and focus more on curative measures. Care is delivered mostly by medical personnel in a one-to-one doctor/patient relationship. Such care is often contradictory, posing a problem in the principle of social equity, particularly in developing countries (WHO, 2001). Patients have to be treated in totality with consideration that they belong to a society. According to WHO (2001), care to be rendered should be based on the needs of the population, rather than on the needs of health structures and centralized specialists facilities. If care is decentralized, active participation of the community and family is required, and thus should be undertaken by unspecialized general health care workers. This is the main reason that led to WHO introducing the concept of primary mental health care in 1978 to stress the need for mental health to be integrated into primary health care (WHO 2001).

WHO (2008) acknowledges that mental health is an essential part of health and emphasizes that mental and physical health problems are interwoven. Many people suffer from both physical and mental health problems. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders. There is still an enormous treatment gap for mental disorders. In all countries, the gap between the prevalence of mental disorders and the number of people receiving treatment is significant. Integrating mental health into primary care helps close this gap. Primary care for mental health enhances access. When mental health is integrated into primary care, people will easily access mental health services nearer to their homes, thus keeping their families together and maintaining their daily activities (WHO, 2008).

WHO believes that the ultimate goal of primary health care is better health for all and has identified the five key elements to achieve this goal: reducing exclusion and social disparities in health (universal coverage reforms), organizing health services around people's needs and expectations (service delivery reforms), integrating health into all sectors (public policy reforms), pursuing collaborative models of policy dialogue (leadership reforms) and increasing stakeholder participation (WHO, 2008). Integration of mental health into PHC services will yield good benefits including promotion of respect for human rights and minimizing stigma and discrimination. Most authors support the trend of integration of the mentally ill patients into the normal pattern of health care involving the utilization of general hospitals and clinics (Allwood & Gagiano, 1997; Lazarus, Freeman & Rispel, 1995).

Although PHC for mental health is an essential component of any well-functioning health system, it is vital that fully effective and efficient primary care for mental health must be complemented by additional levels of care. These include secondary care components to which primary care workers can turn for referrals, support, and supervision. Linkages to informal and community-based services are also necessary.

Integration of mental health into primary health care should take place in collaboration with other services in the community in order to deliver comprehensive mental health care services. Services include nutrition, and basic necessities, such as shelter and clothing. In practice, mentally ill persons are always excluded from projects that benefit the general public in the form of poverty alleviation and self-empowerment initiatives, as they are mostly perceived as unpredictable (WHO, 2001).

Most specialists use the word “mental health” interchangeably with the word “psychiatry”, whereas psychiatry does not necessarily meet the needs of the mentally ill. Psychiatry refers to the branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders and is the medical area of specialization that concentrates on mental disorders, whereas mental health is broader and refers to the well being of an individual (Allwood & Gagiano, 1997 p. 26). Sartorius (1997) also argues that mental health programs are broader than psychiatry because mental health programs are activities aimed at promoting mental health; preventing mental illness; and ensuring the treatment and rehabilitation of the mentally ill. If all services are integrated at PHC, the primary health care setting will then be the ideal environment to deliver such comprehensive mental health care services. Sartorius (1997) also highlights that some managers and other health care workers perceive mental health specialists as obstacles to integration in the interest of protecting their domain.

In the United Kingdom, psychiatrists managed to follow WHO recommendations made in 1973 to collaborate more closely with primary health care services. This has been linked with the development of a variety of community psychiatric services, moving towards community care based services for mentally ill persons (Bouras, Brough, Tufnel & Watson, 1986). According to the study by these authors, it was reported that in the period between 1979 and 1982 about 1533 clients were seen and managed at home with the help of family and local services. As psychiatric problems were increasingly becoming common, patients were now seen by general practitioners and very few referred to psychiatrists. Previously, community mental health services were under resourced and therefore inaccessible to citizens, except through mental institutions; this

partnership with local general practitioners and other disciplines has strengthened community mental health services It is argued that mental health cannot remain a field of specialists and practiced in mental health institutions but needs integrated effort. Most authors, like Allwood and Gagiano (1997), posit that in most countries, mental health specialists are in short supply, being concentrated either in cities or in the private sector and hence not accessible to ordinary citizens.

WHO strongly advocates for a shift away from institutionalization to community based care approach. People should not be isolated and locked away in mental institutions which are usually situated in remote areas far from towns or cities, thus restring movement of patients. "*There is a need to close down all asylums and treat people with dignity*. *Such facilities should be replaced with well-organized community based care services and psychiatric beds in general hospitals* (WHO, 2001, p., 4). This move will facilitate integration of mental health into general health care.

2.5 Integration of MH into PHC in Developed Countries

Most developed countries have adopted the recommendations by WHO to integrate mental health services into general health and have incorporated this in their health policies. Following a public audit done in 1995 which revealed challenges and problems faced by psychiatric and mental health care delivery in France, France decided to adopt the WHO recommendations and in 2005 introduced a psychiatric and mental health care plan for the period 2005-2008. This plan aimed at improving the mental care supply and the involvement of patients, their families and health professionals in policy decisions concerning mental health care. It also aimed at addressing challenges linked to stigma and discrimination as well as improving the quality of care and research in this area and implementing programs for specific disorders or population groups. The French government's effort to introduce this "*psychiatric and mental health plan 2005-2008" was* to move from a structure-and-service-based-approach to a global approach taking into account community needs.

Retrieved from http://.hpm.org/en/Surveys/IRDESFrance/06/Psyciatric and MentalHealthPlan_2005-2008.html on 16/02/2013

The implementation of this plan was effective; this was evident from the report given by GDOH delegates from MH programmes that visited France in 2006 and came back with a positive report. They reported that mental health services were more community based with strong referral systems from hospitals to community services and families are more involved in the treatment regimen of their family members. GDOH had signed an agreement with the French government which was called the “French Twinning Project” which aimed at the development of exchange programmes between the two governments to improve mental health service delivery (GHDSD- Strategic Plan, 2009-2014).

Pincus (1980) believes that PHC is vital, especially in dealing with psycho-social needs, thus it is important to make efforts to integrate mental health into the general health. This will need the development of skills, knowledge and attitudes toward mental health in the primary care workers for effective interventions, especially during situations of disasters. PHC settings as the entry level for health will assist in addressing issues of access to mental health care services, inadequate resources and the issue of the stigma attached to mental illness caused by institutionalization. The stigma of mental illness is a scourge; families are even scared to disclose if they have a family member who suffers from mental illness; thus a need to make communities aware of mental illness. The only solution to alleviate stigma is to integrate mental health into general health and treat people suffering from mental illness the same as those with physical illnesses. The stigma attached to mental illness can be detrimental to those affected by mental illness and their families. Stigmatization can lead to people being labeled; referring to all patients as deranged, violent, homicidal, incompetent and unpredictable and being prejudiced against and isolating them; hence it has larger implications than mere prejudice. Therefore it is vital for the law to protect people with mental illness (WHO, 2001).

WHO (2001) viewed the issue of integrating mental health into PHC as a policy issue needing immediate intervention. This led to the adoption by various countries of the

policy to integrate MH into PHC. Mental health policy reforms initiated in a number of countries, especially the developed countries, brought about improvements in the way in which the mental health services were delivered (WHO, 2001). Most developed countries, like Italy, initiated the Mental Health Care reform process as early as the 1970's. The Italian Parliament embarked on legislative reforms to bring about radical change to mental health care throughout the country. Implementation of new mental legislation resulted to a tremendous drop in admission rates to mental hospitals by 53%. Obligatory admissions declined from about 50% in 1975 to about 20% in 1984 and 11, 8% in 1994 (WHO, 2001 in Mohlaokane, 2003).

In Australia, it was reported that MH legislative reforms led to an increase in total budget on mental health care to 30% in real terms. More money was spent on hospitalization of patients prior to MH policy reforms, but with implementation of new measures, the government managed to save about 20% of the budget and bed occupancy rate in hospitals dropped by 42% (WHO, 2001) . It is also reported that in Australia efforts have been made to integrate mental health services for older people into general health services. General medical officers provided primary care for mental health, with the advice and support of community psycho-geriatric nurses, psychologists, and geriatric psychiatrists. Over time general practitioners were capable of working independently and required less advice and support, and achieved better outcomes in terms of maintaining continuity of care. The key to this model is support, collaboration, and sharing care between primary care, community services, and specialist services, which include community-aged care, geriatric medicine, and old age psychiatry (WHO, 2001).

A research was done in the United States of America (USA) to describe models of integrated care used to assess how integration of mental health services into primary care settings or primary health care into specialty outpatient settings impacts patient outcomes. The authors described that integrated care programs have been tested for depression, anxiety, at-risk alcohol, and Attention deficit hyperactivity disorder (ADHD) in primary care settings and for alcohol disorders and persons with severe mental illness in specialty care settings. Their findings concluded that in general, integrated

care achieved positive outcomes but efforts to implement integrated care are usually hindered by financial barriers. They believe that communities are more readily accommodating towards integrated care, at least for depression (Butler, Kane, McAlpine, Kathol, Fu, Hagedorn & Wilt, 2008).

The generalists who are against integration of MH into PHC believe that this policy decision by WHO has been imposed on PHC as an additional service which will need more resources and the mental health specialists are passing the buck and are lazy. It is further argued that the use of such facilities by the mentally ill whose behavior at times is disruptive expose unskilled health personnel and other patients to danger including destruction of property (Petersen, 1999). However, some studies indicate that violence by psychiatric patients was increased among patients with personality disorders and those who had a history of violence (WHO, 2001). WHO (2001) also reported that most people with mental disorders are not violent and only a small proportion of mental and behavioural disorders are associated with an increased risk of violence. Therefore provision of a comprehensive mental health service can decrease the likelihood of such violence. The governments should play a stewardship role of any health system and take responsibility and ensure that proper health policies are in place.

A study was conducted in USA to determine whether mental disorders commonly seen in primary care impact on quality of life and how this compares with the impairment seen in common medical disorders. The study revealed that mental health problems are not only prevalent in primary health care but are responsible for a large proportion of the impairment in health related quality of life by patients, often exceeding the impairment associated with common medical disorders. Therefore, primary care aimed at improving health-related quality of life needs to focus on the recognition and treatment of common mental disorders (Brody, Davies, deGruy lll, Hahn, Kroenke, Linzer, Williams & Spitzer, 1995).

In the effort to integrate MH into PHC in California, a team of health professional initiated a project; the Integrated Behavioural Project (IBP) that aimed at accelerating

integration of behavioral health services into primary care settings with the focus on services in Californian CHCs. The main objectives were to increase access to behavioral health services, reduce the stigma associated with seeking treatment, improve treatment outcomes and strengthen linkages between MH and PHC. The project started by conducting developmental and initiative specific design activities and selected seven primary care clinics and two clinic consortia to receive grants and serve as demonstration sites in order to build capacity, study operations, evaluate approaches and identified policy and system barriers to integration. This project was beneficial; it resulted in collaborative care which was rolled out through California (WHO, 2008).

Many studies reveals that usually general personnel fail to diagnose physical complaints caused by mental illness, leading to repeated and expensive investigations in the attempt to find physical causes for the symptoms. Numerous ineffective and costly medications may be prescribed, wasting state funds. No wonder patients end up shopping around and visit many different health facilities in a fruitless search for effective treatment. Scarce health resources are thus frequently wasted, and patients may be needlessly exposed to drugs that do nothing to help them and may actually give rise to dependence and further mental and emotional difficulties (WHO, 2001). It is in this context that the WHO and a number of authors in mental health care support training of generalists in mental health skill as a pre-condition to the integration process. However, the integration of MH into PHC does not mean that mental health specialists are not required. The role of specialists in this context should be one of providing supervision and training. Appropriate supervision of non-specialists health care workers is an essential component of the integration of mental health into primary health care, without which the effectiveness of primary health care programs would be fruitless (Pincus, 1980; WHO, 2008).

2.6 Integration of MH into PHC in Developing Countries

WHO (2008), in its assessment, indicated that in developing countries mental health does not receive the attention it deserves. Pilot programs on integration of MH into PHC were conducted in some developing countries like Brazil, China, Cambodia, India,

the Islamic Republic of Iran, Pakistan, Philippines, Senegal, Sudan and South Africa. These pilot programs indicated that integration has not been taken seriously because the approach has not being rolled out to cover the whole country.

WHO (2008) has reported several achievements made by some of the developing countries including Brazil where, in the district of Sobral, primary care practitioners conduct physical and mental health assessments for all patients. They initiate treatment and manage patients at primary care level and only refer those they cannot manage and request an assessment from a specialist mental health team, who regularly visit the family health centres. There are joint consultations between mental health specialists, primary care practitioners, and patients. This model not only ensures good quality mental health care, but also serves as a training and supervision tool whereby primary care practitioners gain skills that enable greater competence and autonomy in managing mental disorders.

Islamic Republic of Iran has taken the integration of MH into PHC seriously and this is occurring nationwide. Provision of mental health care by general practitioners is viewed as part of their general health responsibilities and patients therefore receive integrated and holistic services at primary care centres. If problems are complex, patients are referred to district or provincial health centres, which are supported by mental health specialists. The most important feature of the Iranian integration of mental health has been its national scale, especially in rural areas. Community involvement is promoted and community health workers play a crucial role in ensuring that MH services are accessible to all by identifying and referring people in their villages to primary care for assessment. To support the integration process 16 000 out of 25 000 general workers and 5 500 out of 8 100 general practitioners were trained and are actively engaged in providing mental health services. Other innovative activities involved the integration of prevention of substance abuse efforts within the primary health care system, and primary prevention on mental health focusing on suicide, epilepsy and mental retardation. The program was independently evaluated by the WHO and is graded as an example of a very successful program of its type (WHO, 2008). Regardless of the

many achievements, in a study conducted by Gharraee, Shariat and Mansouri (2007) in Iran, the following challenges which hinder integration were identified; existing negative attitude among health policy makers and program designers, limitation of financial resources dedicated to mental health and arguments of psychiatrists and staff members of large psychiatry hospitals

In spite of the aforementioned limitations, through several evaluations, studies, and reports, the national mental health program of Iran has been proved to be a successful one in decentralization of the services (WHO, 2008).

The other countries in the region, which have set up programs to integrate mental health services into primary health care, are Pakistan and Saudi Arabia. Their national health policies have identified mental health as one of the priority areas, and have developed from 1996 national mental health programs focusing on providing accessible and affordable mental health care nearer to where people stay through primary health care. All categories of primary health care personnel have been trained on several developed methodologies to capacitate them on mental health issues. In Pakistan, training is integrated into the ongoing professional development initiative through district health development centers. Training is decentralized and is implemented by means of using the “train the trainer model” with an in-built evaluation mechanism. It is indicated that more than 2000 primary health care physicians and 30 000 other primary health care personnel are engaged in providing mental health services within the existing services. There are several psychiatrists from this region who have undergone training on the principles of providing community based care from the WHO collaborative centre. This has equipped them to facilitate referral and information system support to primary health care personnel in their respective areas (WHO, 2008).

In some parts of Saudi Arabia; PHC physicians provide basic mental health services through primary care, and those who have received additional training, serve as referral sources for complex cases. A community mental health clinic provides complementary services, such as psychosocial rehabilitation and the mental health specialists provide

ongoing support and training to the primary health care staff. This has resulted to better management and care of mentally ill patients at primary level and early detection of mental illness thus preventing unnecessary referrals to hospitals which are more restrictive in nature (WHO, 2008).

In most African countries health services are still fragmented. According to a study done in Zambia to explore health providers' views about mental health integration into primary health care, despite the 1991 reforms of the health system in Zambia, mental health is still given low priority. This is evident from the fragmented manner in which mental health services are provided in the country and the limited budget allocations, with mental health services receiving 0.4% of the total health budget. Most of the mental health services provided are curative in nature and based in tertiary health institutions. At primary health care level, there is either absence of, or fragmented health services. This study also revealed that the service providers strongly supported the integration of MH into PHC services, as a way of facilitating early detection and intervention for mental health problems. Participants believed that this would contribute to the reduction of stigma and the promotion of human rights for people with mental health problems (Cooper, Flisher, Lund, Kapungwe, Mwanza, Mwape & Sikwese**,** 2010).

However, health providers felt they required basic training in order to enhance their knowledge and skills in providing health care to people with mental health problems. The authors concluded that integrating mental health services into primary health care is critical to improving and promoting the mental health of the population thus the need to provide the health workers with basic training in mental health. It is further explained that none of Zambia's strategic health plans and policy documents have addressed and incorporated mental health. Mental health services appear to have been inadequately incorporated into the primary health care in Zambia, a problem shared with many other low-income African countries (Cooper, et.al, 2010).

Whereas in Uganda, the health minister took the initiative and put mental health on the map by putting measures in place to integrate mental health with primary health care in

1996. According to the WHO report (2008), plans are in place to build 6 mental health care units at 10 regional referral hospitals, and reduce the capacity of the 900 bed national psychiatric hospital by half. This is an indication of a policy shift from institutional care to community based mental health care. These are some of the gains made through the integration of mental health into general health care.

Since the assessment done by the WHO (2008) indicated that integration of MH into PHC is not a priority in most of the developing countries, it is vital for the policy makers to ensure that there are strategies put in place to strengthen mental health. This can only be achieved through training programmes aimed at capacitating primary health workers to recognize any potential mental illness in order to be able to provide quality care. WHO (2008) asserts that mental health care is a basic and essential building block for ensuring lifelong good health, an aspect that is neglected in developing countries. Allwood and Gagiano (1997) also support WHO that it is of vital importance to patients that all primary health care workers have training in the diagnosis and management of mental disorders and that clinics be adequately staffed.

Having influenced policy direction in mental health, it was necessary for the WHO to monitor compliance with the policy recommendations, thus the publishing of the WHO assessment tool (2005). This assessment tool was developed to assess key components of a mental health system and thereby provide essential information to strengthen mental health systems.

Most of the developing countries are faced with challenges in integrating MH into PHC, including the need to simplify mental health care skills and continually review and transform them in order to suit the reality of the community needs. The big challenge for clinicians who value caring for ill people by themselves is to refer stable chronic patients to be managed by general practitioners at PHC and the need to devote significant time to periodic support and supervision of the non-specialists (Kumar & Murthy, 2008).

For integration to be successful in developing countries, policy makers need to consider taking mental health seriously and ensuring availability of appropriate training programmes for the general health care personnel and availability of basic mental health care medication at primary health care level. Mental health specialists are required to provide support to and monitor general health care personnel. Effective referral links between primary, secondary and tertiary levels of care need to be in place. Funds must be redistributed from tertiary to secondary and primary level of care or new funds must be made available. Recording systems need to be set up to allow for continuous monitoring, evaluation and updating of integrated activities (Kumar & Murthy, 2008; WHO, 2008).

The WHO report (2008) indicated that there is a limited number of psychiatrists and availability of an extensive primary health care network in most countries; therefore the only answer will be integrating MH into PHC where all patients will be seen by generalists. Besides the WHO initiatives, there are few studies in developing countries focusing on the integration of mental health into primary health care especially in SA, thus the need for more research. Integration of mental health care into primary health care is regarded as an affordable option to provide mental health care services. Because of the vast challenges and competing needs within the health care systems of most developing countries, mental health is seldom a priority; as a result, policies guiding the development of such services are non-existent. African culture does support community responsibility, which is conducive to mental health, but there is still a need for MH to be part of primary health care (WHO, 2001). Authors like Baasher, Carstairs, Giel and Hassler (1975) and Kilonza and Simmons (1998) argue that African culture does support community responsibility.

Another aspect that should not be ignored is the importance of partnerships with the traditional health sector as this approach facilitates integration of mental health into general health streams. In most developing countries, traditional medicine is flourishing. It caters to a large population and it manages many common mental disorders (Patel, Gwanzura & Simunyu, 1995). These authors believe that formal links

between systems of medicine can make use of their different approaches, which in many ways complement each other and cited that the programme of training of traditional midwives in obstetric services is well recognized and can provide a model for mental health care in the community.

2.7 Models of Integration in South Africa

Many international and national mental health reforms had a major influence in the mental health policy direction in South Africa. Integration of mental health into general health care with the necessary resources and support has been found to be a better option than institutional care. The principles along which mental health reforms were to take place were guided by the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996), which aims at protecting the human rights of all citizens of SA.

The laws and regulations which were amended post 1994 paved the way for the formulation and transformation of mental health policies that promote integration of MH into PHC. The most important legislation that influenced mental health legislative reforms in South Africa is the Constitution of the Republic of South Africa, 1996 (Act No.108 of 1996) and its Bill of Rights, which was promulgated in 1997. These led to the need to be vigilant in efforts to overcome multiple forms of differences and inequality that lead to discrimination and abuse.

There was a need to widen the mental health care capacity base in terms of increasing the rights to prescribe medication, or to take final diagnostic decisions by including general health care practitioners (Foster, Freeman & Pillay, 1997). Allwood and Gagiano (1997) argues that the only way for any country to provide adequate treatment for the mentally ill is to treat them as ordinary patients within the primary health care system. The White Paper on the Transformation of the Health System in South Africa of 1997 and the Mental Health Care Act of 2002 made provision for the integration of mental health into primary health care.

Since 1997, primary care for mental health has been the official policy of the national government. Following the adoption of the national policy, all provinces engaged in

improving mental health services at community level and integrating mental health into primary care. A national programme for training in primary care was developed to facilitate this process. The Primary Health Care Package by the NDoH (2001) that aims at guiding implementation of primary health care services in the provinces includes mental health as one of programmes to be rendered at PHC level. Nurse generalists should be able to identify and manage patients with depression, anxiety, stress-related problems, and severe mental disorders such as schizophrenia and bipolar disorders and be able provide maintenance medication and care for chronic stable patients, as well as to offer basic counselling. All clinics should receive regular visits from dedicated mental health or psychiatric nurses; have 24-hour access to a mental health specialist for consultation; and be able to make referrals when necessary.

It is difficult to put all this theory into practice; progress has been seen in some areas and provinces, the majority of clinics, CHCs, and mobile units now provide mental health services. In other areas, patients must travel to hospital outpatient departments or to other designated clinics to receive mental health care. In some instances, mental health services are provided by a psychiatric nurse, who is available on certain days (WHO, 2008). The WHO further identified some barriers to full mental health integration that include lack of support by general health service managers at all levels, from facility managers to district health managers; shortage of mental health professionals to provide ongoing supervision and support to primary care practitioners. Restrictions that prohibit primary care nurses from prescribing common psychotropic medications and lack of funding to support and sustain mental health services in primary care are also the biggest challenges.

Some of the research conducted on this topic supports WHO and reveal that most of the clinics in SA are unable to attend to patients with mental illnesses, as a result, patients have to travel far to get psychiatric assistance and this may impact negatively on them as they do not have the financial means to travel, therefore may not receive much needed help. Availability of psychotropic drugs is also a challenge; integration

means that the clinics must make available the treatment for those people needing assistance (Mohlaokana, 2003; Ngunyen, 2004).

Decentralization and integration of mental health into primary health care at a district level forms the core of many mental health policies. A situational analysis was conducted in 2010 by the Mental Health and Poverty Project (MHaPP) which was a five year study of mental health policy, legislation and services in 4 African countries: Ghana, South Africa, Uganda and Zambia. This study indicated that such processes are at different stages with varying degrees of success in each country. It was reported that SA provides a greater degree of decentralized care with respect to dedicated psychiatric beds and availability of psychotropic medication at district level but lacks community-based rehabilitation programmes and effective services for de-institutionalized care of patients with chronic and serious psychiatric disorders. This project came up with three areas of intervention: improving policies, plans and legislation for mental health, improving mental health information systems and developing district-based models of service delivery (Desai, Goel & Patel, 2009).

These interventions were undertaken and, in SA, mental health services were integrated into primary health care systems mostly in typical resource-poor districts focusing in capacitating non-specialists to provide mental health care. Following this project, a multi-sectoral community collaborative implementation framework was adopted to improve mental health service delivery at the district level in SA with emphasis on increasing both access to mental health services as well as empowering community members to have control over their mental health. The framework included the establishment of a multi-sectoral community collaborative forum that comprised a number of different stakeholders, this forum has to ensure that services are culturally competent and meet community needs; provide training to PHC personnel in the identification and management of mental disorders appropriate for their level and improve the capacity of community members to identify and manage mental disorders appropriate for their level. Community Health Workers (CHWs) were trained to identify

and refer persons with mental disorders across the three country sites. South Africa also provided training for CHWs in basic counseling skills (Desai, Goel & Patel, 2009).

The WHO, in its report (2008), describes two distinct best practices in providing integrated mental health services and a partnership for MHPHC in SA. The first model for integrating mental health into primary care was identified and conducted in Ehlanzeni in Mpumalanga and varies somewhat from clinic to clinic. Differences depend on multiple factors such as the clinic's size and location, the training and qualifications of its nurses, and the willingness of health workers to participate in the integrated model. Two distinct service models are used. In the first model, a skilled professional nurse sees all patients with mental disorders within the primary care clinic. In the second model, mental disorders are managed as any other health problem, and all primary care workers treat patients with mental disorders. Importantly, clinics have tended to adopt the model that best accommodates their available resources and local needs. From a starting point of almost no MH services at PHC in 1994; mental health services were mainly rendered at hospital level, half of the clinics in the district were providing mental health services by 2002, and by early 2007, more than 80% of clinics were delivering services. Primary care nurses and patients are generally satisfied with the integrated approach (SA Federation for MH, 2009; WHO, 2008).

In the Western Cape Province in the Moorreesburg District, there is partnership in rendering MH care services. General primary care nurses provide basic mental health services in the primary health clinic, and specialist mental health nurses and a psychiatrist intermittently visit the clinic to manage complex cases and provide supervision to primary care nurses. Patients are seen within the same clinic thus improving access to mental health care and reducing potential stigma. Primary care practitioners are generally satisfied with the model and appreciate the regular visits by the mental health nurse and the psychiatrist, who provide ongoing in-service training as well as support for complex cases. It is reported that this model is currently considered as the best model at a provincial and national level for possible implementation in parts of the country with similar characteristics (WHO, 2008).

WHO (2008) asserts that the diversity of these two best practice examples, within the same national policy framework, shows the importance of considering and carefully examining local resources, opinions and needs when designing and implementing mental health services in order to define solutions that are tailored to the specific situation.

It is evident from the above information that smooth policy implementation requires many preconditions and one of them refers to the assessment of resources and availability of resources (Gulhati, 1990). It is also evident from the above studies that skills development in mental health is crucial in facilitating integration of MH into PHC. Petersen (1999) in her study on the integration of mental health into PHC involving clinic nurses in KZN believes that training in mental health empowers nurses to be able to detect mental problems earlier and refer appropriately. Empowering clinic nurses with MH skills instills confidence in them because if they lack skills they will feel helplessness and frustrated at not being of help to patients. The author further explains those logistical constraints such as high patient loads and a lack of privacy in mobile clinics and where there are infrastructural problems, as is always the case in most PHC clinics and posed a challenge to integration (Petersen, 1999).

Different people interpret the process of integrating MH into PHC differently thus this raises a concern. Integration has been narrowly interpreted as only adding psychiatric care to the workload of the PHC personnel; this interpretation has also been common around the globe. There is a need to explain the process to PHC staff and highlight the importance of treating patients holistically. If these misconceptions continue, primary mental health care will be compromised, and comprehensive, integrated primary mental health will remain just a dream (Petersen, 2000).

SA has well designed policies, but implementation of these policies remains a problem. It is believed that implementation problems can be influenced mainly by lack of various resources, like trained human resources, infrastructure as well as finance (Cloete,

1995). Mokgoro (1997) posit that the main challenge facing the country in terms of policy is that the existing necessary technical, institutional and human resources capacity is not used to enhance sustainable implementation to the policies that are in place.

Although there are demonstrated advantages of integrating mental health into primary health as explained in a section of the study; there is very little progress made in implementing the policy worldwide. It is essential to also look into other issues that may impact positively or negatively on the transformation process.

In a study conducted in the Free State on evaluation of Mental Health Services where clinic nurses were interviewed, it was revealed that MH services are still run vertically because visiting mental health teams continued to take the main role in patient care, PHC nurses lack mental health skills, no supervision is done by MH teams and, of course, nurses need to have positive attitudes towards taking greater responsibility for mental health care work and training is required to increase their scope of practice with regard to drug use and management (Freeman, Lee and Vivian, 1999). All the studies discussed have shown a need for training of PHC staff and support by MH specialists for integration to be successfully implemented.

2.8 Theoretical Framework

2.8.1 Integration of MH into PHC as Change Process

The White Paper for the Transformation of the Health System in South Africa is a strategy aimed at transforming the health system of SA post 1994. This also led to policy changes in MH legislation, thus needing people in organization to do things differently. The strategy is aimed at bringing about change by decentralizing the mental health services to the lower levels of health care in order to improve access; this means integrating MH into PHC which is the lowest level of care. After 1994, SA set about reforming its outdated apartheid-era mental health legislation, thus the promulgation of the MHCA (No 17 of 2002) in 2004. This legislation was a major step taken to change from the past and the thrust of this act is community care which also contributes to us considering integration of MH into PHC as policy issue requiring change.

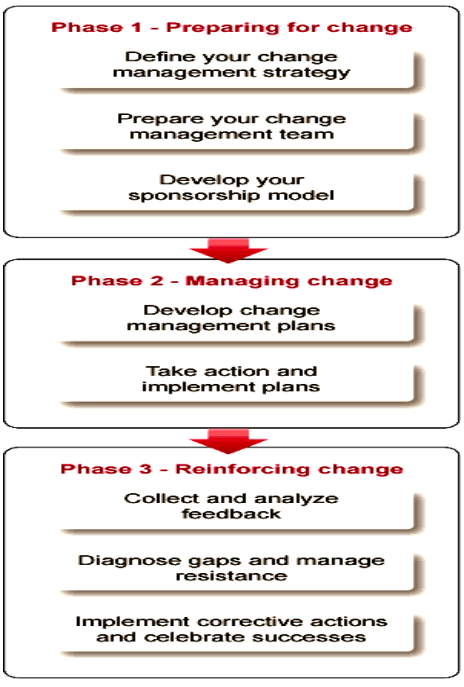
For any change to be implemented successfully, it is important to communicate the change properly to those who are responsible to ultimately execute the change. For implementation of integration of MH into PHC to be successfully managed as a change process, it is advisable to apply simple principles as suggested by scholars and experts on change management like Kotter (1996). Kotter (1996) suggests that successful change process involves thoughtful planning and sensitive implementation. Consultation with, and involvement of, the people affected by the changes is crucial. If you force change on people normally you will meet with resistance. Change must be realistic, achievable and measurable. Before starting any organizational change, one needs to set objectives and state exactly what one wants to achieve with this change, why, and how will we know that the change has been achieved and who will be affected by this change, and how will they react to it? How much of this change can we achieve ourselves, and what parts of the change do we need help with? These aspects also relate strongly to the management of personal as well as organizational change (www.strategies-for-managing-change.com/change-management-theories.html).

Any policy naturally follows the formal channels of communication within the organization. Any policy has to follow official paths prescribed by management and generally follows the organization's chain of authority. Ivancevich, Lorenzi and Skinner (1994) explain that there are different ways which can be used to communicate information within the organization; information can be communicated downward, upward, or horizontally, and can be oral, written or non-verbal. Usually and mostly policies are disseminated down the organizational hierarchy from managers and supervisors to subordinates in the public or government sector through use of memoranda, circulars, protocols, procedure manuals and other formal instructions, like job descriptions - subordinates are often just told what is expected from them. This type of communication is not always adequate because employees may need more information than just a job description; explaining exactly the roles of other sections. In the case of integration of MH into PHC, the roles of all sections in the districts should be clearly defined. Nevertheless, downward communication from senior managers can

leave employees misinformed, feeling disconnected, and less satisfied with their work. (Ivancevich et al., 1994)

Ivancevich et al. (1994) further explain that most policy statements or guidelines communicated by means of a downward communication can be inadequate to guide the necessary policy implementation and institute the desired change. This is mainly due to the absence of implementation plans or step by step procedure guidelines to close the gap between policy and implementation. As explained above, the manner in which change is communicated is an important determinant to acceptance or resistance to that change. The PHC personnel are expected to implement the integration process; therefore it is crucial that policy issues are communicated properly to them. This will help to link change, as an issue emanating from policy which requires commitment to implementation. Consultation before implementation of any change is crucial. Engaging people who are meant to implement change is important because they will be committed and become part and parcel of the transformation system (Kotter, 1996). Ivancevich et al. (1994) suggest steps to be followed in managing change effectively that involve preparing for change, managing change and reinforcing change. This process involves carrying out change in phases.

Figure 1: Management of change



Adapted: from www.strategies-for-managing-change.com/change-management-theories.html - retrieved 17/05/2013.

When instituting change, the organization has to consider the type of change needed. Lussier (1994) argues that the organization should specify exactly what the organization will actually be changing. The author further explains change can involves strategy, structure, technology or people. Many organizations fail to implement change because they tend to concentrate on a particular change in isolation, rather than looking at the whole system as each variable influences the other, these variables are intertwined. A change in strategy results in a change in structure (Lussier, 1994). In a health system, changing any policy may result in requiring additional resources or adjustments as the case may be in integrating MH into PHC; PHC personnel have to be trained in MH to be able to detect mental illness early. In order to achieve the goal of integrating MH into PHC; it was important for the National Department of Health to institute change from a non-effective strategy of centralization of the MH services to an effective one of decentralization in order to improve access. But change itself has intended and unintended consequences, which is one of the objectives of the study.

General hospitals have to undergo physical restructuring to accommodate the mentally ill as required by the MHCA (2002), so do the clinics. Specialized Mental Health care personnel have to play a role of being consultants, supervisors, and mentors and offer technical support to the PHC staff. Districts have to ensure that there are complete MDTs as a requirement in order to support the periphery in mental health care, a situation that is difficult because of scarcity of psychiatrists and allied staff within the district.

As indicated above that any change in one aspect can directly or indirectly impact on the other variables, thus a change in structure will definitely impact on technology. The added workload in clinics requires the latest methods in data capturing and processing. Personal details of consumers require to be captured including diagnosis and its classification and medicines control. More management devices are required to deal

with the amount of information generated including linking with the central health information system, for example computers with all the relevant software including email, fax machines and photocopiers. Most of the clinics in Gauteng do not have computers and information is still captured manually and there are no data capturers especially to capture data at the specialized psychiatric clinics (MHD, 2011/2012). Change in structure and technology will definitely affect the way the employees perform their daily tasks. This change will require a change in people's skills, knowledge, attitudes and performance. People are the most important resource in any organization. The impact of change on people is of priority to ensure success in a change process (Lussier, 1994).

In managing change, the organization has to establish how this change will affect both the technical and social aspects. The technical aspect affects the physical routines of the job thus resulting in changes in that area, whereas the social aspect of change refers to how those affected by change may think it will alter their established relationships in the organization. The nature and size of the technical aspects of the change does not determine the presence or absence of resistance nearly as much as does the social aspects of change. This may be the case in the integration of Mental Health into primary health care where general health care workers face an additional workload that will definitely change their social relationships, especially where no additional staff was allocated to assist with the added responsibilities. Nevertheless, one of the benefits in integrating MH into PHC as indicated by the WHO (2001), is that no additional staff is required at PHC to accommodate mentally ill people but MH skill are essential. Social relationships may be affected in terms of extended hours of work, reduced lunch and tea-time, rescheduling of leave and cancellation of study leave. These are some of the aspects of change that the study seeks to identify in order to come up with appropriate recommendations to these challenges (Dalton, Lawrence & Greiner, 1970).

When instituting the technical change, it is important to develop a natural respect for the knowledge and skill of functional personnel. Health as a sector consists of diverse

specialties and specialists, who possess scarce skill and are very difficult to replace once lost. As indicated in this study that some studies done on this topic have revealed the shortage of psychiatrists in most of the developing countries, thus it is important for the organizational leaders to manage people properly. Most psychiatric specialists are highly sought after in the private sector and internationally. Management is sometimes engrossed and pressurized in bringing about change and became insensible of the different kinds of things that may be bothering people. Hence the above mentioned authors conclude by indicating that the social aspect of change is what determines the presence or absence of resistance to change (Dalton et. al., 1970).

Within mental health itself, there is a dramatic transformation in the approach to mental health care that has ethical, social and legal implications that are quite stressful to the health care workers. The area of mental health has been neglected for a long period, thus making it difficult for provinces with very little or no resource base, to support such a transformation process as required by both The White Paper on the Transformation of the Health Care System in South Africa of 1997 and the MHCA of 2002.

To facilitate any change, the leaders should consider those who need to implement the change and keep them informed of the change. They want to be informed of the reasons behind a decision so that they can understand its logic and how it fits the wider picture. They want to have some input into deciding what should be done through participating in the decision making process. This is the important aspect of change that may have been overlooked in communicating the integration of mental health care into PHC (Ivancevich et. al., 1994).

Most authors argue that managing change is complex, because it is often accompanied by unforeseen challenges. Change should be regarded as a rational step-by-step process, no one method can be sufficient. One of the key problems resulting from the change process is the way change is communicated to those who are entrusted with the responsibility of executing the change process (Carnall, 1995). Most people are more comfortable with the traditional way of doing things; thus introducing new things may

threaten stability resulting in resistance. It is therefore important to look into resistance to change in explaining some of the problems experienced in the integration process.

2.8.2 Resistance to change

People resist change due to many reasons. Lussier (1997) argues that uncertainty resulting from fear of the unknown related to outcome of the change is one the major reasons. In the case of PHC, nurses who have not worked in psychiatric hospitals and worse those not trained in MH, it is a fact that they will fear mentally ill people because of lacking skills to manage them. Inconvenience can result from the reluctance on the part of the employees to disrupt their routine due to comfort. One of the conditions for the integration of Mental Health into primary health care is skill development among the primary health care workers that mean additional work in terms of learning. Self-interest results when employees are more concerned about their best interest rather than that of the organization. To some primary health care nurses, adding mental health care to their routine work is regarded as an unnecessary workload and as such, a burden rather than improving access to the services (Lussier, 1997).

Some employees fear that with change, their jobs might be lost or a change in the work schedule may occur, with the resultant loss of social relationships. It has been a concern by those health care workers who have specialized in Mental Health care that integration may reduce the recognition of their specialization to an extent that they might find themselves performing general health care duties. Loss of power results in an actual or perceived loss of power, status, security and especially, control. As a result, employees may resent the feeling that someone else is controlling their destiny. It has been a common perception by mental health specialists that mental health is a specialized area and as such, cannot be practiced by any health care personnel who do not hold the necessary qualifications. Hence the appeal by WHO to psychiatrists in the United Kingdom, to work closer with the primary health care services (Bouras et al., 1986)

Dalton et al. (1970) posit that some of the problems of resistance to change are due to negative attitudes toward the introduced change. The responsibility lies with

management to influence these attitudes and deal with the problems of their source. Although when resistance does appear, it should be thought of as a symptom of a bigger problem. It requires those in leadership to carefully define the real problem in order to come up with the most appropriate solution. The study has looked into indicators of resistance to change and the appropriate recommendations to address these challenges. Some of the individuals rationally understand the need for the change, but emotionally fail to adjust to the new situation. Such subordinates require support it they are expected to cope

Access to information by those in the leadership put them at a competitive advantage in comparison with the employees when it comes to understanding contextual issues driving change. Policy makers and those who manage mental health services understand the need for change better than the primary health care nurses at the operational level who at times have never seen such policies nor understand the reasons behind the transformation process in Mental Health care (Dalton et al., 1970).

In order to manage change, various processes of change have been explored and might assist in implementing the integration process and contribute to recommendations to future efforts to roll out the integration process. According to most literature, two people that have contributed immensely in terms of change management theories are John M. Fisher and John Kotter. Fisher's Process of Transition model explains how people respond to change and his work is based on earlier studies by Elisabeth Kubler-Ross who identified five stages of grief but Fisher went further by identifying eight stages that people follow in succession through a change process; he explains that people go through stages of anxiety and denial, happiness, fear, threat, guilt and disillusionment, depression and hostility, gradual acceptance and moving forward. Some people move more quickly through the stages than others, depending on their temperament, life experiences, degree of control and so on. People may regress to an earlier stage depending on their situation.

Therefore it is vital for the health Managers to consider these factors when introducing change like integrating MH care into PHC services. To effectively manage the change process, the leaders should be able to plot where people are on the transition curve, and respond appropriately to support the people who are expected to execute the change. Timing is extremely important when managing change. If you attempt to force change through before the majority of people are ready, then the change is not likely to be as effective in the long term.
www.strategies-for-managing-change.com/change-management-theories.html

Kotter (1996) suggests that bureaucratic culture, a low level of trust within the organization, lack of team work and leadership skills within middle management also hinder effective implementation of change. The author further suggests that creating major change in an organization requires putting together a team with enough power to drive the change process, establishing a sense of urgency and assisting with the assimilation of the new changes as part of the organizational culture, developing a vision that will direct the change effort and strategies for achieving the vision, communicating the change vision using every vehicle possible by constantly communicating the new vision and role modeling the expected behaviour to employees, empowering broad-based action by getting rid of obstacles, changing systems or structures that undermine the change vision, appointing, promoting and developing people who can implement the change vision and developing better leadership and more effective management including good succession plans is also vital (Kotter, 1996).

Most authors of the change process literature share a number of common features in the change process, especially stakeholder involvement, needs analysis, creating a sense of urgency, gaining broad base support, empowering those involved in the change process, development of implementation plans, including monitoring and evaluation. Consultation, participation and consensus play a vital role in the change process. Resistance to change is regarded as neither good nor bad, but as a symptom to existing problems that can be resolved if correctly identified.
www.strategies-for-managing-change.com/change-management-theories.html.

The study seeks to obtain information that may indicate the presence of resistance to change in the implementation of the integration of mental into primary health care as stipulated in the White Paper on the Transformation of the Health System in South Africa and the MHCA of 2002.

2.9 Summary of the Chapter

This section presented a review of literature relevant to the area under study and is very important because it gives more insights that may help integrating MH into PHC more effectively in SA. Theoretical background for this study was done, giving the overall view of integration of MH services in general health globally. Main concepts were defined. Experiences of both developed and developing countries were presented, highlighting good practices which can be adopted by SA. Some South African models of integration were presented, indicating that it is possible to implement integration process using different models.

Views of different authors on change were presented to demonstrate integration of MH into PHC as a change process and indicating how to deal with resistance to change. Many studies have been done on integration of MH into PHC in the United States, the United Kingdom and Australia yet few studies have been done in African countries, especially SA. Therefore, there is a need to do research on how best MH care can be integrated into PHC services utilizing the minimal resources. According to literature, there is still a lack of support from specialized MH personnel to the PHC staff and negative attitudes by PHC staff. The review provides the basis on which the research problem is premised and indeed a theoretical framework to guide this enquiry. In general, the literature shows how critical and important is the integration of mental health into general health and the need to treat people holistically with dignity and not discriminate against mentally ill persons.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

This section presents the research methodology applied in the study and describes how the research was conducted. This includes the research approach, the research design, data collection methods and data analysis including validity and reliability of data collected. Research methodology is defined as the process that the researcher will use in collecting data and whereby the researcher draws meaning from the experiences and perceptions of participants (Creswell, 2009; De Vos, 1998). The study used a qualitative method of research to enable the researcher to interpret the exact challenges experienced by the health professionals in PHC settings working with the mentally ill patients, what their views with regard to mentally ill persons and the integration of MH into PHC are, and what are the suggested solutions to the problems.

3.2 Research Approach

The study used a qualitative research approach in order to investigate the reasons why integration of MH into PHC is slow and lagging behind other districts in Gauteng. This approach allowed the researcher to go deeper into the issue or phenomenon under study and the researcher was able to probe for more information. As such, a qualitative approach has been chosen to help gather detailed and in depth information on the problem. In using a qualitative approach, the researcher gets to involve respondents during data collection, getting to understand the situation better (Creswell, 2009). One of the distinctive characteristics of a qualitative research approach is that it enables the researcher to understand the meaning of what participants are trying to construct about their experiences. Qualitative research has been described as an effort in understanding situations of participants in their uniqueness within the context of the research (Merriam, 2002). The researcher was able to observe the respondents and how they responded to questions posed to them.

3.3 Research Design

The case study as a research design was used to understand why the integration process is slow in this district in order to identify challenges facing the health professionals re integration of MH care into PHC services. White (2002:40) defines a case study as, “an extensive study of a single situation such as an individual, family or organization”. In this case, JHB Metro district is the unit or organization under study. A case study has features of being both exploratory and descriptive and provides more detailed information. In this case study, some quantifiable information such as the number of health professionals as well as the number of those trained in MH was gathered, in order to gain more insights about poor integration of MH into PHCs in JHB Metro district.

Yin (1994) explains that a case study provides the researcher with an understanding of the meaningful characteristics of real events, provides empirical evidence and complexity that can be easily understood. Merriam (2002:11), in describing a case study, states that “it is the unit of analysis that determines whether a study is a case study which defined the case”. This case study is unique and would be representative of the health professionals working in PHC settings in JHB Metro health district. The results could be used to assist the department in redesigning and improving policies as well as a support system. The researcher used the case study in understanding the challenges that are experienced by health professionals working in PHC settings in JHB Metro health district through in-depth interviews where participants were interviewed one by one. Case study findings cannot be generalized, as asserted by Merriam (2002). Hence, the challenges that are experienced by health professionals working in PHC settings in JHB Metro health district may not be concluded as the case for all other districts within Gauteng or other provinces. Therefore, in this research a descriptive contextual exploratory research design was followed because exploratory research often relies on secondary research, such as reviewing available literature and/or data, and more formal approaches through in-depth interviews and the JHB Metro district was used as the case study (Merriam, 2002).

3.4 Data Collection

In-depth interviews were used which allowed for deep understanding of the issue between the researcher and interviewees. The interview question guide was used and the topics covered included information on the total number of health professionals in each selected CHC as well as their qualifications in mental health. This guide comprised open-ended questions which enabled the researcher to gain a deeper understanding of the phenomenon. Consent from the interviewees was obtained prior to interviewing them. The participants were asked questions relating to how they perceive integration of mental health into primary health care services, the challenges they are experiencing with regard to the integration of Mental Health into primary health care and also challenges with respect to the requirements of mentally ill patients and the available knowledge and skills to carry out the new responsibilities as well as the solutions to these challenges.

The one-to-one interviews lasted for one hour as it required participants to express their views on the issue at hand and to allow the researcher to probe further for better understanding. Semi structured interviews with purposively selected participants from selected PHC clinics were the main source of data. In the process of data collection, the researcher carefully read through the interview questions and responses by the interviewee to ensure that the main issues had been captured, as suggested by Leedy and Ormrod (2005). For the purpose of getting more information to back up the information given by the participants, it was vital to collect secondary data. In this research, secondary data was collected through document reviews such as patients' registers and statistics records. Secondary data is important in research as it contains information which is easily available and can be used to confirm data from interviews (Leedy and Ormrod, 2005).

3.4.1 Sampling

Neuman (2006) defines a sample as a small collection of units from a larger collection or population, such that the researcher can study the smaller group and produce accurate generalizations about the bigger group. In this research, purposive sampling, also referred to as non probability sampling, and commonly used in qualitative research

was used, as it focuses on sources that can give most information and hence a good understanding of the problem. The type of sampling was suitable for the study because it mainly focused on the health professionals; multi disciplinary teams as well as Managers working at the 10 Community Health Care centres in JHB Metro district that provide 24 hr services.

From the 10 CHCs namely; Alexandra, Chiawelo, Discoverers, Lenasia South, Lillian Ngoyi, Hillbrow, Itireleng, Mofolo, Stretford and Zola clinics; Discoverers, Chiawelo, Mofolo and Zola CHCs are partially integrated but the other six have not integrated MH into PHC. From the four partially integrated CHCs, the Researcher utilized two CHCs namely Discoverers and Zola. One (1) PHC nurse generalist and one (1) PHC doctor in Zola CHC and one (1) Psychiatric trained nurse and one (1) psychiatrist from Discoverers CHC were interviewed. From those not integrated at all the researcher interviewed one (1) Occupational Therapist and one (1) psychologist from Hillbrow CHC as well as one (1) Social Worker and one (1) PHC nurse from Alexandra CHC. Two (2) Managers from these CHCs, one from Discoverers which is partially integrated and one from Hillbrow which is not integrated were also interviewed. As training of PHC staff is key to facilitate integration of MH into PHC; the Provincial training facilitator was also interviewed. The size of the sample consisted of eleven (11) people covering all members of the multi-disciplinary team. Participants have experienced challenges on different levels and were all willing to answer questions during interviews; they were even willing to offer solutions to the challenges and help achieve the departmental mandate.

3.4.2 Primary Data

Interviews were used in this research in collecting data that was relevant to the research questions and purpose of the research (Saunders, Lewis & Thornhill, 2003). Semi-structured interview questions were used by the researcher in this study. A semi-structured interview contained sub-questions and probing questions as suggested by Merriam (2002). Open-ended questions were used in this research because they enabled the researcher to gain in-depth information which led to probing questions. Ghauri and Gronhaug (2010) suggest that primary data is so beneficial because data is

collected from the main source in answering questions pertaining to that particular problem. However, amongst its limitations, it is time consuming and a cost burden. Thus, it was vital that before conducting the interviews, the researcher briefed and introduced the purpose of the research in order to gain the informed consent and confidence of the interviewees.

The purpose of the interviews was to investigate factors that led to challenges that are experienced by health professionals in order to recommend strategies for consideration to improve access of mental health services to all citizens. Much as the study is descriptive, it is also intervention focused. The study attempts to identify the existence of a problem, give an explanation to why the problem exists and provide recommendations to improve service delivery.

3.4.3. Secondary Data

In this research, secondary data helped to review and analyse documents from GDHSD Strategic Plan (2009- 2014) and APP (2008), MHD business plan (2008) and annual report (2011/12) as well as the Staff Establishment documents of relevant CHCs (2011/12). Secondary data was also collected through document reviews such as patients' registers and statistics records. Secondary data helped the researcher to gain more knowledge and understanding of the issue under study in-depth based on the primary data (Craig & Douglas, 2000 quoted in Ghauri & Gronhaug, 2010). Merriam (2002) emphasized that the strength of documents as a source of data is because they do not alter the setting of the researcher but would be essential in collecting data through interviews and observations (Merriam, 2002).

3.4.4. Presentation of the Research Findings

Data collected was presented using graphs to present the number of personnel working in the identified CHCs and their skills in MH, views of respondents on integration as well as describing the challenges they anticipate or have experienced in integrating MH into PHC in JHB Metro health district

3.5 Data Analysis

Data analysis is an essential part of qualitative research. Analysis of data started with the first interview, observations on site and analysis of documents accessed within data bases in relation to the study (Merriam, 2002). The researcher studied the data to gain understanding whether participants were answering the research problem. This allowed the researcher to take note of the emerging themes and concepts thus categorizing them with the next data; in order to avoid being overwhelmed with lots of data. Creswell (2009) asserts that the heart of data analysis is in the formation of categories. The emerging themes were similar in all participants.

After categorizing the data, the researcher managed to organize it into folders and went through the data collected several times. This made it possible for the researcher to identify the themes and sub-themes, integrating and summarizing the data. Later, the data was analyzed using literature reviews and the theories to make sense of the findings (Leedy & Ormrod, 2005). The researcher followed the following steps as suggested by Leedy and Ormrod (2005): The questions were designed and tested; interviews were carried out on different participants by recording, transcribed and coded according to responses within the questions. Thematic analysis was carried out and lastly interpreted.

3.6 Validity and Reliability in Research

3.6.1 Validity

Neuman (2006:188) asserted that "*validity suggested truthfulness. It refers to how well an idea "fits" with actual reality"*. Data was validated by member-checking that ensured accuracy of the findings hence themes were taken back to the participants to determine whether the data given was accurate enough (Creswell, 2009). Through this method, the interviewees were able to express and explain challenges freely hence giving a chance to the interviewer to seek for more clarification where this need arose. In order to ensure validity, the researcher compared information using different sources; empirical data, responses from the all eleven participants and strategic documents from GDOH. The secondary data was also useful to validate the collected data that it yielded

unbiased information concerning the desired outcome. Closed and open-ended questions were used to gather data on qualifications, information on skills, resources, attitudes and knowledge. Open-ended questions were used to solicit information with regard to challenges and other related perceptions.

3.6.2 Reliability

Neuman (2011) asserted that reliability is the consistency and dependability of data. It is suggested that the same thing recurs under similar conditions. The main focus is on challenges experienced by health professionals working at PHC settings in JHB Metro. Reliability is defined as consistency in the findings over time and accurately representing the total population under the same method and the instrument should be reliable (Golfashani, 2003:598). Reliability was addressed by making sure research and investigative questions are consistent in meaning across all eleven (11) participants, delivered objectively. The analysis of this research was informed by responses from the eleven (11) participants. However, information obtained cannot be generalized to the entire population of the Province.

3.7 Summary of the Chapter

This chapter presented the methodology used in the research and adopted a qualitative approach and case study research design. Both primary and secondary data were collectively used in investigating challenges experienced by health professionals using interviews and document reviews respectively. Purposive sampling which is a non-probability method was used in selecting a sample of eleven (11) health professionals working at the CHCs in JHB Metro health district. Reliability and validity was enhanced through the data collection methods maintaining accuracy and consistence

CHAPTER 4

FINDINGS

4.1 Introduction

The data was recorded, and then transcribed manually for the analysis. Chapter four will present the responses of the participants, as obtained in the interviews. This showed that the analysis was built on understanding the main research questions which were focusing mainly on how integration of MH into PHC services is perceived by the health professionals; what were the challenges facing the health care personnel regarding integration as well as the requirements of mentally ill patients and the available knowledge and skills to carry out the new responsibilities.

The interview guide and the research questions were used by the researcher in guiding the participants, in order for the researcher to understand the phenomenon of why there are challenges regarding integration of MH into PHC. Questions included the number of health professionals in all selected CHCs and those with skills and knowledge pertaining to MH issues.

The findings are presented according to the questions as grouped in Appendix A

4.2 Results (Section A)

4.2.1. Professional categories as well as training in MH

In Section A, the questionnaire covered the total number of Registered nurses, doctors and allied staff working in each of the four identified CHCs, their qualifications as well as their training in mental health even if is a short course.

Table 3: Number of Registered Nurses in the Facility

	PARTIALLY INTEGRATED		NOT INTEGRATED	
	Zola CHC	Discoverers	Hillbrow	Alexandra
Total Registered Nurses (R/N)	62	65	80	75
R/Ns without Psychiatric Qualification	22	34	37	35
R/Ns with Psychiatric Qualification	40	31	43	40
Trained PHC Nurses	12	18	20	30
Trained PHC Nurses with Psychiatric Qualification	7	8	10	14
Trained on 10 Days MH Module	10	11	15	0
R/Ns without Psychiatric Qualification – have not attended 10 DAY MH Module	7	13	12	19

Graph1: Registered nurses and training in MH training in each CHC

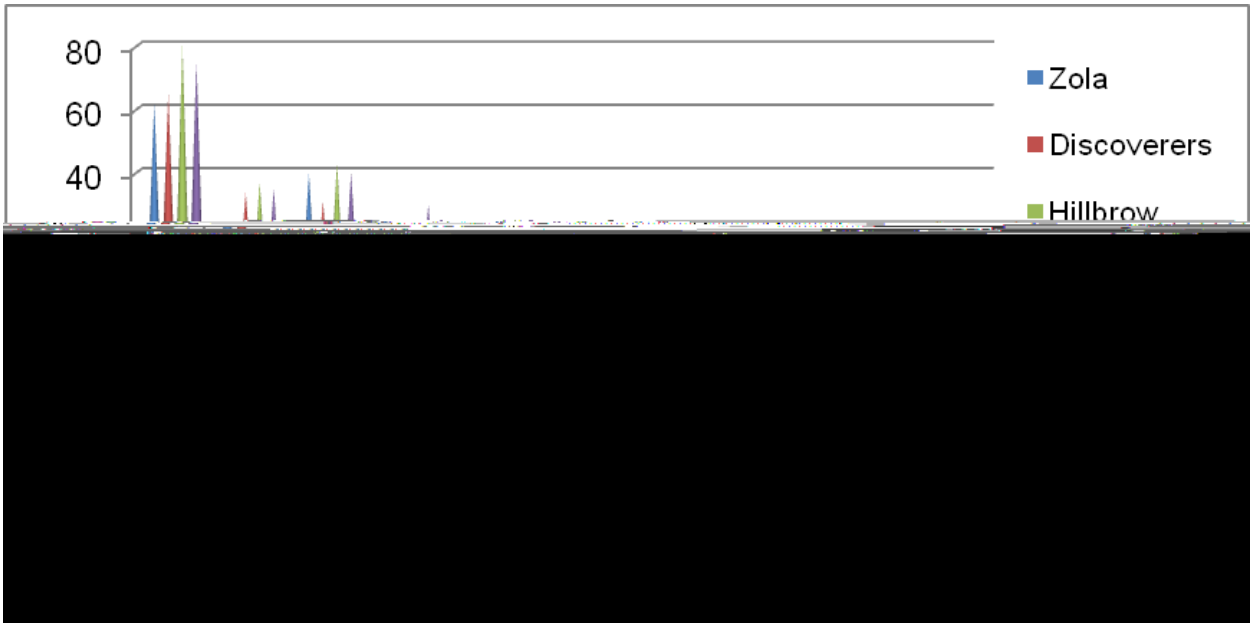


Table 4: Number of Allied Staff in the Facility

	PARTIALLY INTEGRATED		NOT INTEGRATED	
	Zola CHC	Discoverers	Hillbrow	Alexandra
Psychologists	2	3	3	2
Intern Psychologists	3	2	2	0
Social Workers	2	3	4	5
Occupational Therapists	2	2	2	3

Graph 2: Allied staff in each CHC

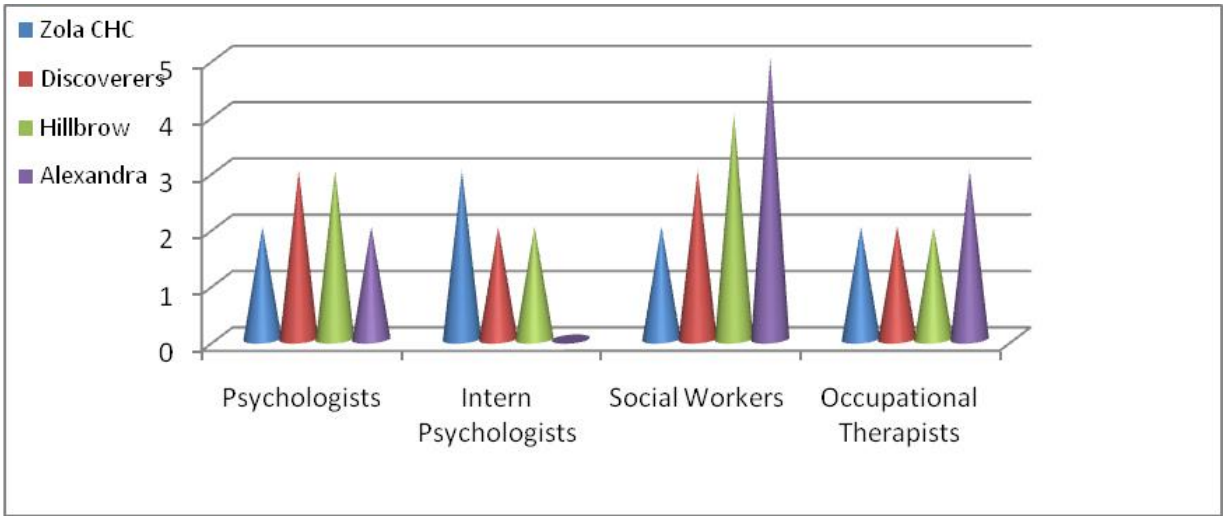
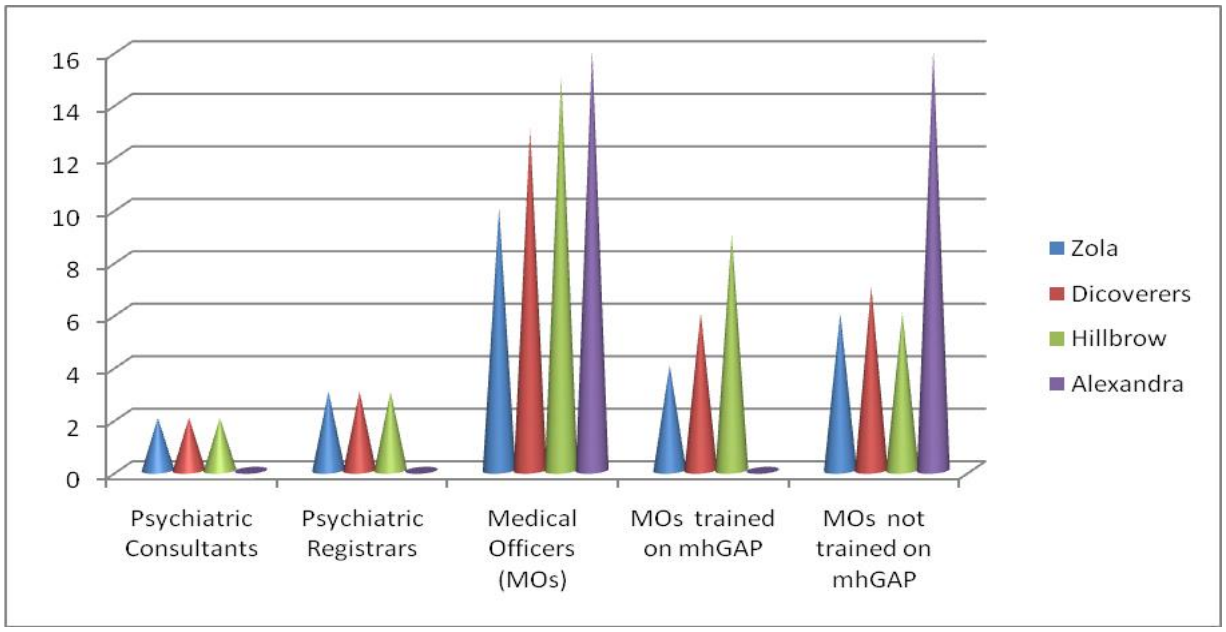


Table 5: Number of Medical staff in the Facility

	PARTIALLY INTEGRATED		NOT INTEGRATED	
	Zola CHC	Discoverers	Hillbrow	Alexandra
Psychiatric Consultants	2	2	2	0
Psychiatric Registrars	3	3	3	0
Medical Officers(MOs)	10	13	15	16
Medical Officers trained on mhGAP	4	6	9	0
Medical Officers not trained on mhGAP	6	7	6	16

Graph 3: Medical personnel and MH training in each CHC



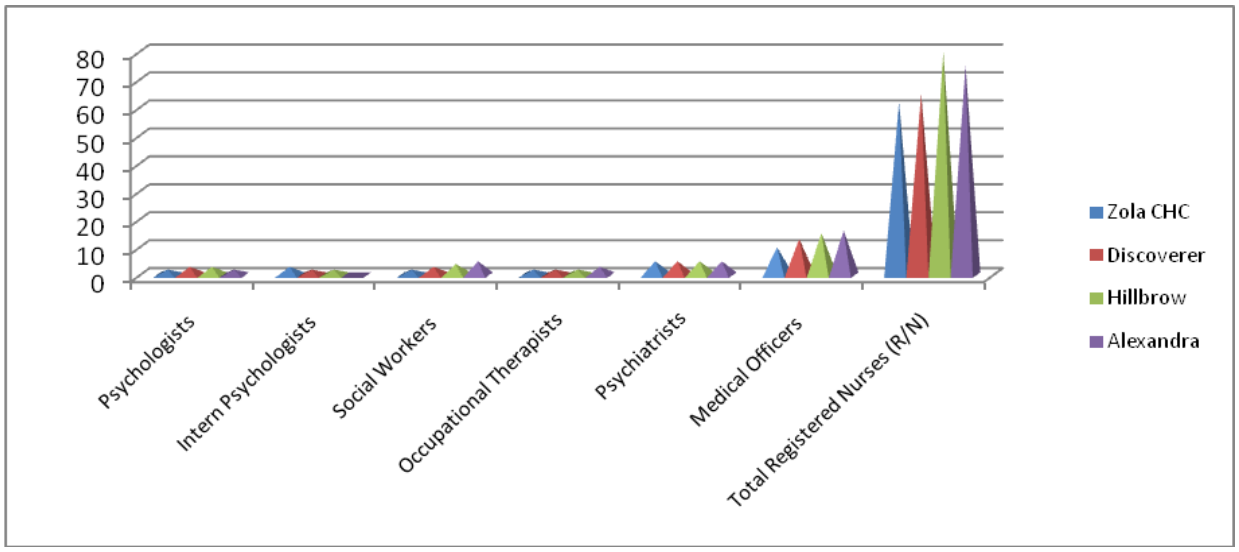
4.2.2 Human resource per Professional category

This section is important, for any facility to operate effectively it is important to assess the total number of the human capital who will contribute enormously in the achievement of the objectives of each and every programme within the identified CHCs including MH.

Table 6: Human resource - Professional category

	PARTIALLY INTEGRATED		NOT INTEGRATED	
	Zola CHC	Discoverers	Hillbrow	Alexandra
Psychologists	2	3	3	2
Intern Psychologists	3	2	2	0
Social Workers	2	3	4	5
Occupational Therapists	2	2	2	3
Psychiatrists	5	5	5	5
Medical Officers	10	13	15	16
Total Registered Nurses	62	65	80	75

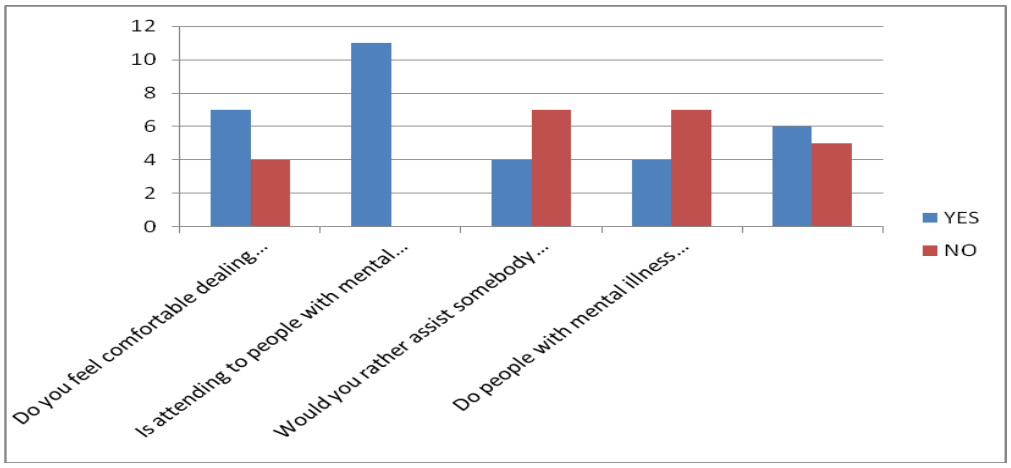
Graph 4: Health workers per professional category in each CHC



4.3 Results (Section B)

This section presents the findings of all respondents on their views towards mentally ill persons. The respondents were asked whether they feel comfortable dealing with mentally ill patients and if "no", they had to indicate why. The questions according to the questionnaire and findings are plotted in the following graph:

Graph 5: Views towards mentally ill persons



These are some of the reasons stated by the PHC staff: *"...we feel comfortable with the more stable patients but in general mentally ill people are unpredictable and cannot be*

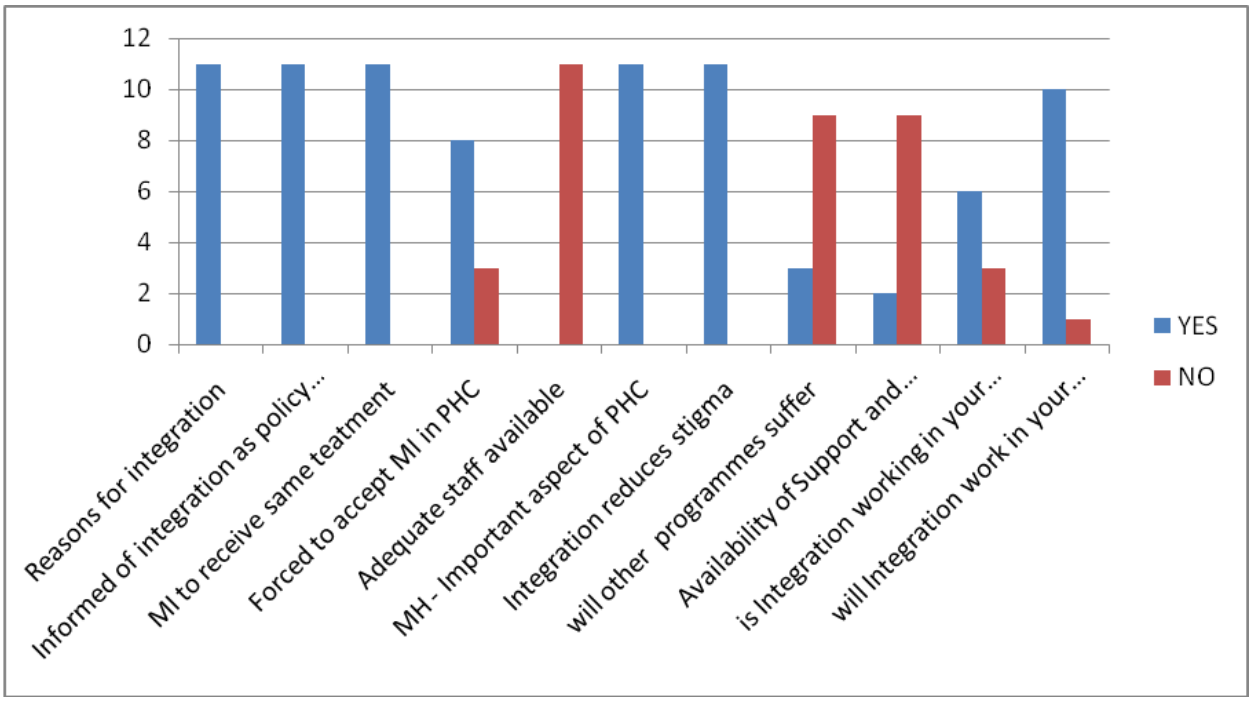
trusted especially if one does not possess the skills to look after them". "*All doctors have theoretical background on MH but somehow lack experience due to non exposure to dealing with mentally ill persons*". The MH practitioners expressed that they are comfortable in dealing with the mentally ill as this is their specialty. Provincial MH Training facilitator expressed herself and said *"…the PHC nurses are not willing to put learned skills into practice because most of them are trained in MH and others have undergone the 10 days MH Module training".* The specialized team felt that it is important to treat mentally ill people like any other person suffering from a physical problem. In that way the mentally ill people will respect you and will not display any aggressive behaviour unless he/she is psychotic, needing treatment.

4.4 Results (Section C)

4.4.1. Experiences of the Health Professionals on integration

This section presents the findings of all respondents on their experiences on integration. The questions as listed in the questionnaire were asked and responses of all the eleven participants are plotted in the following graph

Graph 6: Experiences on integration



4.4.2. Views of the Health Professionals on Integration

The participants responded by saying that integrating mental health into primary health care is a good strategy to improve access to mental health care services.

These are some of the responses from the personnel not trained in mental health "*…integration does not only improves access to the mental health services but also offers the mentally ill an opportunity of receiving treatment in their own communities".* : *"…access should correspond to the quality of the service, it does not mean showing up at the clinic and finding nothing in terms of the prescribed medication at the clinic".* They supports the WHO initiative to integrate MH into PHC; and believe that for integration to be successful, the services should be provided by skilled and committed nurses who understand the needs of the mentally ill and who know how to address them to deliver the services. Most importantly, the necessary medications should be available at all times. The social worker emphasized the benefits of integration and indicated that integration aims at dealing with the stigma attached to mental illness. "*There should be no segregation of patients; all users to be in the same queue and only referred if they cannot be managed at PHC level*". One of the PHC nurses argued that her views regarding integration is that all the primary health services should be available in the clinic but be delivered by different people skilled in those areas and was supported by the psychiatric nurse who believed when interviewed that she believes that MH is a specialty, but feels they can see the new cases and all the difficult ones but PHC nurses should be able to screen, assess and managed simple cases.

All the participants raised an important issue that the process was not well communicated to the role players. They indicated that integration as strategy to implement policy and bring about change requires the involvement of all stakeholders. *"…integration is interpreted in three different ways, firstly it is said to mean one nurse at the clinic performing all health care functions including mental health. The second version relates to all services in a facility; delivered by different nurses in areas that they are most skilled in. The third version regards services delivered at the clinic on different days, for example, child health services on Mondays, Mental health care on Tuesdays*

etc. With people interpreting integration differently; this poses a problem as implementing the process will not be standard in the province; making difficult for those who suppose to implement the process."

The strong feeling from all participants was that integration of mental health into primary health was not well communicated to those responsible for its implementation and hence no clarity to what needs to be done and how to do it. One of the PHC nurses said: *"…people need to be properly informed of any change as to be able to participate effectively".*

The Psychiatric Registrar said *"We need to ask ourselves what the benefits of the policy are. If the aim is to improve access to the mental health services we need to work hard to achieve that. All who are involved in the implementation need to understand the process well and be informed what are resources needed and those available to undertake this change. How will we know that we are on the right tract? How will we know when we are there? We can have the best personnel but if there is nobody to ask such questions and answer them we are nowhere."*

The allied staff felt that they are always side lined and were not given any information regarding their role as part of the MDT on integration. Limited information paralyses one and makes one passive. They said that: "…*information on integration should be disseminated to an extent that it forms part of our daily terminology in mental health and this will keep people informed and clear all the confusion."* According to their observations in all clinics where down referred patients are seen *"…integration refers to one community mental health nurse attending to all mental health patients in the various clinics without any help from other nurses. This is an extension of the specialized MH service which is offered at the secondary level not integration".* This leads to mental health service users refusing to be attended to by any other nurse except that particular one. This can lead to problems when the nurse is unavailable.

The PHC nurse from the partially integrated CHC commented that most of the mental service users are angry with the situation because they have been put in the hands of

nurses who do not understand them and thus prefer somebody who is conversant with their health problems; i.e. the psychiatric nurse at the secondary level. The PHC staff felt that managers are more concern about pointing fingers to those who are failing to see MH patients, instead of supporting them so that they can have a good start. All respondents agreed that the will to implement integrated mental health services is there among clinic nurses but inadequate resources hamper it. The question raised was how to address the negative attitudes of those refusing to participate in the care of the mentally ill, because currently the output and performance of most of the clinics is low. Patients are referred straight to the specialized/ secondary level unit or hospital without the slightest effort to assess their problem, which add more stress to the patients in terms of being tossed around and additional costs.

One of the PHC nurses had this to say "*integration is a process of change and people are trying to adapt to that change. This change process can work if we were well equipped and empowered to deal with the situation. The ultimate goal is that patients will be in a position to access the services closer to home."* The medical officer indicated that "…*realizing the everlasting benefits we will derive from integrating mental health into primary health care we should look at the following challenges, logistical support and patient health information and awareness to both health care workers and the community. The major problem is the shortage of skills of health care personnel who are already in the service and need to be addressed including commitment to delivering the services."*

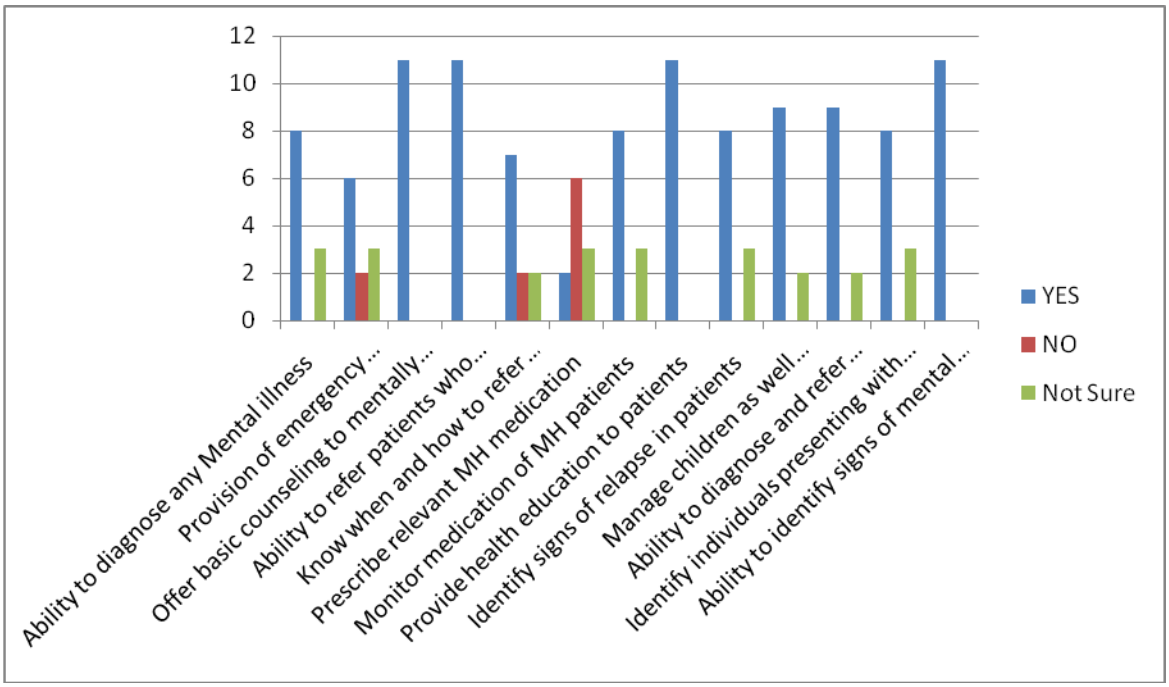
This section covered the responses from all participants regarding their views regarding integration of MH care into PHC services; the challenges of this process is discussed fully in 4.5, section E of this report.

4.5 Results (Section D)

This section presents the findings of all respondents regarding their knowledge and skills in mental health which will assist them in managing mentally ill patients thus

facilitating the integration process. The questions asked as reflected in Annexure A and responses of all the eleven participants are plotted in Graph 6:

Graph 7: Health professionals interviewed and their knowledge and skills on MH



4.6 Results (Section E)

Section E covers the responses of the respondents on problems or challenges they are experiencing in providing integrated mental health services as well as the solutions to the identified problems. This section has offered an opportunity to engage in a consultative process, a common understanding of the problem and consensus towards solutions. Information from this section has offered a deeper understanding of the reasons behind the slow progress made in the integration of mental health into primary health in this region. Solutions provided formed part of the recommendations that have been documented in the study. Most of the problems or challenges identified were common in all people interviewed and include the following:

4.6.1 Shortage of staff including MH Specialists

Shortage of staff has been cited mainly by the PHC staff including their managers as the most serious problem hampering progress with the integration process. Shortage of staff is related to shortage of registered nurses qualified in mental health care and the clinics are run by nurse generalists without a qualification in mental health care in these CHCs, therefore making it difficult to deliver a comprehensive service that is inclusive of mental health at the clinic level

The two PHC trained nurses and one PHC doctor interviewed regard mental health as a specialized area that requires intensive labour and is time consuming They verbalized procedures like interviews, history taking, mental status examination and diagnosis, counseling and ultimately prescribing treatment or referring the client for further diagnosis or treatment to the hospital in comparison with physical health care requires a lot of time; PHC clinicians deal with large volumes of patients, mostly needing urgent interventions as a matter of life and death thus unable to spent more time which is needed to deal with psychiatric patients, the doctor even verbalized that they will be taking over the work of psychiatrists who are specially trained to look after these patients. In addition to their work load they have to do a physical examination which is required to rule out any physical illness that might be contributing to the existence of the mental symptoms. The following statements are quoted from the responses of the PHC nurses, their managers and the PHC doctor who participated in the study:

"*What will they do if PHC clinicians see their patients?" "Mental health is a specialized area and as such should still be kept separate from the other health services".*

"*Integration of the mental health program is so good but shortage of staff is the main problem, as it is, we are not coping with the workload even before the mental health was incorporated."*

They expressed a concern that they are expected to deal with the heavy burden of HIV/AIDS and now with mentally ill patients. "*We do not have even enough time to give proper counseling pre and post HIV testing, due to a large number patients coming in daily to the clinic."* The mentally ill have been negatively affected by shortage of staff in some of the clinics and as such are said to be intolerant of long queues, they become

irritable and aggressive. "*Mental health patients are very demanding and are getting very upset when they have to wait (like other patients) for their turn, to be helped and counseled".*

The PHC manager at the CHC which is totally not integrated felt that

"*Shortage of staff in the clinic contributes to the ineffectiveness in rendering a quality and comprehensive service including mental health, because even now without mental health being rendered the other services are suffering."*

."…other services in the clinic will suffer. Not that I don't think providing mental health care as important. It is extremely important, but our resources (counseling rooms, human resource, etc.) are already exhausted to their capacity. *Adding another requirement and responsibility and integrating mental health into primary health care, can only be done if clinics are given more resources, especially human resources. If more registered nurses trained on MH are allocated to the clinic, then integrating mental health care at a primary level is possible."* In addition to a shortage of registered nurses, the managers expressed concern over the ratio of male nurses to female nurses in dealing with mentally patients who are perceived to be violent and dangerous, and verbalized *"Sometimes we experience some problems with those who are extremely violent who need strong men to hold the patient when giving him injection to calm him down, aggressive patients are difficult to help at the clinic."*

"Over and above the shortage of staff are the constraints of space in our clinics. "…Clinic not conducive for mental health services, for example, rooms for counseling patients are not available."

The PHC doctor interviewed feels that specialists should be around to diagnose the patients, prescribe treatment and offer them the necessary support when it is necessary. Because as PHC doctors and nurses there are those psychiatric medications which they are not allowed to prescribee. This is what they highlighted in their responses:

"…not enough psychiatrists to see and treat the patients. Scheduled psychiatric treatment needs to be evaluated regularly to be able to change or adapt the psychiatric treatment."

"…psychiatric doctor to visit all clinics because hospitals are too far, patients cannot afford transport when referred to hospital and relapse due to lack of treatment."

Shortage of specialists in mental health care at the clinics and health care centers has been identified by both MH specialists and generalists as an obstacle to integrating mental health into primary health care. In all the identified CHCs; it was reported that there are no dedicated ssocial workers as well as OTs to work at the specialized clinics leading to an incomplete MDT who cannot look at the patient holistically.

The psychiatric nurse interviewed complained that she is also overworked as sometimes works alone as registered nurse especially if the other R/N is on leave; the PHC managers do not allocate a person to relieve with the excuse that they are short staffed and their nurses are not experienced to manage mentally ill people. This situation makes it difficult for her to render proper nursing care and psychiatric patients feel neglected. The psychiatrist raised concern of too much workload due to the fact that only two registrars are allocated at the specialized clinics because of shortage of psychiatrists on training and they see up to more than forty patients each per day; making it difficult for them to do proper assessments and refer the stable chronic patients to PHC. They acknowledge the fact that as specialists they are expected to support PHC doctors and mentor them to facilitate integration of MH care into PHC services but they do not have the time. The two consultants in the region are mostly responsible for supervision of the registrars, management issues as well as in-service training of the PHC doctors and have to oversee all clinics in the district thus are not able to help with seeing of patients; they only intervene with difficult patients.

4.6.2 Lack of mental health care skills among PHC staff

Shortage of mental health care skills among PHC staff including doctors and nurses has been seen by the all respondents as also a problem hampering progress in integrating mental health into primary health care. The PHC nurses and the two PHC managers cited their inability to deliver the mental health care services in the clinics due to lack of mental health skills. Some of the nurses were trained a long time ago and have

forgotten their skills because they are not put into practice and some have not been trained on MH. Some of responses from them include the following:

"*The registered nurses should be given in-service education on how to deal with the mentally ill patients as most of them don't have psychiatric courses."*

"I have never attended a workshop on mental health. I have never been trained on mental health. I have no information on mental health."

The PHC doctor also verbalized that she is not confident in managing mentally ill patients as she has never worked in any specialized hospital and her skill she learned from medical school need updating. The Provincial training facilitator emphasized the importance of putting learned skills to practice and argued that many PHC nurses have skills but are reluctant to utilize them.

The psychiatric team also raised the problem of shortage of skills at PHC as the major problem citing that patients come back to the specialized MH clinic because PHC nurses are not able to help them, and indicated that this was raised by one of the down referred patients who stated *"The nurses do not understand my mental health problems and do not know how to assist me".* One patient even requested the team to inform the government that: "*Let the nurses who participate in our care be trained and more nurses should be added. Because at times we become being high (relapsed) and if the nurse is intolerant and lack the necessary understanding, the situation can only be worse".*

The PHC nurses with psychiatric qualification and those who have undergone the 10 days MH Module training indicated that lack of in-service training makes it difficult for them to learn about changes in mental health care. They feel they need to up-date their knowledge and skills in order to improve their performance in mental health care and to be able to totally incorporate MH into PHC services.

4.6.3 Negative attitude of PHC staff

The Psychiatrist and Psychiatric nurse interviewed verbalized their frustration and stated that the PHC nurses do not treat psychiatric patients well. Most of the nurses have been trained on the ten day MH Module training but are still very reluctant to see the mentally ill. These are some of the responses: *"… Other departments do not take*

MH seriously and they even mock us and label us referring to us as "mental sick" and pass remarks like:
"….if you are referring patients to PHC what will you be doing, you want to go off early and do shopping whilst we are slaving for you". They feel that this integration process is becoming frustrating because the PHC are not prepared to see MH patients despite training given. They verbalized that it is difficult to offer support and guidance to people who ridicule them. The psychologist indicated that the PHC staff contributes to the relapses of down referred patients; she posits that she had to intervene now and again and counsel patients who relapse. The specialist staff indicated that some patients indicated that they encounter problems when they present with a physical problem as well.

The clinics are said to be experiencing shortage of medicines for physical problems compared to the hospital. "*…service users are given panado tablets for almost every problem"*. "*The patients indicated they feel not accepted especially if their specific nurse allocated to manage them is not on duty and most of the time they are segregated from the other service users because the nurse feels that they are noisy and uncooperative".* They have to use the back door and are seen on separate days from other patients *"By using a back door it is clear that we are mentally ill and cannot mix with other people".* Patients thus relapse because they feel that they are treated as animals and are feared. They verbalized to the MDT that they wish to sit next to other patients in a queue as they can be patient and tolerant if treated fairly; as stable chronic patients they are able to control their emotions. The psychiatric nurse felt disgusted when talking about the attitude of PHC staff to mentally ill patients and stated: *"…attitudes of other nurses towards the mentally ill are enough to discourage patients to come for treatment."*

MH is not treated as a priority, the PHC facility manager neglect this service and is the last unit to get resources like stationery; in Zola CHC the doctors use scrap papers to write progress reports of patients. The staff felt that they are not taken seriously and MH has to fend for its self. The budget is allocated for the whole facility but does not make

provision for MH; thus making it difficult to engage in activities that require funds like establishing and sustaining support groups as well as MH promotion.

4.6.4 Lack of Management Support

This challenge goes hand in hand with the above discussed challenge of negative attitudes. According to information gathered during interviews; the Provincial MH training facilitator reported that the MHD has had several meetings with different district senior management preparing to roll out the integration process. During these meetings, plans were drawn up on how the process should unfold; requested skills audit to be done. Some districts respondent positively and their trainers were trained on the 10days MH module and have started to integrate MH into PHC, with the exception of JHB Metro health district. In CHCs like Alexandra where MH services are not rendered, they were hearing about the skills audit exercise for the first time; this shows that the information was never disseminated to the people who are supposed to execute the process. In both the semi and not integrated CHCs, the training facilitator has met with some resistance from facility managers who refuses to release the nurses to attend the 10 day MH Module training and stating that they cannot leave the busy clinic for such a long period.

The situation is worse with the PHC doctors; they fail to turn up for arranged training by the psychiatric consultants thus discouraging them. The Principal Family Physician who is in charge of the PHC doctors does not honour appointments to discuss the role of PHC in integration of MH into PHC. The PHC staff indicated that there is poor communication from the district health office with regard to developments and changes in mental health and other services, thus causing confusion. "*All services provided by a PHC are displayed in the bill board outside the clinics but in other clinics especially those under management of the Local Authority; Mental health services are not included"*. These are some of responses from the mental health staff.

4.6.5 Psychiatric medication shortages at the clinics

Mental health medication forms part of the treatment regime of the mentally ill. Most of the patients rely on medication to remain stable and fully functional. Lack or irregular supply of medicines to the clinics is mostly responsible for patients defaulting and eventually relapsing if they cannot get their regular supply of the medicines. Mental health services cannot be integrated into primary health care without this important component of medical care. PHC nurses as well as the psychiatrist and psychiatric nurse indicated that shortages of medicines at the clinic limit their ability to deliver mental health services and this is how they portrayed the situation:

"*The system of ordering drugs is demanding on the nurses; despite the availability of Pharmacy on site the nurses are expected to do the ordering and also carry on with their nursing duties".* The PHC nurses and their managers complained that most of the drugs are not included in the PHC Essential Drug List (EDL). The psychiatric nurse indicated that some patients are discharged on tertiary level medication which is available at tertiary hospital and needs motivation by the psychiatrist. These are some of the responses:

"…*there is a problem with treatment; usually it is not available to patients causing relapses."*

"Most of psychiatric drugs are usually out of stock and the answer we get is that the department has not paid the suppliers."

"It is difficult to sustain the process of down referring chronic stable patients to PHC because the users are usually turned back and referred to the secondary level clinic due to shortage of medication".

Poor supply of medicines for mental illness raised concern among the participants. The service users are resorting to go on their own to the hospital after failing to obtain medicines at the clinic for a period of 2-3 months; this was reported by the specialized team. Relatives bring in some patients after realizing that the patient has relapsed and are complaining that it is more costly and rather their relatives be followed up at the specialist clinic than wasting time and bring them to the PHC clinics. If users do not get

their prescribed treatment; they will relapse and end up causing harm to others or property in the community and end up as state patients.

4.6.6 Lack of family and the community support

In strengthening community MH; it is vital to actively involve families and other community structures in the treatment regime of the patients. Support on the care of the mentally ill is an integral part in delivering a comprehensive and integrated mental health care service at primary care level. All the participants indicated that families are not cooperative; they prefer to take their relatives to clinics far from where they leave because of the stigma associated with mental illness even if they have to pay for travelling costs and do not accept the illness of their relatives. These are some of their responses in relation to this challenge:

"Families staying with the mentally ill do not bring them for treatment."

"*Family members may not accept that their relative is mentally ill more especially due to dagga smoking."*

"Families do not believe that dagga can cause mental illness."

Other problems seen as the hindrance to the integration process are lack of community support groups and non-government organizations that can help the mentally ill in the community. Availability of such groups will help to give extended support to the mentally ill in the community which is beyond the ability of the health care professionals to can do.

The non-cooperation of the local police to help the families of mentally ill patients has been cited as a major problem. The South African Police Services are obliged to assist with the mentally ill in the community according to the MHCA of 2002. According to all respondents; SAPS seems not to be aware of their role. In a situation where the health professional are faced with a violent and dangerous patient in the community or clinic the police refuse to help them. On a number of occasions, the health professionals are faced with dangerous situations which sometimes end up in casualties and leave people wounded. This is how the health professionals as well as families expressed their frustrations with the situation:

"*We experience a problem if there is a dangerous or psychotic (relapsed) mentally ill patient in the community as the police refuse to come and intervene."*

Transporting of psychiatric patients has been cited as another problem as sometimes the patient had to be transferred quickly in order to be assessed by a psychiatrist. Other problems mentioned with regard to transport are related to the availability of emergency services (EMS). The response rate of the ambulance depends on availability and takes hours In addition to that, the psychiatric nurses most of the time experience other problems whereby ambulance drivers are refusing to transport emergency mentally ill patients and this what the nurse had to say:

"Ambulance drivers do not assist us and sometimes refuse to transport patients to nearest hospital".

4.6.7 Poor referral systems

The referral systems in health care are essential to give guidance to the health professionals at all levels of care. All health professionals should be able to know all the levels of care from the primary to the tertiary or specialized level health and be aware of the referral systems within these levels of care; in terms of who to refer to, what information is required, what procedures to follow when referring, where to refer depending on the condition of the patient, mode of transport and whether the patient will require an escort or not.

But some of the participants were not sure of the procedures involved. The PHC nurses expressed their views on this matter and stated:

"…*referral systems are not clear." "…there are no protocols for referral."*

"*I am not sure where to refer patients presenting with signs and symptoms of mental health illness for the first time.* "*When referred to the hospital for diagnosis and treatment they come back untreated stating that the hospital staff stated that this can be done at the clinic; I am just confused" hospital send them back*."

4. 7 Recommended Solutions by the respondents

Several recommendations were made by the respondents including recruiting more registered nurses trained in MH in order for the clinics to deliver a comprehensive and integrated primary health care service. The PHC nurses indicated that they understand

that integration is a policy issue and highlighting that the main problem is that the clinics were already overloaded with patients more especially due to the HIV/AIDS epidemic. They felt that shortage of staff is a long-standing problem which requires urgent attention. All the respondents expressed that they are aware of the GDOH's financial situation but this situation should not compromise the delivery of comprehensive quality patient care. These are some of their responses: *"….without enough human resources, we cannot provide this service". "More nurses must be employed to deliver a comprehensive nursing care to all patients." A tired nurse will in any case not be able to counsel a patient to the best of her ability."*

The PHC nurses and their managers gave reasons to have mental health care specialists to work at primary health care level: "*Specialists will conduct a proper assessment, diagnosis and prescription of the correct medicines for the patients". "They will be in a position to handle crisis situations like violent patients because the specialists have the knowledge and skills".* A short course is not adequate to meet the needs of the mentally ill compared to a person qualified in the job. Qualified nurses will be in a position to train others, conduct home visits to trace defaulters and educate family members with regard to mental illness and the role which the family and community can play in mental health care. One of the PHC managers commented: *"all the staff at the secondary or specialized MH wing within the facility should be absorbed and be under the staff establishment of the clinic; this will be the only solution to integrate MH care into PHC services and address the problem of shortage of staff with MH skills*".

"….*to integrate mental health at primary health care level in theory is correct; there should be other support systems in place." Since Psychiatrists are a scarce resource it will be advisable for the Psychiatric doctors to visit weekly to help with problems the nursing staff encounter at the clinic*". They believe that the other important contribution is to train more males to become psychiatric nurses and be placed in PHC clinics even if is just for their community service obligations for a certain period and they should be rotated.

In addressing the MH skills, they recommended that *"Staff without psychiatric nursing should further their studies in psychiatry." "Primary health care nurses should be sent for a short course or a diploma."* It is also suggested that in-service education be offered to qualified nurses to update their skills on a regular basis.

The specialist team felt that lack of office space should be addressed; nevertheless management should ensure that the available resources are distributed fairly among all programmes in the facility and special needs to be accommodated e.g. ensuring that there is adequate space for conducting support groups and clinic ward rounds by the MDT. The PHC staff believed that if more consulting rooms were added to some of the existing facilities, the mentally ill may be attended to in a much better way and given the privacy they deserve.

Availability of medication is a crucial matter which needs to be addressed urgently; MH services cannot be run smoothly if there is inadequate supply of medication. To keep chronic mental health patients stable; prescribed treatment should be given and monitored. Responses given re solving of supply of medication are as follows: "*Emergency medication to control violent patients should be available". "There should be no shortage of drugs from the pharmacy. Drugs should be supplied when ordered and if drugs are out of stock this must be communicated timeously." "Implement a user friendly drug ordering and storage system." At CHCs, all medicines should be obtained directly from the pharmacy on site; more pharmacists and assistants should be employed". "…a mentally ill patients` state and treatment cannot be compared to that of other patients*, *it is different; they relapse if they do not get medication, and this can lead to many complications*". The training facilitator felt that the EDL for primary care should be revisited to allow more clinicians to be able to prescribe treatment beyond schedule 4; as most trained PHC nurses can only prescribe medication up to schedule 4, most of psychiatric drugs are schedule 5 drugs.

Involvement of family members, South African Police Services and the community at large in mental health care is crucial. The respondents felt that for the integration

process of mental health into primary health care to be successful, family members of the mentally ill must be involved in their care. The respondents gave these solutions: *"clinics to have open days where health education talks could be given to families and also those who bring patients to the clinic regularly and emphasizing the importance of supervising them on taking treatment". "… Social workers to do home visits to identify the mentally ill patients and talk to the relatives as to be able to refer them to join available support groups, explaining to them not to hide mentally ill patients. The health workers should be more involved in educating the community and families on the causes of mental illness; how to identify people suffering from mental illness and importance of follow up care to the patients." " …treatment protocols with clear referral pathways should be made available at all clinics*. These protocols will help in guiding the PHC staff to make informed decisions and refer appropriately. Up skilling the PHC staff is crucial and will help reduce negative attitudes as the PHC staff will be in a better position to deal with and manage mentally ill people. District management should be supportive and ensure that all resources are distributed fairly and consider the needs of all programmes including mental health.

4.8 Summary of Chapter

After the data was transcribed, it was found that most of the participants indicated challenges like; lack of support and supervision from management, poor communication, poor supply of medicines, negative attitudes of PHC staff, family and community involvement and lack of support by members of the SAPS. However, a number of factors led to the challenges faced but most participants attributed these challenges to the lack of support and supervision from management especially when introducing changes; as well as the negative attitudes of the implementers leading to resistance to this change. Nevertheless the participants presented some solutions to these challenges which can help in facilitation of the integration process.

CHAPTER 5

ANALYSIS AND INTERPETATION OF FINDINGS

5.1 Introduction

Primary and secondary data was collected and presented in chapter 4. This chapter discusses the findings by looking at both the presented quantitative information which is the number of health professionals as well as those trained in MH in each CHC and qualitative data in relation to the arguments discussed in the literature. There are a number of positive and negative experiences revealed by the study. The positive aspects revealed will be presented first and then the negative challenges which need urgent intervention will be analysed

5.2 Accessibility of mental health care services

The study revealed a positive aspect that the integration of mental health into primary health care will contribute to the improvement of access to the mental health care services. All participants agreed to the fact that integration is a policy issue aimed at improving access to the mental health services at the lowest level of care which is affordable. There is an agreement that integration improves access because users are able to receive their medication supply from facilities closer to their homes. There is a consensus that mental and physical health problems are interlinked**.** Many people suffer from both physical and mental health problems. Integrated primary care services help ensure that people are treated in a holistic manner, meeting the mental health needs of people with physical disorders, as well as the physical health needs of people with mental disorders. Integration promotes collaborative effort where workload is shared among the health professionals instead of the current situation of providing vertical MH service delivered by specialists only. The findings support the provisions by the White Paper on the Transformation of the Health System in South Africa of 1996 and the Mental Health Care Act of 2002 that the integration of MH into PHC is aimed at improving access to the MH care services. The findings also support the recommendations by the WHO and findings by several other authors (Allwood et. al 1997; Freeman, et. al. 1999; Mohlaokane, 2003; and Brody, et. al. 1996). WHO (2001) suggests that the management and treatment of mental disorders in primary care is a

fundamental step which enables the largest number of people to get easier and faster access to services. According to findings presented in chapter 4, it was revealed that the majority of the professional nurses in the study do not perceive it to be a problem to attend to the mentally ill in the clinics. This is a positive indication to integration aimed at improving access. 30 % of participants verbalized that MH service will somehow interfere with other programmes as caring for the mentally ill is time consuming and only 10 % were negative and seeing success of integrating MH into PHC still being a dream.

5.3 Reduction of stigma associated with mental illness

Another positive aspect revealed by the study is that the participants all agreed that the integration of MH into PHC will assist in reducing the stigma attached to mental illness. By using common health facilities helps reduce the stigma attached to mental illness. These views supports the findings by Pincus (1980) that general health care settings are regarded as representing an important resource for mental health care in the community and will assist in addressing the issue of stigma attached to mental illness. Another advantage revealed by the study is that patients can receive treatment for both mental health and physical problems from the same place. Findings from this case study support the findings of Mohlaokane (2003) that the integration helps to reduce stigma against mental health care because mentally ill patients receive treatment at the same site as the other general patients in one of the models of integration being followed in the Mpumalanga district.

Contrary to the above positive aspect, it was also revealed that some PHC nurses refuse to see mentally ill patients due to their negative attitudes. It was indicated that the attitudes of some of the nurses are unacceptable and impact negatively on service utilization resulting in defaults and relapses. Freeman et al. (1994) indicated that nurses require reorienting their attitudes to that of taking greater responsibility for mental health care work. According to the mental health professionals, attitude problems in this regard, are best addressed with knowledge and skills because when the nurses understand what they are dealing with and how to manage the problems; they tend to have a better understanding of mental illness.

A number of challenges to integration of MH into PHC revealed by the study are resource related and support needed from management. The champions of change management like Kotter (1994) believe that for successful change to occur, the leaders should guide and support those who are expected to implement the change. Therefore, for integration to occur, management needs to be supportive. Gulhati (1990) believes that smooth policy implementation requires many preconditions and one of them being assessment of resources and its availability. The study revealed problems related to human resources, poor supply of medicines, lack of management support, negative attitudes of PHC staff, family and community involvement and lack of support by members of the SAPS.

5.4 Shortage of Skilled Staff including MH Specialists

The study revealed that there is a general shortage of nurses and other health care personnel, especially a critical shortage of MH care specialists. This supports the findings by Lazarus, et. al. (1995) that one of the motivating factors to the integration of mental health into primary health care in South Africa is based on the critical shortage of mental health care professionals. Health care personnel that leave the services due to different reasons are not replaced. There is very little recruitment of new health care personnel into the services; most of the vacant posts are not filled due to financial constraints of the department. The findings support the recommendations by the WHO (2001), that for effective service delivery to occur, there need to be sufficient numbers of staff with the knowledge to deliver the services. Shortage of staff as revealed by the study supports the findings of Petersen (1999) where she indicated that logistical constraints resulting in high patient loads pose a challenge to integration. The importance of human resource in the management of change as is the case with integration is further emphasized by authors like Lussier (1994); Dalton et al (1970) and Lovel (1994). The lack of psychiatrists has a negative impact on the quality of the services delivered at PHC level; patients are sometimes wrongly diagnosed leading to prescribing wrong treatment. Doctors complained of too much workload; this might lead

to treatment reviews that are supposed to be done six monthly being not done resulting in service users staying on treatment that might be unnecessary for a long period.

Shortage of skilled medical staff in MH may have negative implications for those service users who qualify for a disability grant who can end up not benefiting for the grants due to the lack of a mental health disability assessment required to complete the application documents. Given this scenario, all the nurses can do is merely to refer patients to the hospitals. The study revealed that patients are referred from the clinics to the hospitals to medical officers in hospitals who are equally lacking in mental health care skills. What the medical officers do is to make a further referral to the specialized mental health institutions; thus nursing patients in a more restrictive environment against the principle of the MHCA. Referring patients to specialized services is more costly to the province and the problem to some extent, has been attributed to the shortage of skilled personnel in MH at the primary care level.

Skills form part of institutional arrangements that need to be addressed for successful implementation of any policy. Dalton et al. (1970) argue that technical aspects are one of the important tools of change. In mental health, skills are one of the technical aspects necessary to institute change in the way mental health services are delivered as mental health is more human resource driven. With the shortage of skilled nurses at the primary health care level, it is difficult to integrate mental health into primary health care. As a result, the aim of integrating MH into PHC in order to improve access to the MH care services will therefore be difficult to attain. In the overall recommendations, the WHO stresses the importance of developing countries to increase and improve training of mental health care professionals, who will not only provide specialized care but also support the primary health care program (WHO 2001, p. 111).

The study revealed that PHC staff, especially nurses working as frontline personnel, lack skills in mental health care; even those trained in short courses on MH are not confident to see and manage mental health users. The study revealed that 44 % of PHC nurses have a formal qualification in MH but are not practicing their skills.

Petersen (1999) posit that training in mental health skills empower nurses, and lack of skills results in a sense of helplessness and frustration at not being able to give help to mental health service users. Frustration has also being expressed by MH specialists that the service users are complaining of not receiving the services they need or deserve. Problems revealed by the study confirm the findings by the WHO that personnel at PHC clinics usually fail to diagnose physical complaints caused by mental illness resulting in prescribing numerous ineffective and costly medications. Patients end up visiting many different health care facilities in a fruitless search for effective treatment. Scarce health resources are thus frequently wasted, and patients may be needlessly exposed to drugs that do nothing to help them and may actually give rise to dependency and further mental and emotional difficulties (WHO, 2001).

The study supports the recommendations by the WHO (2001) and The White Paper on the Transformation of the Health System in South Africa (1996) that PHC nurses require training. It also support the findings of Nickels et al. (1996) and Allwood, et al. (1997) that it is important for primary health care workers to be trained in MH skills in order for integration to be a success. The shortage of staff also impacts on the ability of the nurses to attend the necessary training on mental health care skills. Managers fail to release staff to attend short courses provided by the department to up skill them even if these courses are not adequate as nurses who have undergone a short course in mental health cannot be compared to the mental health specialists in terms of competency. The mental health specialists still play an important role in terms of delivering wide spectra of mental health services. It further supports the recommendations by WHO (2001, p., 111) that such professionals will provide specialized care as well as support the primary health care programs, it is revealed from the study that about 81 % of the participants were complaining of not being supported by the specialist teams.

5.5 Psychiatric medication shortages and other treatment modalities at the Clinics

The study revealed that there is a poor supply of mental health care medication to the clinics. This results in frequent changes to the prescriptions, severe side effects, lack of access to medication, frequent referrals to other health care facilities, defaults and relapses. The PHC nurses as well as psychiatrist and psychiatric nurse indicated that shortages of medicines at the clinic limit their ability to deliver mental health services. The study supports the recommendations by WHO (2001) that lessons from other countries which could help other governments for integration to be successful, policy makers need to consider that basic mental health care medication must be available at primary health care level. The study revealed a shortage of working space in the PHC clinics, thus impacting on provision of integrated care. Some clinics are too small to accommodate the various treatment methods required to manage the mental health problems. There are no counseling rooms, there is limited privacy and no room to contain and control aggressive and violent mentally ill service users. The study supports the arguments by Lussier (1994) and Dalton et al. (1970) relating to the facts that change impacts on both structural and technical changes. The findings of the study revealed that in general, integrated care will achieve positive outcomes but efforts to implement integrated care is usually hindered by financial barriers. Butler, Kane, McAlpine, Fu, Kathol, Hagedom and Witt (2008) believe that communities are more ready to accommodate integrated care, at least for depression. Even depressed patients need privacy; shortage of counselling rooms will impact negatively in treatment of depressed individuals. The study also revealed that even in big CHCs; mental health services at the secondary level is not given first priority and provided with little space, thus restricting the MDT in performing their duties. These findings supports the arguments by many authors, as stated in the WHO report (2001), as well in the MHD annual report (2011), that mental health is not taken seriously and is always viewed as the step child of health services.

5.6 Lack of Management Support

The study revealed lack of management support as one of the main challenges. Integration of MH into PHC services as a policy and instrument of change was not well communicated to those responsible for its successful implementation. During implementation those responsible must be supported throughout the process; this was not the case with the integration process. The study therefore supports arguments by Ivancevich, et al. (1994) that for a change process to be successful, it depends also on how it is communicated to those who are responsible to ultimately execute the change. He argued that most policy statements are communicated by means of a downward communication, which can be inadequate to guide the necessary policy implementation and result which could lead to the desired change.

5.7 Lack of family and community participation

The study revealed that MH care users do not get the necessary support from the family members and the community. Family members play a fundamental role in the follow up care, taking of medication, personal hygiene, nutrition, proper use of the disability grant and emotional support. The study also revealed that community members abuse and violate the rights of the mentally ill and this is against the MHCA. The WHO report (2001) recommended that integration of mental health into primary health care should take place in collaboration with other services in the community in order to deliver comprehensive mental health care services. Such services include nutrition, and basic necessities such as shelter and clothing, including the SAPS as well as the EMS. Families sometimes fail to bring patients to the clinic for follow up medication and nurses are not able to follow them up due to transport problems. If home visits are not done to follow these patients up, this will lead to them defaulting on their treatment and relapsing. Dealing with emergency cases becomes a problem; urgent referrals to hospitals may wait at the clinic for a period of even more than five hours due to delays of EMS to respond. Family members are at times compelled to arrange and meet the costs of transport to the next referral level. Integration of MH into PHC as a policy issue to be legitimate must be in a position to draw resources for its implementation,

something that is not happening in this case. This supports arguments by Lussier (1994) that, for any policy to be legitimate, relevant resources should be in place.

Community members play a major role in caring for the destitute through day care centres, provision of shelter or boarding place, support groups and general care including reporting any abuse of the mentally ill. Authors like Baasher, et al. (1997) and Kilonza and Simmons (1998) believe that African culture supports community responsibility, which is conducive to mental health being part of primary health care and is of vital importance to the integration process, but may not prevail in some African societies.

5.8 Poor referral systems

The study also revealed that the referral systems in health care is poor; thus leading to unnecessary and wrong referrals and jeopardizing the patients' rights. Patients end up at the most restrictive environment in psychiatric institutions instead of being nursed in general hospitals nearer to where they live and these violations are against the requirements of the MHCA. WHO (2001) emphasizes the importance of availability of referral guidelines to assist the health professionals to refer appropriately, according to the assessment findings.

5.9 Summary of the Chapter

Chapter five involved analysis using the theoretical framework and literature review based on the findings of the research. Most of the challenges analyzed were based on challenges hindering effective integration of MH into PHC. All challenges raised are attributed to the lack of support by senior management and not taking MH seriously as a priority programme. Integration of MH as the policy mandate is understood but management fails to provide to those responsible for the implementation with necessary resources especially staff. Management has to ensure that staff is supported and given the opportunity to attend in-service training on MH issues. Ongoing support is necessary in order for the process of integration of MH into PHC to become a reality.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The research attempted to investigate the challenges with regard to integration of mental health into primary health care services in the Johannesburg Metro Health district as this district is lagging behind in integrating mental health into primary health care services. The study described the main challenges facing the health professionals in integrating mental health into primary health care services that include: shortage of trained mental health staff, negative attitudes of PHC staff, lack of support from senior management, shortage of skills in mental health care, poor supply of medicines, lack of family and community involvement including lack of support from the members of the South African Police Services and Emergency Medical Services. The participants suggested some recommendations to improve access to the mental health care services at the lowest level of care, including gaining the support of senior management and addressing attitude issues of PHC staff, which is mainly due to PHC staff not feeling confident in managing mentally ill persons because of a lack of MH skills.

South Africa has legitimate policies like the White Paper on the Transformation of the Health Services in South Africa of 1996 and the Mental Health Care Act of 2002 which aim at improving access to the mental health care services as well as addressing the issue of stigma attached to mental illness. The findings of the study revealed a gap between what the integration policy says and policy implementation in terms of resources available to make the policy a realty The policies should be in a position to have the necessary organizational aspects in place, that are necessary for the successful implementation and sustainability of the policy. Organizational capacity, capability and structure are crucial in policy implementation. Commitment of both politicians and managers is crucial in implementation of any policy so that they can make resources available.

There is lack of adequate resources and processes recommended by WHO and other international and national researchers as a prerequisite to the successful integration of

mental health into primary health care. The importance of management support cannot be over emphasized in provision of necessary resources for the process of integration of mental health into PHC services. In order for this process to be successful, it requires the necessary support in terms of the identified management inputs and processes.

For any policy to be well implemented, it is crucial to ensure availability of necessary resources including psychiatric medication. For integration of mental health into primary health care to be successfully implemented, there should be more collaborative effort and commitment among all stakeholders. It is as a result of not working together and the identified gap between policy and implementation that the integration of mental health into PHC has not moved at the pace that it should have since 1994. It can also be concluded that access to the mental health care services in the Johannesburg Metro Health District is still posing a major challenge due to lack of support and commitment from senior management as it was indicated that some clinics are managed by the Provincial government whereas others are under the Local Authority.

6.2 Recommendations

This research evoked remarkable feedback from most of the participants who seemed eager to share their experiences on the topic of integration of mental health into PHC services. Over and above the solutions suggested by the participants, a number of recommendations arise from the study including recruiting registered nurses with mental health qualifications and if these are not available, they need to be trained in MH and to be mentored. Qualified personnel who are already in the service should be made aware of the important role they can play in integrating mental health into primary health care. They should be allowed to attend necessary in-service education on mental health issues.

To overcome the problem of mental health services being a vertical programme, all current MH staff need to report to the facility manager instead of reporting to the mental health coordinator.

Other Mental health care specialists like the psychiatrists and clinical psychologists have to be recruited, and measures to retain them instituted at the district level. Much as this is a broader challenge that affects the country, Gauteng province can still contribute in a meaningful way by portraying better recruitment and retention policies.

The head of Family Medicine should encourage the PHC medical officers to attend the in-service training offered by the psychiatric consultants as it was indicated that they are taught mental health care at the medical school but need coaching and mentoring. Skills development programs should be embarked upon to cover all primary health care professionals.

Information on mental health as a program should be disseminated through developed programmes for all managers. All managers should be familiarized in policies related to mental health care. This will enable managers to support such policies and to draw realistic plans for successful implementation. This will also assist the managers in understanding the implications of policies and allocate adequately resources for the implementation of such policies. It is vital to empower managers at all levels, especially the facility managers, who will be more instrumental in implementing the process of integrating mental health into PHC services.

The mental health component needs to be integrated into community health programmes. Psychiatrists should play a key role in training, with the emphasis to train trainers from community medicine who will in turn, play a key role in training future generations of general health care workers.

Supporting the PHC staff is crucial; the study revealed that health workers usually do not get support, resulting in poor recognition and treatment rates for mental illness. There is a need for training programmes to be followed by the provision of regular supervision in the clinical settings. This is best achieved by public health physicians and nurses trained in the management of these disorders.

There should be training programs for continuous professional development in place. Each PHC facility has to ensure that the in-service training programme monthly plan includes mental health topics. Currently, other health care professionals are compelled by their registering bodies to be exposed to continued professional development through the point system, except nurses. In-service education is important to keep professionals up to date with the transformation processes within mental health care and the latest treatment approaches and technology.

Integration of mental health into primary health care should be properly communicated to all the relevant stakeholders in order to facilitate participation and commitment to service delivery. Communication promotes active involvement of all role players, especially those expected to implement the process. Such communication will be inclusive of treatment guidelines, protocols and effective referral systems.

The study has revealed a shortage of resources, including disparities among the various clinics, thus integration of mental health into primary health care needs to be introduced in a cascading manner depending on capacity in the various clinics, for example, health care personnel, skills, medications and transport. As a result, it may not be feasible to expect implementation to take place all at once. Those clinics in other districts that have demonstrated successful implementation of the integration process should act as learning sites for the others.

There is a need to improve in the management of drug supply from the depot to the clinics; thus ongoing communication with the pharmaceutical section is crucial. Most mental illnesses are by nature chronic diseases that need to be managed through drug therapy, a function that could be easily carried out at the clinic level. But the effectiveness and the efficiency of the approach relies to a large extent to a good supply of the relevant medicines at clinic level. It is recommended that each CHC or large PHC should have a dedicated pharmacist with pharmacists' assistants on site who will be responsible for ordering and issuing of medication. This will ease the burden on the

overworked nurses, as revealed in the study who are expected to do the ordering, the nursing staff will therefore concentrate on management of the side effects of the drugs.

The addition of more working space for the implementation of the comprehensive primary health care services as outlined in the National Primary Health Care Package programs is important. The problem goes beyond mental health care and adversely affects other programs like HIV/AIDS that is also adding to mental health related problems.

Partnership with the private health care systems is important. Most national mental health programmes employ governmental resources for health care delivery. However, resource constraints of governments prevent such programmes from reaching many sections of society. Therefore partnership with the private sector will make a significant contribution to health care. At present, the participation of the private health sector in most national programmes is negligible. There is a need to involve the private sector, especially NGOs, in the mental health programmes so that the available resources are efficiently utilized. Community based mental health resources need to be strengthened and to introduce psychosocial rehabilitation that will assist mental health service users to improve their functional level and support them to live independently. These are facilities like day care centres, assisted living units; residential care centres, sheltered employment and participation in all self empowerment and poverty alleviation projects.

Partnership with the traditional health sector should not be ignored. As indicated in the literature, in most developing countries, traditional medicine is flourishing and caters to a large population and it manages many common mental disorders. Therefore forging partnership with traditional health sector is important and formal links between systems of medicine can make use of their different approaches, which in many ways complement each other. Training of traditional healers is therefore crucial.

The lack of awareness about mental illness, the role of early recognition and the need for treatment result in the absence of demand for mental health services. District MH

staff need to be involved in conducting mental awareness campaigns and involve the community radios and newspapers to make the community aware of the mental health services nearer to where people stay. The lack of cooperation from SAP and EMS can be overcome by developing a level of understanding between these departments and guidelines on how to manage mental health care services and facilitate collaboration by ongoing communication.

Any strategy used in isolation will be much less effective than a combination of approaches. All available resources should be geared towards improving community care for mental disorders.

6.3 Areas for further research

Despite many studies done on the importance of integrating mental health into general health services, there are still research gaps, especially with intervention and economic evaluation studies. The following areas need to be reviewed:

Research need to be conducted on an economic analysis of mental health care programmes in low-income countries. This research will help to inform policy and service development. There is a need to demonstrate the financial advantages of managing mental disorders in the community before governments will support such initiatives on a large scale.

A systematic formal impact studies need to be done to evaluate the impact of the 10 day MH Module that is being conducted by the GDOH as most participants have revealed some concerns during this research.

Research need to be conducted in the area of community based mental health care services; identifying roles of all community stakeholders in provision of a holistic service to the mental health care users and support to their families.

Stigmatization of mentally ill is still a major problem thus it is vital to conduct studies to identify strategies and best models for combating stigmatization among the mentally ill in the South African context.

Results as well as recommendation of this study will be communicated to the GDOH senior management with the view of conducting an impact evaluation of the integrating mental health into primary health care to determine any improvement in access to quality mental health care services in JHB Metro district.

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APPENDIX A

QUESTIONNAIRE ON THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE

A. BASIC BACKGROUND INFORMATION

Rank

Trained in MH or not

Are you working with mentally ill? How long?

Number of registered nurses in your facility

Number of Medical officers in your facility

B. WORKING WITH MENTALLY ILL PATIENTS/ EMOTIONAL PROBLEMS

Answer with Yes or No

Do you feel comfortable dealing with mentally ill patients?

Is attending to people with mental problems take – up too much time?

Would you rather assist somebody with a physical problem first than one with mental problem?

Do people with mental illness make you feel uncomfortable?

Do you think people with mental illness are dangerous?

C. YOUR VIEWS ON THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE.

Answer with Yes or No

Should your service be should be integrated at primary care level?

Have you been informed about integration as a policy issue?

Do you feel the mentally ill should receive services like all other people?

Do you feel forced or pressured to accept and treat mentally ill patients?

Does your clinic have adequate staff to attend to the mentally ill patients?

Do you think providing mental health is an important aspect to deliver comprehensive primary health care service?

Will Integrating mental health into primary health help to deal with the stigma attached to mental illness?

Will other services in the clinic suffer if we integrate mental health?

Will you be able to get support and supervision to cope with patients with mental illness and emotional problems?

Is the integration of mental health working in this clinic?

Will integration of mental health work?

D. SKILLS AND KNOWLEDGE

Do you have the skills to do the following?

Answer with Yes, Not Sure or No

Diagnose any mental illness

Provide emergency management of an acutely psychotic patient

Offer basic counseling to a patient who is depressed or anxious

Refer a patient who requires intensive counselling.

Know where and how to refer patients for further mental health treatment.

Prescribe any relevant mental health treatment.

Monitor the medication of psychiatric patients.

Provide health education to patients with chronic mental illness and their families

Identify signs of relapse in patients with chronic mental illness.

Detect, manage or refer a child/ adolescent with behavioural or emotional problems.

Detect, manage or refer a child with mental retardation

Detect and treat individuals with alcohol and substance abuse problems.

Detect, treat and refer individuals with domestic violence related problems.

PROBLEMS AND SOLUTIONS

What are the obstacles or problems you see in providing an Integrated Mental Health service in the clinic? List them

……

……

What could be done to overcome these challenges?

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APPENDIX B

RESEARCH PROJECT ON THE INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE IN THE JOHANNESBURG METRO DISTRICT

PARTICIPANT CONSENT FORM

I_____ willingly give consent to taking part in this study which has been explained to me by Mrs. Nonceba Sennelo. This research study is being conducted for academic purposes with the University of the Witwatersrand.

I understand that participation in this study is voluntary and that no compensation for participation will be given. I also understand that I am free to withdraw my consent to participate in this research project at any time without prejudice. Refusing to participate will involve no penalty or loss of benefits.

The interviews will be conducted by Mrs. Nonceba Sennelo and she has reassured me that whatever is discussed with me will remain confidential.

I willingly give my consent to participate in this study and upon signing this form I will receive a copy.

_____ _____

Interviewee signature Date

_____ _____

Witness Signature Date

_____ _____

Mrs. Nonceba Sennelo Date