INTER-PROFESSIONAL COLLABORATION AMONG MEMBERS OF THE MENTAL HEALTH TEAM AT VHEMBE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA

by

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DISSERTATION

Submitted in fulfilment of the requirement for the degree of

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at the

UNIVERSITY OF VENDA

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DECLARATION **11618318**

I, Tshililo Edwin Makhwanya declare that **INTER-PROFESSIONAL COLLABORATION AMONG MEMBERS OF THE MENTAL HEALTH TEAM AT VHEMBE DISTRICT OF LIMPOPO PROVINCE, SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference and that this work has not been submitted before for any other degree at any institution.

SIGNATURE:..... DATE :18/8/2014

T.E MAKHWANYA

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DEDICATION

I hereby dedicate this thesis to my family that has been with me exercising patience and understanding as I laboured through the journey.

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Unto Him be glory and honour for the strength and courage to complete this thesis amidst all occupational, family, social and religious challenges.

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ABSTRACT

Despite the available literature on the effectiveness and efficiency of inter-professional collaboration, members of the mental health team continue to operate in silos. The purpose of this study was to explore and describe the status of inter-professional collaboration among members of the mental health team in Vhembe district. This was a qualitative, descriptive and contextual study. Five core members of the mental health team from selected hospitals were purposively selected, namely the medical practitioner, the clinical psychologist, the occupational therapist, the social worker and the psychiatric nurse.

Four focus group discussions were conducted to collect data making use of a research assistant and an interview guide. Data was recorded, transcribed, and analysed using the Tesch 8 steps of data analysis. The findings of this study included the understanding, benefits, functionality and barriers of inter-professional collaboration as well as the recommendations.

Five themes inclusive of: understanding of inter-professional collaboration, the benefits of inter-professional collaboration, the state of functionality of inter-professional collaboration, the barriers to inter-professional collaboration, and measures to improve inter-professional collaboration. The main recommended measures included: commitment to the use of a team approach; conducting in-service training on inter-professional collaboration, ensuring the use of coordinated scheduled quality multi-disciplinary team meetings; and management support.

Inter-professional collaboration was understood as the working together as a collective. Efficiency in the management of a mental health care user was seen as the benefits thereof.

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Functionality of inter-professional collaboration varied from efficient to less efficient according to health facilities. Health facilities also varied in terms of barriers encountered though there were common ones. Measures to improve inter-professional collaboration were stipulated: commitment to the use of a team approach; in-service training on inter-professional collaboration, the use of coordinated quality multi-disciplinary team meetings; and management support.

Key words: Inter-professional collaboration, mental health team member; multidisciplinary team, mental health care user, mental health unit.

ACCRONYMS

MDT	Multi-Disciplinary Team
FGD	Focus Group Discussion

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OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Inter-professional collaboration is increasingly recognized as essential for effective service delivery in terms of increasing access, enhancing quality and safety of care, enhancing coordination and efficiency of care, enhancing staff morale, and reduction of burnt out and turnover (Curran, Glynn & Godwin 2007:i; Newell, Jivanjee, Schultze, Friesen & Hunter 1994:1; as well as Blackely, Boyden, Hobbs, Walsh & Allard 2006:461)

Inter-professional collaboration is essential to the improvement of communication, addressing deficiencies in health professionals' communication, as well as the provision of effective healthcare services (Barrere & Ellis 2005:13; Begat, Ellefsen & Severinsson 2009:226; as well as Blancett 2010:49). It has addressed fragmentation, discontinuity and lack of receptiveness.

Inter-professional collaboration is characterized by shared aims, inter-dependence, a collegial and equal relationship between the participants and shared decision-making, particularly, among the mental health team members (Collin, Vallala, Herranen, Viinikinen & Paloniemi 2008:1). The view is supported by Clifton, Dale and Bradshaw (2007:21) underpinning a patient centered flexible health and social care service approach. Staffs works across professional and organizational borders in flatter and non-hierarchical structures.

Having acknowledged the therapeutic value thereof, it was valuable to explore inter-professional collaboration among mental health team members at Vhembe district of Limpopo province, South Africa.

1.2. BACKGROUND OF THE STUDY

Internationally, there is extensive literature on the potential benefits of inter-professional collaboration among members of the mental health team towards addressing fragmentation, discontinuity and lack of receptiveness. It is believed that can improve the quality of care (Blickensderfer 2011:125 as well as Collins 2010:820). It has been the focus of interest, as quality of care is depended on collaboration, competencies of health care providers and

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knowledge (Collins 2010:817); Bruner, Waite & Davey 2011:235 as well as D' Amour, Goulet, Labadie, Martín-Rodriguez & Pineault 2008:237).

In Australia, according to Reeves and Lewin (2009:59), most professionals support inter-professional collaboration among members of the mental health team as they believe that it provides patients with continuous hours of contact. In the last decades, in England and in Canada, according to Reader, Flin, Mearns and Cuthbertson (2007:350); as well as Collins (2010:890), inter-professional health care teams were the focus of interest, as quality of care was depended on collaboration, competencies and knowledge of health care providers.

The challenge for middle income countries like South Africa, according to WHO (2001), has been to increase access to mental health care through integration with the primary health care system (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood, Flishers & the Mental Health and Poverty Research Programme Consortium 2009:1)

The South African government, in order to improve the mental health services, promulgated the Mental Health Care Act no 17 of 2002, whose objects; among others include the regulation of mental health care treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources (Mental Health Care Act No 17 of 2002 Section 3). However, it is still challenged, among others, by the serious shortage of mental health professionals where the ratio of psychiatrists is 0.28 per 100 000 population instead of 1/100 000 population (Burns 2011:104).

South Africa has formal collaborations between the government department responsible for mental health and other departments / agencies in most provinces across a range of sectors. However, activities aimed at promoting mental health and preventing mental disorders are scarce, and occur only in a small number of sectors such as mental health units. Some provinces have established inter-sectoral forums for mental health and inter-sectoral collaboration. At district level, such inter-sectoral collaborations are the exception rather than the rule (Mental Health and Poverty Project 2009:1).

Despite the benefits of inter-professional collaboration among members of the mental health team, there is little or no evidence that could be located on the implementation thereof in South Africa. The researcher sought to explore and describe inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.

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1.3 PROBLEM STATEMENT

During a district mental health summit held in 2011, as the members of the mental health team were presenting their views of mental health service within the district, it was evident that the available mental health professionals were operating mainly in silos.

According to Cornish, Church, Callahan, Bethune, Robbin, and Miller (2003:63), single providers or disciplines are no longer able to meet all the health care needs of an individual. Inter-professional collaboration among members of the mental health team is central in the provision of quality mental health care. Health professionals are therefore urged to work together in teams. Vhembe district amidst its shortage of mental health professionals is faced with the challenge of optimising the use of the available human resource. The extent to which the available mental health team members were collaborating inter-professionally is a matter for exploration and description, hence the proposed study

1.4 PURPOSE OF THE STUDY

The purpose of this study was to explore and describe the nature of inter-professional collaboration among the mental health team members at Vhembe district of the Limpopo Province, South Africa and generate recommendations for improvement.

1.5 RESEARCH QUESTIONS

According to Polit and Beck (2004:77), research questions, are direct rewordings of statements of purpose, phrased interrogatively rather than declaratively. In order to attain the purpose of the study, the following research questions on inter-professional collaboration among mental health team members were formulated:

- What are the views of mental health team members regarding the nature of inter-professional collaboration at Vhembe district of Limpopo Province, South Africa?
- As members of the mental health team at Vhembe district of Limpopo Province, what do they think are the benefits of inter-professional collaboration?
- How is the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?
- As they collaborate among the mental health team members at Vhembe district of Limpopo Province, what did they find to be the barriers?

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- In their opinion, what measures could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?

1.6 OBJECTIVES OF THE STUDY

According to Burns and Grove (2005:156), objectives are "clear, concise, declarative statements expressed in the present tense and for clarity with only one or two variables". The objectives of the study were:

- To explore and describe the views of the mental health team members at Vhembe district of Limpopo Province with regard to the nature of inter-professional collaboration.
- To describe the benefits of inter-professional collaboration from the perspective of the members of the mental health team at Vhembe district of Limpopo Province, South Africa.
- To describe the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.
- To explain the barriers experienced by the mental health team members at Vhembe District of Limpopo Province in South Africa as they collaborate inter-professionally.
- To recommend measures that could be put in place to improve inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

1.7 SIGNIFICANCE OF THE STUDY

According to Marshall and Rossman (2011:68), the significance of the study should contribute meaningful body of scientific knowledge. The results of this study may form the basis for the recommendations to provide a vehicle for the presentation of participants' views as defined by them and can be used to foster quality mental health services and change by reaching authorities at Vhembe district and policymakers at Provincial level of the Department of Health regarding inter-professional collaboration among mental health team members.

Secondly, the results of this study could add to the existing body of knowledge regarding inter-professional collaboration among mental health team members at Vhembe district of

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Limpopo Province in South Africa and elsewhere in the world. Such knowledge could be applied to improve inter-professional collaboration among members of the mental health team as well as the quality of care to the mental health care users at Vhembe district of Limpopo Province in South Africa.

According to Canadian Inter-professional Health Collaborative (2010:8), inter-professional collaboration seemed better when it has been introduced early in one's professional career. Knowing the extent of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province in terms of benefits, activities, barriers, and what could be done to improve it. The academic sector could also apply the results of this study to socialize students into the culture of inter-professional collaboration among mental health team members during education and training of the students.

1.8 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this study is outlined in three categories namely the meta-theoretical assumptions (my belief as a researcher in this field), methodological assumptions and theoretical assumptions.

1.8.1 Meta-theoretical assumptions

According to Botes (1995:110), meta-theoretical assumptions address the nature of the reality for the researcher. These assumptions have their origin in philosophy. They are not testable and deal with the human being and society. The researcher's values and assumptions stemmed from one's professional work, working with families and communities. Having grown up in a rural communal life where we survived through supporting one another as a community, and having appreciated and developed amidst the shortage of health professionals, I believe that:

- Despite the actual and or predicted increases, the health workforce supply will not be able to keep up with the increasing demand for health care services.
- "Munwe muthihi a u tusi mathuthu" which can literally be translated as "one finger can never be able to scoop food made of loose maize seeds". This is an idiomatic expression reflecting that in silos, little can be achieved.
- The available health workforce, working collectively as a team, can optimally improve the quality of care and health outcomes.

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1.8.2 Methodological assumptions

Methodological assumptions are concerned with the nature and structure of the science of research, and include the preferences and assumptions of the research (Mouton, 1996:124 as well as Mouton & Marais 1990:20). The methodological assumptions, which will guide this study, are in line with the functional approach of Botes, Nolte, and Poggenpoel's (2001:66), which implies that research should be functional and should contribute to the body of knowledge and the improvement of the quality of life.

According to Berg (2009:158) focus group discussion is a useful strategy either as a stand-alone data gathering-strategy or as a line of action in a triangulated project. It is thus assumed that focus group discussion will be able to produce data that will provide the description on the nature of inter-professional collaboration among members of mental health team at Vhembe district of the Limpopo Province in South Africa as an integral part of quality mental health care.

1.8.3 Theoretical departure

A number of social psychology theories have been used in the inter-professional literature. Barr et al (2005:1) identified social exchange theory Challis et al. (1988:188), cooperation theory Axelrod (1984:5), relational awareness theory Drinka et al. (1996:51) and team reflexivity (West 1996:560) as highly relevant approaches for informing the inter-professional literature. Cooperation theory maintains the need for cooperative behaviour by all parties engaged in collaboration. Lack of such behaviour results in a loss to the overall enterprise and to the parties themselves.

1.9 DEFINITION OF CONCEPTS

1.9.1 Inter-professional collaboration

Inter-professionalism involves knowing what is unique to each profession, understanding differences and being able to discuss as equals the variety of contributions to each care situations. It aims at establishing professional identity so that all practitioners will be able to share an integrative ethos (Downes 2001:21).

Inter-professional collaboration among mental health team members, according to Smith, Stone and Bull (2008:166), refers to when professionals from different background work

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together to improve the quality of patient care. Instead of working independently within a loosely constituted group, they work as an interdependent team to provide comprehensive care.

In this study, inter-professional collaboration will imply working together by members of the mental health team available within the health facilities at Vhembe district of Limpopo Province in South Africa with regard to the assessment, planning, implementation and evaluation of mental health care provided for the mental health care users and services.

1.9.2 Mental health team members

Mental health team members refer to a group of health care workers who are members of different disciplines within the mental health fraternity, each providing specific services to the patient. (Mosby's Medical Dictionary, 2012).

Five core mental health professions that make the bulk of the mental health team according to the National Mental health Education and Training (2002:iv) includes mental health nurse, occupational therapist, psychiatrist, psychologist and a social worker.

In this study, members of the mental health team will refer to the psychiatrists allocated for the district, medical practitioners allocated to the mental health units, the clinical psychologists, occupational therapists allocated in the district, regional and specialised hospitals, psychiatric nurses available in the mental health units, and social workers allocated to the hospitals at Vhembe district of Limpopo Province, South Africa.

1.9.3 Collaboration

According to Dimitriadou, Lardaniti, Theofanidis, Psychogiou, Minasidou, Konstadinidou-Straukou and Sapountzi-Krepia (2008:141), collaboration refers to the act of working with another or others on a joint project. It is a process of common work with acceptable goals and philosophy, while the comprehension of particular characteristics of the individual is essential. It is a relation of interdependency built on respect and understanding the unique and complementary perspective each profession makes to achieve the desired outcomes.

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In this study, collaboration will refer to the act of working and or interacting together by members of the mental health team in the delivery of mental health care services at the hospitals within Vhembe district of Limpopo Province, South Africa.

1.9.4 Mental health care user

According to the Department of Health (2002:10) in South Africa, a mental health care user refer to a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of the user, state patient and mentally ill prisoner and where the person concerned is below the age of 18 or is incapable of taking decisions.

In this study, *a* mental health care user shall refer to a patient who come to the hospitals within Vhembe District for assessment, planning, care, treatment and or rehabilitation as well as evaluation.

1.9.5 Multi-disciplinary team (MDT)

According to Deane and Gournay (2008:9), MDT consists of individuals from a range of professional disciplines and backgrounds whose knowledge and skills usually have overlapping competencies as well as the specific disciplinary skills that each team member brings. Such knowledge and skills are aimed at providing co-ordination of assessment and treatment activities to best meet the complex mental, physical and social needs of service users.

In this study, the multidisciplinary team shall refer to a collective consisting of three or more core members of the mental health team namely the psychiatrist or medical practitioner, clinical psychologist, occupational therapist, psychiatric nurse and or the social worker allocated to provide service to the mental health unit at the hospitals within Vhembe district of Limpopo Province in South Africa.

1.9.6 Mental health unit

A mental health unit in South Africa, according to the Mental Health Care Act No 17 of (2002:12), refers to a health establishment or an institution or a hospital with a building or

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laces where persons receive care, treatment, and rehabilitative assistance, diagnostic or therapeutic interventions that has been designated by the Member of the Executive Council as such.

In this study, a mental health unit shall refer to a building unit that is either attached to a district hospital or part of the specialized hospital that has been designated by the Provincial Department to provide care, treatment and rehabilitation for mental health care users.

1.10 RESEARCH DESIGN

1.10.1 Research design

This is an exploratory, descriptive and contextual qualitative study because it attempts to describe human experiences as provided by people involved (Brink 1999:119).

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1.10.1 Qualitative research

According to Brink (1999:119) as well as Polit and Hungler (2004:15), qualitative research involves the systematic collection and analysis of subjective data provided by involved people about the phenomena, including how they interpret the experiences and meaning attached to the experience.

The researcher chose the qualitative research approach because the study sought to explore and describe the views of the respondents regarding the nature of inter-professional collaboration among mental health care members at Vhembe district of Limpopo Province, South Africa.

1.10.2 Exploratory research

Burns and Grove (2003:482) define exploratory research as formative research conducted to gain knowledge of a phenomenon. This study sought to explore the nature of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

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1.10.3 Descriptive research

Descriptive research, according to Polit and Hungler (2004:716), refers to studies that have, as their main objective, the accurate portrayal of the characteristics of reasons, situations or groups. The intention of this study was thus to describe the nature of inter-professional collaboration among members of the mental health team, status of its functionality, barriers and measures that could be put in place to improve it.

1.10.4 Contextual research

Contextual studies focus on specific events in "naturalistic settings" (LoBiondo-Wood & Haber 2002:128). This study was conducted in the Mental Health Units where participants were working and were expected to collaborate in their day to day activities. The participants were enabled to share their views and experiences from their work context as they perceived them, hence the intention of contextualization.

1.11 RESEARCH METHODOLOGY

1.11.1 Population

The population for this study included all members of the mental health team working in the Mental Health Units from the sampled hospitals at Vhembe district of Limpopo Province, South Africa.

1.11.2 Sampling

A non-probability purposive sampling was used in this study. The participants chosen for the study included members of the mental health team working in the selected Mental Health Units deemed capable of articulating the phenomenon under study. 19 participants were recruited to participate in the study.

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1.11.3 Pilot interview

A pilot focus group discussion (FGD) was conducted consisting of four (4) participants that met the criteria for the study.

1.11.4 Instrumentation

Three FGDs comprising five (5) each were conducted using a semi-structured interview guide. The interview guide consisted of open-ended questions based on the objectives set for the study.

1.11.5 Data collection

Semi-structured descriptive FGDs were used to collect data for the study. FGDs are designed to obtain the participants' perceptions in a focused area in a setting that is permissive and non-threatening (Burns & Grove 2005:425). To avoid bias, a research assistant in possession of a Masters degree as a Clinical psychologist was used to facilitate the FGDs. Each participant was asked the same questions and the facilitator was allowed the freedom to digress or to probe far beyond the answers to the prepared scheduled questions (Berg 2009:107). Details on data collection are captured in the methodology chapter.

1.11.6 Trustworthiness

Trustworthiness was ensured through the process as described in the methodology chapter.

1.11.7 Data analysis

Collected data was subjected to data analysis. Data analysis, according to Burns and Grove (2003:794), is conducted to reduce, organize, and give meaning to data. In qualitative research, data gathered is analysed on the spot to shape the ongoing data collection process. Qualitative data analysis needs to be conducted with rigor and care (Coffey, Holbrook & Atkinson 1996:189). Rigor in qualitative research refers to striving for excellence and is associated with discipline, scrupulous adherence and strict accuracy (Burns & Grove 2003:39).

In this study, the researcher listened to the recorded data immediately after the session transcribing it verbatim and then subjected the data to content analysis.

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The three steps of Tesch-segmenting; developing an organizing system; and sorting data (coding) were used to analyze the data (Tesch 1990:115). Details of data analysis are elaborated in the methodology Chapter.

1.11.8 Ethical considerations

Ethics in research tends to involve doing what is right and good during research and application of ethical principles to the realm of research (Uys & Basson 2005:96). Ethical measures are as important in qualitative research as in quantitative research and include ethical conduct towards the respondents' information as well as honest reporting of the results. Ethical issues which included permission to conduct the study, coercion, recruitment, informed consent, privacy, confidentiality and protection from harm were considered (Burns & Grove 2005:195). Details on ethical considerations pertaining to this research are presented in the methodology chapter.

1.12 OUTLINE OF THE DISSERTATION

The study consists of five chapters, set out as follows:

Chapter 1: Orientation to the Study

It is an introductory chapter. It discusses the background, rationale, statement of the problem, research questions, objectives as well as the significance of the study. The research methodology, terminology used in the study was also presented. Outline of the research report are also included.

Chapter 2: Literature Review

This chapter discusses the literature review related to the topic on the nature of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

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Chapter 3: Research Methodology

An overview of the methodology used in the study is presented. This chapter describes the research design, population, sampling, data collection and data analysis used in the study. Ethical considerations and measures to provide trustworthiness are also discussed.

Chapter 4: Data Analysis, Interpretation and Discussion

The findings of the study are analysed, interpreted and controlled through the literature.

Chapter 5: Conclusion and Recommendations

This chapter provides the conclusion, including strengths and limitations of the research findings. Recommendations generated from the study are also presented.

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CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The previous chapter gave a description on the background to the research problem, purpose, research objectives, research questions, its significance to the study, definitions of concepts used in the research study, and outline of the research design and methodology.

2.1.1. Purpose of the study

The purpose of this study was to explore and describe the nature of inter-professional collaboration among members of the mental health team at Vhembe district of the Limpopo Province, South Africa and generate recommendations for improvement.

2.1.2. Research questions

The research questions formulated for the study include:

- What are the views of mental health team members regarding the nature of inter-professional collaboration at Vhembe district of Limpopo Province, South Africa?
- As members of the mental health team at Vhembe district of Limpopo Province, what do they think are the benefits of inter-professional collaboration?
- How is the functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?
- As they collaborate among members of the mental health team at Vhembe district of Limpopo Province, what did they find to be the barriers?
- In their opinion, what measures could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?

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2.1.3. Objectives of the study

The objectives of the study include:

- To explore and describe the views of the mental health team members at Vhembe District of Limpopo Province with regard to the nature of inter-professional collaboration.
- To describe the benefits of inter-professional collaboration from the perspective of the members of the mental health team at Vhembe District of Limpopo Province, South Africa.
- To describe the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.
- To explain the barriers experienced by the mental health team members at Vhembe District of Limpopo Province in South Africa as they collaborate inter-professionally.
- To recommend measures that could be put in place to improve inter-professional collaboration among members of the mental health team at Vhembe District of Limpopo Province, South Africa.

It is against this background that this chapter examines the literature related to inter-professional collaboration among members of the mental health team. Areas of best practice or arguments / discussions will be discussed with regard to views, benefits, functionality, barriers and measures to improve inter-professional collaboration.

2.2. THE UNDERSTANDING OF MENTAL HEALTH TEAM MEMBERS REGARDING INTER-PROFESSIONAL COLLABORATION

A wide range of views on collaboration were described by Bruner, Wasteland and Davey (2011:123) suggesting that there are diverse perspectives on collaboration among staff based on professional roles and levels of education. Those with higher levels of education reported the most positive views of collaboration whilst those with lower levels of education reported more negative views of collaboration.

According to Morrow and Jemings (2005:93) as well as WHO (2010:7), inter-professional collaboration is described as the situation where different professionals work together in different capacities around specific individuals, groups of people or issues, forming a continuum of interaction ranging from information sharing to working together interactively on an everyday basis. It occurs when multiple health professionals from different backgrounds

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contributions of all members tend to promote individual development and team interdependence. They recognize the benefits of working together; and see accountability as a collective responsibility (Canadian Health Service Research Foundation 2006:i)

Whilst in an efficient inter-professional collaboration, participants focus on the achievement of results, holding one another accountable for delivering those plans of actions, commitment to decisions and plans of actions, engagement in unfiltered conflict around ideas, and trust upon one another. Functionality varies by situation, as determined by the needs of the patient, the availability of staff and other resources (Mitchell et al. 2012:3).

Regular face-to-face meetings are essential for functionality of inter-professional collaboration. Through those regular meetings, the team will be able to review assessment and plan of care; and review and update criteria for and progress toward hospital discharge. The meetings ensure that the team reaffirms with regularity the applicability of the shared goals and offers an opportunity for clarification of intent and prevention of misunderstandings (Sfetcu 2013:8).

The quality of meetings is influenced by the degree of preparedness by the team members. If members know according to National Cancer Association (2010:12) what information is required from the locally agreed minimum data set of information, they will be able to prepare and be ready to share that information (or have delegated that to another member if they cannot attend) prior to and/or at the meeting. Some members would be able to collect as much of the core data items before the meeting to save time, hence enhancing the quality of the inter-professional collaboration.

On the contrary, according to Reiss and Kirtchuk (2009:462), whilst MDT might be necessary in terms of efficient management, some mental health care users may not be able to access and take advantage of therapeutic interventions because of difficulties in their interpersonal and intrapersonal functioning. For example, those who might have suffered from abuse or neglect in early childhood, and perhaps also experienced continuing victimisation as adults, may, without realising what they are doing, influence their environment time and again repeating the cycle of previous adverse experiences. The patient may feel and behave differently towards various carers.

Attendance of MDT meetings by mental health care user's was also opposed by health professionals because of concerns about the patient's ability to cope with the information

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discussed and the effect their presence would have on the dynamics of the decision-making process. It has been acknowledged that in the MDT, both opportunities and constraints do exist. The identified opportunities were in large part, responsible for the overwhelming clinician support of this format (Devitt, Philip & Anne 2010:19).

On the other side, attendance at MDT meetings by mental health care users was deemed potentially terrorizing, overwhelming, and confrontational for the mental health care user. There was also a concern that the mental health care user would not be able to understand the MDT meeting discussion and might not cope with hearing the expression of differing viewpoints. Additionally, health professionals were also concerned that mental health care user attendance at MDT meetings would constrain the dynamics of the meeting. There was a concern that the mental health care users' presence might limit the expression of opposing opinions (Devitt, Philip & Anne 2010:19).

From the described situation, inter-professional collaboration among members of the mental health team is understood to be generally the working together by different professionals in specific capacities in a continuum of interaction. It involves the sharing of information, working together interactively on a daily basis with individuals, families and communities with an ultimate aim of providing the highest quality of care. Clarity of purpose, roles, respect for one another, preparedness of team members, amongst other things, has an impact on the quality and functionality of inter-professional collaboration. However, the use of the MDT meetings on the mental health care users need to be applied cautiously, as some might have different reactions to the detriment of it on the part of the mental health care user.

2.3. THE BENEFITS OF INTER-PROFESSIONAL COLLABORATION

Inter-professional collaboration has been accepted universally as a model that promotes a collaborative organization in which professionals share goals, make collective decisions and share responsibilities and tasks. It has been regarded by Sicotte, D'Amour and Moreault (2002:991) as the central aspect to success in recent health care systems.

Inter-professional collaboration is important for both the professionals themselves and the users as well as in the production of high quality services. When professionals work on difficult cases, they experience the need for support and that inter-professional collaboration has the potential of addressing those needs. (Odegard 2009:293).

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Zwarenstein and Brayant (2009:2) found that inter-professional collaboration improved patient outcomes though such outcomes were moderate affecting health care processes rather than the outcomes.

Even though the initiation of discussion by professionals might create conflicts between professional groups, according to Mulvale and Bourgeault (2007:50), inter-professional collaboration has the potential of strengthening accessibility and delivery of mental health services in primary care settings.

According to WHO (2010:7), mental health care users were regarded as team members seen on a continual basis ensuring that their needs were best served in a well coordinated team approach . As they participate in their treatment programme, they get informed with regard to the role of the different disciplines.

Mitchell, Tieman and Shelby-James (2008:S63) have reflected that when professionals from a range of disciplines work together, they are in a position to deliver comprehensive care that addresses as many of the patient's needs as possible. Further evidence suggests that coordinated care, which integrates psychologists and other mental health providers within primary care, can enhance access to services; improve quality of care, and lower overall health care expenditures.

The National Cancer Action Team (2010:6) supported the view of comprehensive care when it highlighted that an effective MDT results in treatment and care being considered by professionals with specialist knowledge and skills. Patients being assessed were offered the level of information and support they needed to cope with their condition.

Inter-professional collaboration is increasingly being viewed as a key strategy for providing the best quality and most effective care to people who require multiple services, or who use both acute and primary health care services (HPRAC 2008:4). According to Borrill, et al (1999:5), the teams enabled organisations to speedily develop and deliver services cost effectively, while retaining high quality care.

Borill et al (2000:2) have alluded that the most effective patient care outcomes are achieved when health professionals work together, learn together, and engage in clinical and evaluation of outcomes together as well as generate innovation together to ensure progress in practice and service. A healthcare system that supports effective teamwork can improve

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the quality of patient care, enhance patient safety and reduce workload issues that cause burnout among healthcare professionals.(Canadian Health Services Foundation 2006:i).

The Canadian Health Services Foundation, in its Synthetic Report, found that health professionals working in an inter-professional collaborative manner were more satisfied and had more positive experience when compared to primary health care professionals working in a uni-professional model. Inter-professional collaboration models can provide a broader range of services, more efficient resource utilization, and better access to services, shorter waiting times, better coordination of care, and a more comprehensive care when compared to uni-professional model of primary health care delivery. (Clements et al. 2008:32)

Priest, Roberts, Blincoe, Lawton and Armstrong (2003:474), when studying inter-professional collaboration, revealed the benefits as an increase in clarity regarding roles, approaches and resources, and how to collaborate in practice.

Traditionally, according to Clements et al (2008:26), teamwork when enhanced by inter-professional collaboration, could have a range of benefits such as reducing medical errors, improving quality of patient care, addressing workload issues, building cohesion and reducing burnout of health care professionals.

Gibb, Morrow, Clarke, Cook, Gertig and Ramprogus (2002:339), whilst evaluating the development of health and social care provision in mental health, identified the following outcomes of working together: team members expressed the feeling that their professional role was strengthened; a sense of common purpose; a more efficient and flexible increase in the responsiveness of the service to clients; allowing team members to manage red-tape more efficiently; an increase in staff morale resulting from a decrease in isolation; a good level of team support through the availability and willingness of the team members to share with and listen to each other; and availability of joint training opportunities. Interpersonal and team processes were perceived to be essential precursors to effective and efficient decision making to individual clients.

From the above description, there is sufficient evidence that inter-professional collaboration has the potential to improve access and coordination to health care services and eventually improving health care outcomes such as reduction in inpatient care, decreased mortality rate and increased patient satisfaction. The benefits of inter-professional collaboration are multiple ranging from the health professionals themselves to the health care users. Inter-professional collaboration improves the organizational structure and working processes in the workplace impacting on the staff morale, confidence and level of job satisfaction. It

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provides an environment conducive for creative solutions to complex health care demands of individuals, families, groups of people and communities. However, despite the given benefits, barriers to inter-professional collaboration are also encountered.

2.4. BARRIERS TO INTER-PROFESSIONAL COLLABORATION

Barriers to inter-professional collaboration are vast calling for consideration towards mitigation. Ineffective or insufficient communication among team members was found to be a contributory factor against inter-professional collaboration leading to adverse events. Professional silos were considered to be a barrier to inter-professional collaboration (Shirly 2006:29; Miers and Pollard 2009:31) and increased the risk on the patients and reduced the quality of care (Sargent 2009:178).

Seeing that all professional groups are socialized and inducted (i.e. trained) into specialist knowledge and to differing degrees protective of their specialist role, it was also found to present a barrier to inter-professional collaboration (Downes, 2001:21).

Rivalry between professional groups emanating from power struggles, for example, the power of seniors (experienced) over juniors (inexperienced), were also found to be a barrier to inter-professional working. According to Shaw, Walker and Hogue (2008:297), medical dominance within the mental health team has been perceived as a barrier to inter-professional collaboration by virtue of being responsible for the prescription of medicines. The conflict was fuelled by the arrogant use of power by doctors despite the age of the professional. As a result, nurses at all levels expressed strong views about their marginal place in the multidisciplinary team and wanted greater recognition for their potential nursing contribution.

Daly (2004:78) further propagates that differences in philosophies of care may also pose an inter-professional collaboration barrier. Professional groups are known to have differing moral and ethical philosophies of care. The paternalistic approach of the cure-oriented medic versus the public health and social advocate stance of the health visitor are examples thereof.

The greatest obstacle to inter-professional collaboration according to Clements et al (2007:31) is the hierarchical structure of healthcare. Entrenched attitudes about scopes of practice, professional turf and historical power structures can sabotage the essence of what teamwork is. Healthcare professionals need to address their personal power issues, adopt

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common goals, breakdown hierarchies and the educate patients about how each team member contributes to their care. New developments in health care such as the generic skill-mixing approach, and a drive towards true patient-centred care using patient power to govern the priorities of inter-professional teams, could be the way to overcome these barriers (Daly 2004:78).

Lack of commitment and inadequate decision making of team members was one of the barriers to inter-professional collaboration at team level (Grant et al. 1995:1). In addition to that, without passionate debate, buy in and commitment to decisions may temper with inter-professional collaboration functionality.

According to Mitchell et al (2012:5), in an effective inter-professional collaboration, team members carry out their roles and responsibilities with discipline, even when it seems inconvenient. Team members are disciplined in seeking out and sharing new information to improve individual and team functioning, even when doing so might be uncomfortable. Such discipline allows teams to develop and stick to their standards and protocols even as they seek ways to improve.

Without terms of reference; referral pathways; case presentations; meeting coordination and administration; documenting meetings outcomes; conducive meeting environment; technological equipment for meetings; monitoring of meetings; patient being informed of the meetings resolutions; and communication processes for the patient's general practitioner, clinical teams and others, inter-professional collaboration is likely not to be effective (Ministry of Health 2012:3), hence the barriers.

Otherwise, the Canadian Health Service Foundation (2006:ii) found transformation to inter-professional collaboration being slow as professionals continue to protect their turf or limit scopes of practice in responding to their own needs.

The Western world according to Odegard (2006:2) seemed to agree that management styles could pose potential difficulties to inter-professional collaboration and the quality of record keeping could also result in inactive collaboration, with each professional group having rigid and singular input into patient care. Evidence-based policies and procedures are thus necessary to mitigate the barrier (Daly 2004:78).

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The Canadian Health Services Foundation retrea identified the most serious management challenges or barriers to inter-professional collaboration. They include lack of designated responsibility for ensuring collaboration; history and tradition as people want to perpetuate the status quo, either to stay within the comfort zones or to protect vested interests; and ineffective communication unless multiple strategies are put in place to ensure effective communication within and between professions, as well as vertically within institution (Clements et al. 2008:32).

Significant inter-professional collaboration is difficult if there is insufficient time allowed to change the historic ways of professional communication and interaction (Clements et al. 2008:32).

Otherwise, factors that were found to signal the likely failure in implementing collaborative practices by experts according to Clements et al (2008:32) included among other things, lack of time to bring people together to reflect and to change; insufficient inter-professional education, including continuing education, and the persistence of professional silos; systems of payment that do not reward collaboration; few links between collaborative practice and individual goals; and the absence of efforts to capture evidence for success and communicate this to key stakeholders, including the public.

Finances and resource allocation may also pose a barrier to inter-professional collaboration. Professionals having markedly different pay scales according to their professional group and their role can be a source of conflict and a barrier to inter-professional collaboration. Seeing monies being used to employ staff from one group to provide a service normally provided by another can cause resentment. Staff shortages can also damage interaction as groups withdraw in an attempt to limit demands made upon them (Daly 2004:78 as well as Clements et al 2008:32).

Political agendas according to Daly (2004:78) may also create inter-professional collaboration barrier in that it is not unusual for health care professionals to feel caught between government drives based on targets and patient discontent. This has a direct effect on the patient-professional relationship and alienates professional groups as they disassociate themselves from others where targets and services might be failing.

It can thus be summarised that barriers to inter-professional collaboration barrier are vast and may include inefficient communication amongst professionals; insufficient time to meet; differences in the finance and resource allocation amongst professionals; differences in the

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philosophies of care such as curative model versus preventive model of care; management styles and quality of record keeping; and or political agendas that might impact on the achievements of targets against patient's needs as well as fragmentation of health care services.

2.5. MEASURES THAT COULD BE PUT IN PLACE TO IMPROVE INTER-PROFESSIONAL COLLABORATION

Measures that could be put in place or addressed to improve inter-professional collaboration barrier include among other things, the structure, system and processes; workplace environment, location, role clarification, integration and team building.

According to the Ministry of Health (2012:3), it is necessary that a structure for inter-professional collaboration barrier be put in place. Mitchell et al (2012:18) have indicated that the quality of inter-professional collaboration barrier meetings can be improved by the availability of terms of reference; referral pathways; case presentations; meeting coordination and administration; documenting meetings outcomes; conducive meeting environment; technological equipment for meetings; monitoring of meetings; patient being informed of the meetings resolutions; and communication processes for the patient's general practitioner, clinical teams and others. The quality of team working, according to Borrill et al (1999:6), was powerfully related to effectiveness of health care teams in terms of clearer objectives, level of participation, level of commitment to quality, and level of support of to innovation.

Sicotte et al (2002:991) as well as Martin-Rodriguez et al (2005:132) have suggested that the formalization of functions and processes appeared to enhance inter-professional collaboration among different professions and was fundamental to the coordination of services. Co-location as it is with members of the mental health team working within the same health facility may re-enforce professional boundaries or visa versa (White and Featherstone 2005:12).

According to Collin et al (2011:2) an open workplace climate and improvement of mutual trust were found to be crucial for the enhancement of inter-professional collaboration barrier. In addition to that, an inclusive participatory style of leadership has also been found to increase the sense of security in a work and improve collaboration. Informal interaction of employees outside the patient care improve inter-professional collaboration barrier.

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Meetings, according to Callaghan (2005:339), were found to be key components in aiding communication and understanding between different professionals. Allness and Knoedler (2011:8) as well as National Cancer Action Team (2010:8) recommended that meetings should be locally negotiated and scheduled when the majority of the team members can be able to attend having accommodated the varying caseloads of the team members.

Informal means of communication are enhanced by geographical proximity of the team members. In the digital age according to Mitchell et al (2012:16), team communication was not limited to in-person communication, such as in team meetings.It also incorporated all information channels (i.e. progress notes, electronic health records, telephone conversations, e-mail, text messages, faxes, and even "snail mail). Many channels of communication may be employed by team members to achieve their purposes.

D'Amour et al (2008:188) have suggested that transition to inter-professional and inter-organizational collaboration required addressing interactional, organizational and socio-political factors. It required understanding of components that inform a single professional knowledge and identity.

Overt organizational commitment and strategies to develop inter-professional collaborationare required to change practice (Jackson 2011:29). The main factors supporting multidisciplinary teamwork according to Wilson and Pirrie (2000:vi) are committed individuals who play a key role in team development; staff with a common sense of purpose or vision and who work together to achieve it; clearly negotiated team roles; and explicit support for such developments at the organisational level. It is necessary that inter-professional collaboration barrier gets anchored in the political and administrative management levels.

Gunn and Blount (2009:237) highlighted that health professionals have different languages that may pose barriers. They further emphasized that to maintain collaborative relationships, whether co-allocated or coordinated, collaborative practices must be integrated into daily patterns. Collaboration should be treated as a process and not as an event.

A formal programme of team building according to the Mental Health Commission (2006:40) should be undertaken at the earliest stage of team formation to enable the team to develop a common vision and principles of operation.

From the above description, it is evident that terms of reference for inter-professional collaboration, coordination of meetings, both formal and informal communication, co-location

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of team members as well as organizational and individual commitment are essential to improvement thereof.

2.6. SUMMARY

This chapter presented a discussion on the aspects related to the nature of inter-professional collaboration among mental health team members. An over view on the views of mental health team members regarding inter-professional collaboration, the benefits of inter-professional collaboration, the functionality of inter-professional collaboration, the barriers of inter-professional collaboration, and the measures that could be put in place to improve inter-professional collaboration.

The next chapter focuses on the research methodology adopted to perform the study. A description of the research, methodology, data collection, data analysis, efforts to ensure trustworthiness and ethical considerations are presented in chapter 3.

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RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter described and or provided a literature review to the study. This section presents a detailed description of the methodology, the research design and approach utilised in this study with regard to population and sampling, data collection, analysis, and ethical considerations.

3.2. RESEARCH METHODOLOGY

According to Brink, Van der Walt and Van Rensburg (2008:191), research methodology entails the methods that the researcher used to explore the research problem or to answer the research question.

3.2.1 Purpose

The purpose for this study was to explore and describe the nature of inter-professional collaboration barrier among mental health team members at Vhembe district of Limpopo Province in South Africa.

3.2.2. Research questions

The research questions formulated for the study included:

- What are the views of mental health team members regarding the nature of inter-professional collaboration at Vhembe district of Limpopo Province, South Africa?
- As members of the mental health team at Vhembe district of Limpopo Province, what do they think are the benefits of inter-professional collaboration?
- How is the functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?

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- As they collaborate among members of the mental health team at Vhembe district of Limpopo Province, what did they find to be the barriers?
- In their opinion, what measures could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?

3.2.3 Objectives

The objectives of the study were:

- To explore and describe the views of the mental health team members at Vhembe district of Limpopo Province, South Africa with regard to the nature of inter-professional collaboration.
- To describe the benefits of inter-professional collaboration from the perspective of the members of the mental health team at Vhembe district of Limpopo Province, South Africa.
- To describe the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.
- To explain the barriers experienced by the mental health team members at Vhembe district of Limpopo Province in South Africa as they collaborate inter-professionally.
- To recommend measures that could be put in place to improve inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

3.2.4 Research design

According to De Vos (2008:323), the research design is seen as a design or detailed plan according to which the research was conducted, while Mouton (1996:107) describes research design as a set of guidelines and instruction followed in addressing the problem.

In this study, the research design, involved qualitative, explorative, descriptive and contextual research, that was employed to generate an account presenting the nature of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

A qualitative paradigm adopted for this study was defined by Stommel and Wills (2004:442) as research that focuses on interpretive, non-numerical, narrative interpretations. This study

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required a rich and in-depth understanding of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province in South Africa.

The qualitative research paradigm was chosen for this study because of its heuristic value, or its usefulness as a tool for exploration related to knowledge development. It was used to determine current problems in practice and to identify what others were doing in similar situations (Burns and Grove 2009:237).

3.2.4.1 Qualitative

Qualitative research is a research approach that seeks to describe and analyze culture and behavior of humans and their groups from the point of view of the people being studied. Its emphasis is on providing a comprehensive or holistic understanding of the social setting in which the research is conducted as described by Burns and Grove (2003:247). Similarly, De Vos (2008:282) as well as Halloway and Wheeler (1996:17) are of the opinion that without the holistic view, there is little value to qualitative research.

In this study, the researcher sought to explore, understand holistically and describe the nature of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

According to Ulin et al (2005:22), qualitative research values natural settings where the researcher can better understand people's lived experiences. The context of people's lives is critical as it influences their perspectives, experiences and actions. Its process is emergent and flexible. Findings emerge continuously. On that base, this study explored, analyzed and understood the phenomenon under study from the participant's perspectives, experiences and actions.

3.2.4.2 Exploratory research

According to Mouton and Marais (1990:43), the objective of qualitative design is to explore areas where limited or no information exists. The study explored inter-professional collaboration among members of health team at Vhembe District of Limpopo Province, South Africa. Members of mental health team were viewed as experts of their own stories on inter-professional collaboration, which they were invited to share.

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3.2.4.3 Descriptive research

According to Streubert et al (2003:341), descriptive research documents and describes the behaviour, events, beliefs, characteristics, attitudes, structures and processes that occur in a phenomenon. It gives complete and accurate information about a phenomenon that is being studied. This study has documented the behaviour, events, beliefs, characteristics, attitudes, structures and processes in relation to the phenomenon under study team as derived from the FGDs.

3.2.4.4. Contextual research

Mouton and Marais (1990:45) described contextual research as an ideograph research, in that; it is uniquely descriptive within the context of the individual setting. This study was contextual because the researcher, as far as possible, studied the phenomenon under study at the selected hospitals which were the participant's own professional natural setting. The researcher wanted to understand the dynamics of human meaning as fully as possible. Since human behaviour, according to de Vos (2001:280) as well as Burns and Grove (2003:26), was influenced in many ways by the environment or setting in which it occurred, it was assumed that participants would be affected by the environment in which they find themselves in enhancing articulation of their views and experiences of the phenomenon under study, hence a contextual design for this study.

3.3. RESEARCH METHOD

Research method includes the steps, procedures and strategies for gathering and analyzing data in a research investigation (Polit & Hungler 1999:709).

3.3.1 Population

Stommel and Wills (2004:297) define a population as any universe of subjects, cases, units, or observations. The view is supported by Polit and Beck (2008:534) emphasising a population as the entire set of individuals (or objects) having some common characteristic(s); sometimes referred to as the universe.

According to WHO (2001:xiii), the core specialist mental health team members include medical and non-medical professionals such as the psychiatrist, clinical psychologist, social worker, occupational

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therapist and the psychiatric nurse. The population for the study comprised mental health practitioners involved in the provision of mental health care services in the hospitals within Vhembe district namely the medical practitioners, the clinical psychologists, occupational therapists, social workers and the advanced psychiatric nurses.

The target population, according to Stommel and Wills (2004:444), refers to the population of all potential study units that met the study inclusion criteria in which the researcher was interested. Polit and Beck (2008:537) define a target population as the entire population in which the researcher was interested and wanted to generalize the results of the study. According to Streubert et al (2003:341), a target population related to the accessible population, which is the study population defined in terms of geographic location, institutional affiliation, or study unit characteristics to which the researcher had access, given the available resources. Stommel and Wills (2004:299) defined an accessible population as the population, often fixed in time and space from which the actual sample was drawn.

For the purpose of this study, target population included mental health professionals involved in the provision of mental health care services in hospitals within Vhembe district of Limpopo Province, South Africa. All the hospitals with a mental health unit(s) (that is Donald Frazer hospital, Elim hospital, Hayani hospital, Malamulele hospital, Siloam hospital and Tshilidzini hospital) were considered accessible from which the sample was drawn as the furthest hospital was about 60km away from the centre.

3.3.2 Research Setting

According to Burns and Grove (2003:140), the research setting is the environment in which the research study takes place and can be a natural or controlled environment. Natural settings are real-life study environment without any changes made for the purpose of the study. The study was conducted at the sampled health care facilities at Vhembe district of the Limpopo Province, South Africa.

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Figure 3.1 Map of Vhembe district, Limpopo Province, South Africa



Source: Municipal Demarcation Board 2013

Vhembe district is located in the far-north of Limpopo Province, South Africa. It is among the five districts of Limpopo Province. It is bordered in the East by Mozambique, West by Botswana, North by Zimbabwe and in the South East by Mopani and Capricorn districts in the South West (See Figure 3.1 above). The district covers 21 407 square kilometer of land consisting of four local municipalities as reflected in figure 1.1, and the following sub-districts: Thulamela, Makhado, Mutale and Musina. Vhembe district in Limpopo Province has a population of 1,312,203 with a population density of 70.1 people per km2 (Department of Health 2014:15).

Mental health care services in Limpopo Province are provided through designated specialized hospitals and mental health units located within general hospitals, listed 72 hours assessment facilities and primary health care facilities, with the private sector playing a limited role. It is government's policy to integrate mental health care services into Primary Health Care (Department of Health 2013:1). The spiritual and traditional healers also play other roles in the provision of such services.

Mental health services at Vhembe district of Limpopo Province are coordinated by a district mental health coordinator located at the district office. Vhembe district has 8 hospitals comprised of 1 regional hospital, 6 district hospitals and 1 specialised hospital for mental health care users as well

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as 120 Primary Health Care facilities (Department of Health 2014:15). At the time of the study, Mutale Municipality or sub-district did not have a district hospital of its own. Its population depended on Messina and Donald Fraser hospitals which were in other municipalities for hospital care re-enforcing the need to optimally utilize the available human resources.

The 4 district hospitals that had a mental health unit, that is Donald Frazer, Elim, Malamulele and Siloam hospitals, were mainly staffed by psychiatric nurses. The rest of the core members of the mental health team were allocated for the whole hospital. Louis Trichardt and Messina hospitals were two small district hospitals without a mental health unit. At the time of the study, Vhembe district did not have a resident psychiatrist but two (2) visiting ones from the University of Limpopo in Polokwane, which is about 100km - 200km away.

Tshilidzini Hospital is a regional hospital which at the time of the study had 12 usable beds for mental health care users. Hayani Hospital was a specialised mental hospital with 11 mental health Units (inclusive of the Maximum security unit, chronic units for mental health care users and for those living with intellectual disability).

Donald Frazer hospital, Elim hospital mental health units and Hayani hospital, were the three hospitals that had the full mental health team component comprised of medical practitioner (s), clinical psychologist(s), occupational therapist(s), social worker(s) and the psychiatric nurses. NB: At the time of data collection, Hayani hospital did not have a clinical psychologist but a trauma counsellor.

3.3.3 Sample and sampling techniques

Stommel and Wills (2004:443) defined a sample frame as the list or data bank that represents all elements / units / participants of an accessible target population used for the sampling of participants. While Polit and Beck (2004:536) emphasized that sampling frame should be seen as a list of all the elements in the population, from which the sample is drawn, in this study, the sample frame included all the hospitals within Vhembe district with mental health units as described above.

3.3.3.1 Sampling of hospitals

A non-probability purposive sampling was used in this study. According to Burns and Grove (2003:255), purposive sampling referred to judgmental sampling that involved the conscious selection by the researcher of certain participants to be included in the study. The participants that met the eligibility criteria set for the study were selected. In line with Polit and Beck (2008:306),

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subjects judged by the sectional head to be knowledgeable and articulate about the issue under study were purposively sampled and recruited to participate in the focus group discussions.

For the purpose of this study, the researcher obtained the list of all hospitals with mental health units within Vhembe district from the list of designated health establishments administered under the auspices of the State Psychiatric Hospitals of Care and Rehabilitation Centres in terms of the Mental Health Care Act no 17 of 2002, South Africa.

The hospitals were purposively sampled from the list based on the extent to which they had the complement of core members of the mental health team. That was done in order to get the significant number of the FGD's participants and a valid picture in terms of inter-professional collaboration. On that base, Siloam hospital, Elim hospital, Donald Frazer hospital, and Hayani hospitals were purposively and respectively selected for the study. Siloam Hospital also served as a pilot site for the study.

Tshilidzini hospital, though it had met the criteria for inclusion in the study, it was purposely left out since at the time of data collection, its mental health unit was accidentally burnt. Mental health care users at Tshilidzini hospital were cared for less than three days before transferred to other district hospitals with mental health units and the situation was still unstable.

Hayani hospital was selected as it was the only specialized hospital for mental health care users within the district hoping to see a certain degree of inter-professional collaboration among mental health team members.

3.3.3.2 Sampling of participants

Participants for the FGDs were purposively sampled from the selected hospitals as described above. After the permission had been secured from the hospital managements and information sheet had been distributed to the mental health units. The allocated mental health team members in the case of medical practitioners, the clinical psychologists, social worker and the occupational therapists were recruited for participation in the FGDs. In the case of psychiatric nursing, the responsible unit manager,in collaboration with his or her staff, was requested to identify and delegate an advanced psychiatric nurse with two or more years of experience and who would be able to articulate the views regarding the phenomenon under study.In a hospital that did not have a clinical psychologist, a psychometrist or a trauma counsellor was purposively recruited for the FGD seeing that their work was part of psychological services as a replacement. The medical practitioner replaced the psychiatrist as all hospitals did not have a resident one.

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3.3.3.3 Sample size

According to Polit and Beck (2008:308), a sample size is largely a function of the purpose of the enquiry, the quality of information, and the type of the sampling strategy used. Sample size is determined based on the informational needs or data saturation to the point at which no new information is obtained and redundancy is achieved.

In each FGD, every core professional discipline was represented by at least one individual presumed to be able to share more information on the phenomenon under study.

According to Stommel and Wills (2004:284), for most purposes, a group of 6 to 12 members are optimal. In this study, one professional per professional discipline per hospital was purposively recruited and invited to a FGD to avoid dominance by a particular discipline and disruption of the services. In areas where there was only one member of the respective professional discipline, he or she was purposively recruited to participate in the FGD. Where there were more than one participants of the same professional discipline such as nursing, in collaboration with the unit manager, the participant deemed able to articulate the phenomenon under study, was identified and recruited. Each FGD ended up comprised of five (5) participants except for the pilot study that had four (4) as the hospital did not have an allocated medical practitioner. Four (4) FGDs comprised of 19 mental health team members were conducted.

3.3.4 Data collection

Making use of a research assistant, holding a master's degree in clinical psychology and competent in conducting a FGD, semi-structured FGDs were conducted to collect data for the study. Four (4) FGDs were conducted. According to Berg (2009:107), in a FGD, each participant is asked the same questions and the facilitator is allowed the freedom to digress or to probe far beyond the answers to the prepared scheduled questions. In this study, the schedule of questions based on the research questions was used to conduct the FGDs.

3.3.4.1 Advantages of using FGDs

The advantages of FGDs, as noted by Stommel and Wills (2004:284), are an efficient tool for exploring a topic. Participants in this study were encouraged to explore their views to the point of saturation, i.e. when no further new information had become apparent. Group members were able to enhance their own thinking about inter-professional collaboration in response to other group members' contributions. Some key themes and ideas were generated from the interactions among group members. The research assistant could support their interpretations of the FGD data with

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ancillary observations such as audio-tapes of the group sessions. The use of an audio tape reduced forgetfulness, misrepresentations or selective memories on the part of the researcher. Data obtained from focus group discussions was rich and provided "food for thought" for future research. FGDs were flexible and appropriate for exploring the phenomenon under study.

According to Baron-Epel, Kaplan, Weinstein, Manfred and Green (2010:543) acquiescence occurs when a person knowingly would not object to the infringement of his or her rights whilst someone else unknowingly and without malice afore thought makes a claim on their rights. The researcher, as a district mental health coordinator and or a supervisor of the same FGD participants, the risk for acquiescence was high necessitating the use of a research assistant. The research assistant was responsible for the facilitation of the FGD stimulating the exchange of ideas and encouraging debate. In order to enhance the outcome of the FGD on the phenomenon under study, a clinical psychologist from one of the district hospitals that was not part of the selected hospitals, was considered. As a clinical psychologist, she was considered an expert in communication skills and was thus recruited to assist in the facilitation of the FGD.

The research assistant was firstly briefed about the study in terms of the topic, background, problem statement, purpose, objectives, research questions, the research design, population, and sample and data collection. In line with the FGD protocol, according to Ehrmann and Zúñiga (1997:3-57), the research assistant was briefed on the recruitment of participants and the setting for the FGDs. The research assistant was also briefed and given a guide on the introduction of the FGDs, the role of the research assistant, purpose of the session, ethical consideration, ground rules, and research content discussion (See Annexure H).

As data was being collected, the researcher, making use of the research assistant, continued to monitor, evaluate and determine the feasibility of the FGDs; to estimate the time being spent on one FGD; and to try out and refine the planned FGD questions (Leedy & Ormrod 2005:110). The time enabled the researcher to brief the participants on the approximate time likely to be spent with subsequent focus group discussions.

As explained during the introduction to the participants, FGD was recorded making use of an audio tape. The researcher had to listen to the recordings immediately after the discussion whilst transcribing it verbatim to a word document. As the researcher listened to the recordings, he gradually became familiar to the data and also began to get immersed in it towards data analysis.

Monitoring and evaluating the FGDs led to a number of improvements: the refinement of questions, estimation of possible time for the FGD, signing of the consent form before participating in the FGD, as well as the avoidance of the usage of vernacular. Usage of vernacular resulted in participants just taking without a focus.

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Seeing that in the following hospital, the FGD participants were health professionals and not of the same ethnicity, they were encouraged to use a workable language and English became a medium of discussion. Where they had a challenge in expressing themselves in English, they were allowed to use vernacular. Time period was able to be reduced from two hours (2hrs) to 45 – 1hr15 minutes through the usage of English language.

Signing of the consent form before the FGD instead of during the introduction phase of the FGD as it had been in the pilot FGD, it improved the problem where there was a prolonged silence on the audio tape whilst participants were still signing the consent form.

Where participants were responding directly to the facilitator and not discussing among themselves, participants were encouraged to interact among themselves quite often rather than to reciprocally respond to the facilitator. The discrepancy was identified in the transcription of the pilot study by the co-supervisor.

3.3.5. Interview schedule

The research assistant introduced the research question (s) and moderated the focus group to elicit discussions in an unstructured format. The following questions were asked during the FGD:

- What are your views as members of the mental health team regarding the nature of inter-professional collaboration?
- As members of the mental health team at Vhembe district of Limpopo Province, South Africa, what do you think are the benefits of inter-professional collaboration?
- How is the functionality of inter-professional collaboration among mental health team members in your hospital?
- As you collaborate among yourselves as members of the mental health team in this hospital, in your opinion, what do you think were the barriers to inter-professional collaboration?
- In your opinion, what measures do you think could be put in place to improve inter-professional collaboration among mental health team members in this hospital?

As the research assistant was responsible for facilitating the FGD, taking down some notes and managing the audio tape recorder, the researcher was attending to the logistics outside the discussion room. The logistics included signing the consent forms, arranging and guarding the place where FGDs were being conducted from disruptions by mental health care users as they were conducted within the mental health unit where participants were working (Polit & Beck 2008:248).

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The research assistant conducted all four FGDs and wrote brief descriptive summaries that included behaviour and feelings about the FGDs (Ehrmann & Zúñiga 1997:3-57).

3.3.6 Data analysis

The data collected was analysed on the spot to shape the ongoing data collection process. Streubertet al (2003:341) note that this sequential analysis or interim analysis has the advantage of allowing the researcher to refine questions on the spot and pursue emerging avenues of inquiry in further depth. Such continuous analysis is almost inevitable in qualitative research.

As the researcher listened to the recorded data immediately after the session, it was impossible not to start thinking about what was being discussed. Once the researcher and the research assistant leave the field, the textual data (in the form of field notes or transcripts) was transcribed verbatim; and then subjected to content analysis.

The following stages were used during data analysis:

- **Familiarisation** where the researcher substantially engaged in immersion of the raw data by listening to audio-tape, reading transcripts, and studying the notes, in order to list key ideas and recurrent themes.
- **Identifying a thematic framework** where the researcher engaged in identifying all the key issues, concepts, and themes by which the data were examined and referenced. That included the aims and objectives of the study as well as issues raised by the respondents themselves and views or experiences that recurred in the data.
- **Indexing** where the researcher applied the thematic framework or index systematically to all the data in textual form by annotating the transcripts with numerical codes from the index, and supported that with short text descriptions to elaborate the index heading. Single passages of text were combined to comprise a number of different themes, each of which was recorded in the margin of the transcript.
- **Charting** where the researcher re-arranged the data according to the appropriate part of the thematic framework to which they were related, and or forming charts. The charts contained distilled summaries of views and experiences. Thus, the charting process involved a considerable amount of abstraction and synthesis.
- **Mapping and interpretation** where the researcher used the charts to define concept, and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings. The process of mapping and interpretation was

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influenced by the original research objectives as well as by themes that emerged from the data.

3.4 ETHICAL CONSIDERATIONS

Ethics in research tends to involve doing what is right and good during research and application of ethical principles to the realm of research (Uys & Basson 2005:96). Before data could be collected, required ethical considerations were followed. Ethical issues included permission to conduct the study, coercion, recruitment, informed consent, privacy, confidentiality and protection from harm (Burns & Grove 2001:195).

3.4.1 Permission to conduct the study

Permission to conduct the study was sought from the following:

- The Higher Degree's Committee of the School of Health Sciences at UNIVEN (See Annexure A).
- An ethical clearance certificate to conduct the study was also granted from the University SENEX Committee. (See Annexure A)
- Approval to conduct the study was sought from the Provincial Department of Health (See Annexure C), as well as from the following gatekeepers: District office and Health facilities (see annexure D1, D2, D3 & D4); as well as from
- The participants themselves (see Annexure G)

3.4.2 Coercion

According to Essack and Juwah (2007:12), the researcher is expected to seek consent only under circumstances where the prospective participants considered whether to participate or not to participate, minimizing the possibility of coercion or under-influence. The researcher, being the Vhembe district coordinator of mental health services and the research participants involving mental health practitioners at Vhembe district of Limpopo Province, collecting data became an ethical issue. Special attention was given to the potential for coercion, undue influence, power disparities, as well as fairness in the process of selecting participants. Before data collection begins, the following was done:

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In this study, information letters with full explanation of the study inviting members of mental health team to participate in the study were distributed to the selected mental health units in order to recruit participants. In that way coercion was avoided (See Annexure F).

Secondly, before FGDs, participants were provided with consent letters which each read and sign before participating in the study (See Annexure G).

Thirdly, the researcher made use of a research assistant or an independent facilitator, a clinical psychologist from the hospital that was not part of the selected ones to conduct the FGDs in order to collect data.

3.4.3 Informed consent

Informed consent relates to the participant's right to adequate and relevant information before the commencement of the study (Creswell 2005:211). In this study, FGDs took place after recruitment, where the informational letters and consent forms were already handed to potential participants. The information letters and consent forms emphasising the voluntary nature of participating, and the absence of punishment of withdrawing from the study prior to completion were made available to participants (See Annexure E, F & G). Permission to audio tape the discussion was obtained from the participants.

3.4.4 Right to privacy

Participants were assured of protection from loss of dignity, friendship, embarrassment or shame as described by Burns & Grove (2001:195). Participant's names were not used during the FGDs. Instead of addressing them by their names, professional designations were used to address the participants. The participants were advised to signal if they wanted the research assistant to stop the button on the audio tape if they felt that the information they wanted to disclose was not to be recorded. Participant's names were not disclosed in the report.

3.4.5 Confidentiality

In this study, confidentiality was ensured by limiting access to the data to persons directly responsible for the research as propagated by Burns & Grove (2001:195). Participants were requested to adhere to confidentiality. Anonymity was protected by assigning codes to the

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research participants when analyzing and reporting, as a recommended technique by Creswell (2005:211). Confirmation of the research analysis and deduction of themes was done with the participants.

3.4.6 Protection from discomfort and harm

According to Creswell (2005:211), probing questions have to be done cautiously avoiding embarrassment. In this study, the comfort of participants was ensured through the selection of a suitable venue and times. Questions were phrased cautiously in a polite manner and were not humiliating (See Annexure H).

3.4.7 Scientific integrity of the research

- *Honesty*

The researcher maintained honesty in all scientific communications, by honestly reporting data, results, methods and procedures, and publication status after the dissertation's acceptance by the University of Venda, subject to its specifications. The researcher did not fabricate, falsify, or misrepresent data. He did not deceive colleagues, granting agencies, or the public on any part of the subject matter being studied.

- *Carefulness*

The researcher avoided careless errors and negligence by continuing to carefully and critically examine his own work. Accurate records of research activities, such as data collection research design, and correspondence with agencies, supervisors and the institutions participating in this research were kept.

3.5 TRUSTWORTHINESS OF THE STUDY

Mdondolo, De Villiers and Ehlers (2003:91) maintain that the trustworthiness is the extent to which a study is worth paying attention to, worth taking note of, and the extent to which others are convinced that the findings can be trusted. The basic question addressed by the notion of trustworthiness, according to Lincoln and Guba (1985:290), is simple. "How can an inquirer persuade his audiences that the research findings of an inquiry are worth paying attention to?" When judging qualitative work, Stommel and Wills (2004:288) maintain that

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replicability is a key standard convention. As a criterion for data quality, replicability means that the readers of a research report should expect to see enough information about the data collection methods and study design so that these methods could be used again (replicated) in a similar study. Thus, to ensure replicability of this study, a descriptive study design and FGDs were clearly explained. Lincoln and Guba (1985:300) identify criteria employed to judge the trustworthiness of qualitative research. They are credibility, transferability, dependability and confirmability.

3.5.1 Credibility

Credibility standards involve performing specific activities that increase the trustworthiness of the reported findings (Stommel & Wills 2004:289). It can be enhanced through the triangulation of data. In this study, data was triangulated from the four FGDs. Other techniques for addressing credibility include making segments of the raw data available for others to analyse (peer debriefing), prolonged engagement or the researchers substantial immersion in the research process and the use of "member checks," in which respondents are asked to corroborate findings (Lincoln & Guba 1985:313).

In this study, the activities that enhance more credible findings and interpretations were adhered to, and they included: making segments of the raw data available for others to analyse; prolonged engagement and persistent observation with the participants to allow identification of recurring patterns, themes and values for the validation of perspectives; substantial immersion in the research process and the use of member checks.

As a former member of a mental health team at Hayani hospital and currently a district coordinator of mental health services at Vhembe district of Limpopo Province, engagement at the research setting has been prolonged. That enabled the researcher to achieve data saturation and to carry out member checks. Member checks required a return to the FGD participants who were available and present to them the interview transcripts and the interpretation derived from the interviews in order to confirm the accuracy and credibility of the findings as described by Creswell (2005:116).

The credibility of the study was further enhanced by peer review of the methodology at the University of Venda's School of Health Sciences Higher Degree's Committee as well as the University of Venda Higher Degree Committee. Consensus discussions were conducted with experts in qualitative research design and methodology at the presentations.

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3.5.2 Transferability

Transferability, according to Stommel and Wills (2004:288), is conceptually similar to generalisability (external validity) in quantitative studies, which refers to the extent to which findings can be generalized to other situations and target populations. Lincoln and Guba (1985:110) admit that generalisability is "an appealing concept, "because it allows a resemblance of prediction and control over situations. The researcher made references to the raw data, kept available for any interested person (researchers) to cross check or verify (providing one aspect of an audit trail). This detailed information therefore, potentially renders opportunities to interested parties to gauge the extent to which the study findings could be generalisable or transferable to other situations. However, the research report emphasise that the findings of this study might not be generalisable to other sites without repeating the study at such sites.

3.5.3 Dependability

Lincoln and Guba (1985:317) propose one measure which might enhance the dependability of qualitative research. That is, the use of an "inquiry audit," in which reviewers examines both the process and the product of the research for consistency. Stommel and Wills (2004:288) maintain that dependability is conceptually similar to the concept of test-retest and internal consistency (reliability) in quantitative research approaches. Dependability refers to how stable or unstable the data patterns tend to be over time or on different occasions.

An attempt to account for changing conditions in the phenomenon chosen for the study as well as changes in the decision created by increasingly refined understanding of the setting. It is likely that the study might yield similar results even if it could be conducted with other participants in a similar context. Experts were used to validate the methodology. Field notes were written during data collection and discussions with the supervisors throughout the study ensured dependability.

3.5.4 Confirmability

Confirmability, according to Lincoln and Guba (1985:320), refers to the degree to which the researcher can demonstrate the neutrality of the research interpretations, through a "confirmability audit", Stommel and Wills (2004:288), call it "audit trails". This means

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providing an audit trail consisting of raw data; analysis notes; reconstruction and synthesis products; process notes, personal notes; and preliminary developmental information. To meet the criteria for confirmability, the researcher used audit trails, in which approaches to data collection, decisions about what data to collect, and decisions about the interpretation of data was carefully documented, so that another researcher could arrive at the same conclusions about the data and for the protection of human subjects, as required by institutional review boards.

3.6 SCOPE AND LIMITATIONS OF THE STUDY

According to Hostee (2010:87), delineations explains what the researcher is responsible for detailing and not responsible for and why. The scope of the study gets limited living the conclusions not applicable in certain circumstances. Limitations affect how the researcher is able to generalize the conclusions or how confident the researcher is about the conclusions (reliability).

The mental health units at hospitals within Vhembe district of Limpopo Province, South Africa were the centre of focus for this study. Primary health care facilities were not included in the study. Consequently, the results of this study might not be generalized beyond the hospitals and the Vhembe district of Limpopo Province, South Africa.

Only the nature of inter-professional collaboration among mental health team members was studied. Other health professional categories and community members might have different views. However, only the views of mental health team members were obtained. The results of this study may not be generalized to all health professionals.

3.7 SUMMARY

This chapter included a detailed report on the research process and design, which includes methodology, the population and sampling, the data collection method and the instrument that was used in the study. Strategies and methods used to ensure trustworthiness of the study were provided, and steps taken to ensure ethical consideration were outlined.

The following chapter contains a presentation of the data analysis, interpretation and control of the research findings.

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CHAPTER 4

DATA ANALYSIS AND DISCUSSION

4.1. INTRODUCTION

In the previous chapter, the research design and methods were discussed. This chapter focuses on the data analysis strategy and discussion. Data analysis involves the categorising, ordering, manipulation and summarising of data and describing it in meaningful terms (Brink et al. 2008:170). This chapter presents the discussion and presentations of the findings.

4.1.1 Purpose of the study

The purpose of this study was to explore and describe the nature of inter-professional collaboration among members of the mental health team at Vhembe district of the Limpopo Province, South Africa and generate recommendations for improvement.

4.1.2 The research questions

The research questions formulated for this study were:

- What are the views of mental health team members regarding the nature of inter-professional collaboration at Vhembe district of Limpopo Province?
- As one of the members of the mental health team at Vhembe district of Limpopo Province what do they think are the benefits of inter-professional collaboration?
- How is the functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province?
- As you collaborate with other members of the mental health team at Vhembe district of Limpopo Province, what did you find to be the barriers?
- In your opinion, what measures could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa?

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4.1.3 Objectives of the study

The objectives of this study were:

- To explore and describe the views of the mental health team members at Vhembe District of Limpopo with regard to the nature of inter-professional collaboration.
- To describe the benefits of inter-professional collaboration from the perspective of the members of the mental health team at Vhembe district of Limpopo Province, South Africa.
- To describe the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.
- To explain the barriers experienced by the mental health team members at Vhembe district of Limpopo Province in South Africa as they collaborate inter-professionally.
- To recommend measures that could be put in place to improve inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo Province, South Africa.

4.1.3. The sample size

Four (4) FGDs were conducted during November and December 2012. At Siloam hospital, 4 participated in the pilot FGD whilst at Elim, Donald Frazer, and Hayani hospitals, FGDs were comprised of five (5) participants each respectively. In total, there were 19 participants in the study.

The analysis of the qualitative data began in the field, during data collection, using the semi-structured FGD. The data gathered were analysed on the spot to shape the ongoing data collection process. Once the researcher left the field, textual data exploration continued through content analysis.

4.2. DATA ANALYSIS STRATEGY

The framework approach of data analysis, suggested by Pope et al (2000:116) was used in this study (refer to section 3.5). The researcher listened to tapes and studied transcripts with dedication, until familiarity was achieved.

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During this stage, the researcher began sifting pieces of data that were considered relevant to the purpose of the study. The researcher coded and categorized these data chunks, while reading and rereading the transcripts, as a means of developing themes. The researcher developed a detailed index of the data, which categorized the data into manageable chunks for subsequent retrieval and exploration. This was followed by systematically annotating the transcripts with numerical codes, supported by short text descriptors to elaborate the index heading.

The researcher re-arranged the data according to the appropriate part of the thematic framework to which they related; forming tables. The tables contained statements of views and experiences. The researcher used the tables to provide explanations for the findings.

Each theme was described in detail, including their associated categories and sub-categories. The researcher provided "thick" descriptions of what was discussed in the focus groups, and quotes from the FGD participants that illustrated specific themes.

In the discussion section of the research report, the researcher provided commentaries about the knowledge generated by the study's result, including the participant's views regarding the nature of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.

The researcher also discussed specific implications of the findings for mental health care, tying the implications to existing literature, to enhance the credibility of the interpretations of the findings.

4.3. DATA ANALYSIS AND DISCUSSION

The findings are presented in two sections, namely Section A and B. Section A contains a discussion on the biographical data of the participants and section B focuses on the themes and sub-themes that emerged from the data. In section 4.3.1 the demographic data of the FGD participants are presented in quantitative terms in order that the readers can know who these participants were. This might be important for contextualizing some qualitative data presented and discussed.

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4.3.1. Section A: Demographic data of participants

Participants were mental health practitioners. A brief profile of FGD participants was obtained inclusive of gender, professional category of participants, and the range of number of years of experience as mental health care practitioners.

A total of four FGDs were conducted and the demographic details are displayed in table 4.1. The result show that out of 19 participants, the majority of FGD participants (n=12; 63.15%) were females.

Each core discipline in the mental health team (i.e. psychiatry, clinical psychology, occupational therapy, social work and psychiatric nursing) was represented by one member. Psychiatry was represented by a medical practitioner except at Siloam where there was none allocated to the mental health unit (See table 4.1).

Psychiatric nursing was represented by advanced psychiatric nurses except at Hayani hospital where the nurse was a registered forensic psychiatric nurse and the coordinator of the MDT for the hospital). Clinical psychology was represented by a clinical psychologist except at Siloam hospital and Hayani hospital where it was represented by a psychometrist and a trauma counsellor respectively as they did not have one (See table 4.3.

Most of the FGD participants had 0 – 5yrs (n=8; 42.1%), 6 – 10yrs (n= 6; 31.5%) and above 10yrs (n= 5; 26.3%) of experience as mental health care practitioners, respectively (See table 4.4).

Table 4.1: Focus Group Discussions, hospitals and gender of participants

FGD	**FGD no 1**	**FGD no 2**	**FGD no 3**	**FGD no 4**	**Percentage**
Hospital	**Siloam**	**Elim**	**DFH**	**Hayani**	
Gender : Female	3	3	3	3	12 = 63.15%
Male	1	2	2	2	7 = 36.84%
Total	**4**	**5**	**5**	**5**	**19 = 100%**

Table 4.1 shows that all four FGDs had the majority of females (that is 63%) whilst males were 36.84%.

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Table 4.2: No of participants, hospital, discipline and percentage

	No of participants per hospital per FGD				Sub-total	Percentage
Hospital	**Siloam**	**Elim**	**DFH**	**Hayani**		
Discipline: Medicine	0	1	1	1	3	16%
Clinical psychology	1	1	1	1	4	21%
Occupational therapy	1	1	1	1	4	21%
Social work	1	1	1	1	4	21%
psychiatric nurse	1	1	1	1	4	21%
Total	**4**	**5**	**5**	**5**	**19**	**100%**

Table 4.2 shows that all four FGDs had an equal number of participants comprised of 5 core members of the mental health team except for Siloam hospital that did not have a medical practitioner allocated to a mental health unit.

Table 4.3: Participant's discipline, range of years and percentage

	Participant's range of years of experience					Percentage per FGD
Hospital	**Siloam**	**Elim**	**DFH**	**Hayani**		
Discipline: Medicine	0	6 – 10yrs	0 – 5yrs	6 – 10yrs	3	0-5yrs = 25% 6 – 10yrs = 50%
Clinical psychology	6 – 10yrs Psychometrist	6 – 10yrs	Above 10yrs	0 – 5yrs Trauma counsellor	4	0 – 5yrs = 25% 6 – 10yrs = 50% above 10yrs = 25%
Occupational therapy	0 – 5yrs	0 – 5yrs	0 – 5yrs	6 – 10yrs	4	0 – 5yrs = 75% 6 – 10yrs = 25%

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Social work	6 – 10yrs	0 – 5yrs	0 – 5yrs	6 – 10yrs	4	0 – 5yrs = 50% 6 – 10yrs = 50%
psychiatric nurse	Above 10yrs	Above 10yrs	Above 10yrs	Above 10yrs (Forensic & MDT coordinator)	4	Above 10yrs = 100%
Total	**4**	**5**	**5**	**5**	**19**	

Table 4.3 shows that Donald Frazer hospital was dominated by participants who were less than 5yrs of experience whilst Hayani hospital was dominated by participants who were more than 6yrs. The FGD at Siloam and Hayani hospitals did not have a clinical psychologist but were replaced by a psychometrist and a trauma counsellor respectively. In all four FGDs, nursing was represented by the advanced psychiatric nurse except for Hayani hospital where the forensic psychiatric nurse was identified and recruited as he was deemed most appropriate in articulating views regarding the phenomenon under study.

Table 4.4: Number of participants per hospital in relation to the range of years of experience as mental health practitioners and percentage thereof.

	No of participants per hospital and range of yrs of experience				**Sub-total**	**Percentage**
Hospital	**Siloam**	**Elim**	**DFH**	**Hayani**		
Range of yrs						
0 – 5yrs	2	2	3	1	8	42.1%
6 – 10yrs	2	2	0	3	7	36.8%
Above 10yrs	1	1	1	1	4	21.1%
Total	**4**	**5**	**5**	**5**	**19**	**100%**

From the table 4.3 and 4.4 above shows that42% of participants were having 0 – 5yrs; 36.8% having 6 – 10yrs; and 21.1% having above 10yrs of experience as mental health

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practitioners. Donald Frazer Hospital FGD was dominated by participants with less than 5 yrs of experience whilst Hayani Hospital was dominated by those with more than 5yrs of experience. In all the groups, nursing participants had more than 10yrs of experience.

4.3.2 Section B: Presentation on the themes and sub-themes

In this study on the nature of inter-professional collaboration among mental health team members, five (5) main themes were deduced, namely understanding of inter-professional collaboration, benefits of inter-professional collaboration, state of functionality, barriers of inter-professional collaboration and measures to improve inter-professional collaboration. The discussion of the findings will focus on those main themes as reflected in table 4.5.

Table 4.5.: Themes and sub-themes identified regarding the nature of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.

Main themes	Sub-themes
1. Understanding of inter-professional collaboration	1.1. *The use of team approach* working together as a collective or a mental health team
	1.2. *Holistic approach* looking at the and or addressing the needs of the mental health care user in totality
	1.3. *Situational team approach* depending on the needs identified of the patient
	1.4. *Community involvement* engaging those that are in the community or in the Primary Health Care facilities
2. Benefits of inter-professional collaboration	2.1. *Efficiency* in the management of the patient
	2.2. *Information giving* imparting knowledge to both the mental health care user and the team members
	2.3. *Holistic approach* addressing the diverse needs of the clients
	2.4. *Strengthened support* for the mental health care user
3. State of functionality of inter-professional collaboration	3.1. Varied views in the use of the *team approach*
	3.2. Varied views in the holding *multi-disciplinary team meetings*
	3.3. *Infrequent referral* of client to other team members
	3.4. *Poor quality of multi-disciplinary team meetings*
	3.5. Failure to *schedule* multi-disciplinary team meetings
	3.6. Team members failing to *collaborate* amongst each others

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	3.7. *Negative attitudes* of team members' undermining each other.
	3.8. *Unavailability* of other team members affecting inter-professional collaboration
	3.9. Poor *communication* amongst mental health team members
	3.10 *Poor management support* for inter-professional collaboration
4. Barriers of inter-professional collaboration	4.1. *Lack of commitment* in honouring and coordination of multi-disciplinary team meetings
	4.2. *Ignorance* of the *roles and functions* of mental health team members and in knowing what is to be discussed in the multi-disciplinary team meetings
	4.3. *Shortage of resources (i.e. human resources, material resources and infrastructure that is not fit for purpose)*
	4.4. *Poor quality* of multi-disciplinary team meetings
	4.5. *Negative attitudes* or stigma attached to mental health
	4.6. *Burnout* and poor clinical work by mental health team members.
	4.7. *Poor communication* and lack of involvement among mental health team members
5. Measures to improve inter-professional collaboration	5.1. Development of *policies* on inter-professional collaboration
	5.2. Inclusion of inter-professional collaboration in the *job description* of mental health team members
	5.3. *In-service training* on inter-professional collaboration
	5.4. *Taking responsibility* to collaborate inter-professionally
	5.5. Use of quality multi-disciplinary team meetings
	5.6. *Respect* for one another treating each other as health professionals
	5.7. Conducting *team building* activities amongst mental health team members
	5.8. *Involvement of PHC* staff in the multidisciplinary team meetings
	5.9. *Providing management support* to multi-disciplinary team meetings
	5.10. *Attitudinal change* towards mental health
	provision of resources for inter-professional collaboration

The results of the study are discussed along the themes and the sub-themes that were derived from the data. Applicable direct quotes are supplied to substantiate relevant results. Appropriate research reports are also cited to support findings.

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Theme 4.3.2.1: Understanding of inter-professional collaboration

This theme relates to the view that participants had regarding inter-professional collaboration among mental health team members. From the main theme of understanding, four sub-themes were further deduced, namely, team approach, a holistic approach, situational team approach and community involvement which will be the focus of discussion.

Sub-theme 4.3.2.1.1: The use of a team approach working together as a collective of mental health team members

Focus group discussion participants understood inter-professional collaboration among members of the mental health team as the working together by mental health professionals. The sub-theme entails the sharing of expertise, respecting each other's views and giving each other feedback in terms of progress or response regarding treatment and or care provided. Participants viewed it as the multi-disciplinary team approach whereby members of the mental health team are able to come and sit around and discuss the patient in terms of his or her needs. Participants also viewed it as being driven by the needs of the mental health care user (patient) in totality. The view of understanding inter-professional collaboration was discussed in Chapter 2: Section 2.2 and is further substantiated by the following illustrations:

> Participant OD: *"...working together as a team amongst health preferably health professionals so in order to address the needs of the clients in totality regardless of the patient"*
>
> Participant MD: *"...bringing different expertise together with one purpose and respecting every professions view or opinion with one purpose which is patients".*

The participant's views are supported by Collin et al (2011:1) who described it as the bringing together of different expertise to work together as a team with one purpose revolving around the individual patient's needs and interests. In that working together, professionals are engaged in a joint effort promoting and optimizing active participation This view also coincide with Sicotte et al (2002:991) who alluded inter-professional collaboration as a model that promotes a collaborative organization where professionals share their goals and make collective decisions sharing responsibilities. Inter-professional collaboration may be inter-changeably utilized as a multi-disciplinary team which is also defined as *"members of different professions working together"* (MHC 2007:8). It involves a group of people with complementary skills who are committed to a common purpose, performance goals, and

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approach, for which they hold themselves mutually accountable (MHC 2007:11). In this study, inter-professional collaboration was also utilized inter-changeably with multi-disciplinary team.

Sub-theme 4.3.2.1.2: Situational team approach that is dependent on the needs of the mental health care user

In this sub-theme, participants understood inter-professional collaboration among members of the mental health team as being situational. It was viewed as situational in that it was depended on the needs of the mental health care user at that particular time and context. Referral to a particular mental health professional was also deemed to be influenced by the individual needs of the MHCU. The situational view was also substantiated by the following statements:

> Participant CE: *"It depends on the needs on the identified needs. Just because we have got limited resources, actual, when a MHCU comes to the service he needs to be addressed by all these if ever it was possible. Just because the resources are very limited, these guys are not seeing only MHCUs but all patients from other units or other sections".*

> Participant NE: *"is working together as professionals and maybe referring patients to one another looking at the demands or the needs of the patient".*

The participant's view was supported by the Mental Health Commission (2006:12) that alluded that the multidisciplinary team provides the skill range to meet the increasingly complex needs of service users who require the different skills for different professionals. Based on the needs, the relevant skill would then be provided. However, the health professional's view of team membership and collaboration varied i.e. others seeing collaboration as happening within one discipline and others seeing it as happening between two or more (Canadian Health Service Research Foundation 2006:3). Having acknowledged the various operational contexts, WHO (2010:20) has propagated for collaborative practice strategies to be considered according to local needs and challenges. Inter-professional collaboration was said to be most effective when it focuses around the needs on the population that is patient-centred, and taking into account the way that healthcare is delivered in that locality.

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Sub-theme 4.3.2.1.3: holistic approach looking at the needs of the mental health care user addressing them in totality

Participants further understood inter-professional collaboration among members of the mental health team as a holistic approach whereby different members of the mental health team adopt a multi-disciplinary team approach. The holistic approach is further substantiated by the following statements deduced from the raw data:

> Participant ND: *"We are looking at the patient in totality. If maybe the psychologist or the social worker identified whatever problem the patient has"*

> Participant MD:*"We treat our patients holistically. So every aspect of our patients are very important and we don't find one profession with all aspects. So you need varied individuals to do the same..."*

A holistic approach view, was a paradigm shift where health professionals tend to understand the meaning of physical, mental, and social well being of the mental health care user (Wolpert 2005:13). Mental and physical health are understood to be influenced by a combination of the biological, psychological and social factors. Available online: (http://www.who.int/whr2001/main/en/chapter1/00/b2.htm). According to Hellquist et al (2012:1) as well as Chan, Pharma, and Wood (2012:22), a holistic approach or collaborative health care practice enhances the management of complicated diseases as it brings about an array of health care providers ensuring consistent, continuous and reliable care.

Sub-theme 4.3.2.1.4: Community involvement engaging those that are in the community.

Two FGDs further alluded their understanding of inter-professional collaboration among members of the mental health team as not being confined to the hospital but also extending to the community. Such understanding was elaborated by the following illustrations:

> Participant NH: *"Because the MDT has to extend to the community, we need to also engage with those people who live in the community. To hand over all those patients. To say this is the patient and is a state patient, he is coming back. Please take care the periodical report is going to be written when and when and when. So, all those things need to be inter-linked. And make sure that they are treated in totality".*

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Participant CD: *"..the collaboration does not end in the hospital. It has to be extended to the community PHC …"*

The participant's view of inter-professional collaboration extending to the community was supported by the American Psychological Association that highlighted the benefits of inter-professional collaboration as extending to patients, caregivers, providers, and the larger health care system. (Available online: http://www.apa.org/pi/aging/blueprint_report.pdf.) Barr et al. (2005:5) endorsed the sentiment reflecting that inter-professional collaboration operates within practice settings which included the community. For it to be efficient there has to be inter-professional collaboration among members of the mental health team within the hospital as well as with those that provide mental health care in the community.

Extension to the community was again supported by Odegard (2006:2) who indicated that inter-professional collaboration in mental health was not only between professions but also among organizations, education, health, housing, law enforcement, social care, income maintenance and others. It was deemed to be occurring between practice settings such as residential and community; and between sectors such as statutory, voluntary and commercial. The sentiment was also shared by Barr, Hugh, Ross and Fiona (2007:1) who included acute tertiary hospital care to patient-centred, home-based and team-driven care requiring new skills and collaboration between workers and with mental health care users. It is against this view that inter-professional collaboration should not be seen within the confines of the hospital but extended to the primary health care facilities and or the community.

Theme 4.3.2.2: Benefits of inter-professional collaboration

From the main theme of benefits of inter-professional collaboration among members of the mental health team, four sub-themes were deduced namely, efficiency in the management of mental health care user, information giving imparting knowledge for both providers and mental health care users, provision of a holistic treatment, and a strengthened support structure for the mental health care user.

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Sub-theme 4.3.2.2.1: Efficiency in the management of the mental health care user.

Participants outlined increased efficiency as one of the benefits of inter-professional collaboration among members of the mental health team. Efficiency refers to the production of the desired effects or results with minimum waste of time, effort, or skill. According to participants, inter-professional collaboration enhances better understanding and management of the patient in that members were likely to work at the same pace giving each other feedback. It also enhances the achievement of the main purpose of patient management ensuring that the patient gets fully rehabilitated, hence efficiency. Efficiency is substantiated by the following statements:

> Participant NH:*"...that if we don't have multi-disciplinary meetings, we will never achieve anything because its where we come up with solutions of things".*
> Participant OH *"...as a team we will get fully rehabilitated patients who are fully in the community than in the hospital".*

This view of efficiency was supported by Patkar, Acosta, Davidson, Jones, Fox, and Keshtgar (2011:1) highlighting that the aim of MDT meetings is to ensure that all patients receive timely diagnosis and treatment, that patient management is evidence-based, and that there is continuity of care. Regular meetings facilitate information exchange and regular communication flow between all those involved in treatment of the patient. Team members can monitor adherence to evidence-based guidelines and can streamline the resources for improved management strategies, lower waiting times and enhanced cost effectiveness, hence efficiency. Inter-professional collaboration can enhance access to services, improve quality of care, and lower overall health care expenditures, hence efficiency.

However, according to Virani (2012:3), the effectiveness of teams was dependent on the team members' knowledge of one another's roles and scopes of practice; mutual trust and respect amongst the team members; commitment in building relationships; willingness to cooperate and collaborate; and the extent to which the team had organizational supports. It therefore implied that efficiency of inter-professional collaboration was also depended on the mental health team members themselves. A healthcare system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among healthcare professionals (CHSRF 2006:i).

Inter-professional collaboration was increasingly being viewed as a key strategy for providing the best quality and most effective care to people who require multiple services, or who use both acute and primary health care services (HPRAC 2008:4). Accerding to Borrill et al.

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(1999:5), the teams enabled organisations to speedily develop and deliver services cost effectively, while retaining high quality.

Sub-theme 4.3.2.2.2: Information giving imparting knowledge for both the mental health care user and the mental health team member(s).

Participants further saw the benefits of inter-professional collaboration among members of the mental health team as being informed on the part of both the mental health team member and the mental health care user. Team members get well informed with regard to the treatment needs of the mental health care user. One participant stated that the mental health care user also gets informed on the fact that treatment and care needs do not necessarily get provided by one member but by different members. Such enrichment is illustrated by the following statements:

> Participant CE: *" It also imparts knowledge to our patients because when we come here in their mind, whether it is depression, what they know is the doctor".*
>
> Participant NH: *"When working collaboratively, we get to know what the other one is doing and how can I assist that other one with the aim of treating this patient".*

Participant's view of getting informed is shared by WHO (2010:7) as well as Koszyks (2013:1) where mental health care users were regarded as team members seen on a continual basis ensuring that their needs were best served in a well coordinated team approach . However, according to WHO (2010:20) as well as Macfarlane (2005:12), when inter-professional collaboration was appropriately applied, it can equip health workers with the skills and knowledge they needed to meet the challenges of the increasingly complex global health system.

Sub-theme 4.3.2.2.3: holistic approach addressing the diverse needs of the mental health care user

Participant cited the benefits of inter-professional collaboration as a holistic approach that is provided for the mental health care user. According to van Rensburg (2009:146), WHOs definition of health implied a complete state of physical, psychological, social well being and not merely the absence of disease. Focus on all aspects of health would be seen as treating the patient in totality or holistically. The overall beneficiary was seen to be the patient who

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ends up receiving treatment that is provided in totality addressing his or her diverse needs. The totality and or holistic treatment is substantiated by the following statements:

> Participant TH: *"So, the central point is that patient is treated in totality when the multi-disciplinary team approach is applied".*
>
> Participant MD: *"The benefits are so vast. You will find that if the patient is coming with the social problem, the social worker who is takes charge because I cannot do the work of a social worker. The social worker knows the application of grants whatever. The OT knows how to deal with anger management. The doctor will come with treatment. I will come with giving the treatment. This will come with counselling and whatever. So the patient is treated in totality. That is the main benefit of the MDT approach".*

Participant's view of a holistic approach or totality was supported by Mitchell et al (2008:S63) when reflecting that when professionals from a range of disciplines work together, they are in a position to deliver comprehensive care that addresses as many of the patient's needs as possible. According to MHC (2007:11), multidisciplinary teams convey many benefits to both service users and providers working on the team, such as continuity of care, the ability to take a comprehensive, holistic view of the service user's needs, the availability of a range of skills, and mutual support and education.

Further evidence suggests that coordinated care, which integrates psychologists and other mental health providers within primary care, can enhance access to services, improve quality of care, and lower overall health care expenditures (Available online:http://www.apa.org/pi/aging/blueprint_report.pdf). It therefore implies that as mental health team members collaborate, their approach was able to benefit the mental health care user holistically.

Sub-theme 4.3.2.2.4: Strengthened support for the mental health care user

Participants further outlined the benefits of inter-professional collaboration as strengthening support for the mental health care users. Participants, as members of the mental health team, saw themselves as a support structure for the mental health care user as illustrated by the following statements:

> Participant NH: *"When we are working as a Mental Health Team, we are also in a way building support to the patient"*

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Participant SD: *"As a social worker I am going to work with the patient's family and in that way, the family can also go to the ward where they will also be covered in how to deal with this issue. That's why I'm saying it also strengthen support for the patient".*

National Cancer Action Team (2010:6) supported the participant's view when highlighting that an effective MDT results in treatment and care recognized by professionals with specialist knowledge and skills. Mental health care users get assessed and offered the level of information and support they need to cope with their condition. According to World Health Professions Alliance (2013:1), an effective inter-professional collaboration can lead to improved access to health interventions and improved coordination between different sectors for individuals and their families.

Inter-professional collaboration bring together a wide range of primary and mental health care providers, consumers, families and caregivers, hence strengthened support for the mental health care userand enhanced access to information (Curran, Ungar & Pauzé 2006:3; as well as Rose et al. 2011:165).

On that basis, the benefits of inter-professional collaboration are viewed as an enhanced efficient management and support structure for the mental health care user, a holistic approach to patient care and information giving to both mental health care user and the health care provider that are worthy of consideration.

Theme 4.3.2.3: Functionality of inter-professional collaboration

Whilst exploring the functionality of inter-professional collaboration with participants, ten sub-themes were deduced relating to status of team approach, conduction of MDT meetings, frequency of collaboration, failing to schedule MDT meetings, quality of MDT meetings, failing to collaborate as team members, attitudes of mental health care team members, availability of human resource, quality of communication and management support.

Sub-theme 4.3.2.3.1: Variety in the use of team approach

Participants varied as they describe the status of functionality of inter-professional collaborationin their health facilities. One health facility was described as having a functional inter-professional collaboration whilst the other three had challenges except in the Maximum psychiatric ward where there was a visiting psychiatrist who served as a catalyst or team leader. The extent of functionality varied from being efficient to less efficient. Some members

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were taking decisions without the involvement of other team members leaving the other members with a feeling that inter-professional collaboration was a waste of time. Nursing was found to be playing a dominant role in the Maximum psychiatric ward. In the other health facilities members of the mental health team were mainly operating in silos. The described varieties are substantiated by the following statements:

> Participant OH:*"...the patient is being discharged without other professionals knowing or sometimes you are invited in the ward round. And you find that you don't participate at all because there is nothing needed on your side. And you end up wasting time by attending the ward round without you having an input to make regarding different patients".*
>
> Participant OE: *"That perspective of saying let us sit down, dedicate at least an hour, it will improve patients relations and how far are you, where are we going, how is the patient to the community. We are lacking that in this facility at the moment".*
>
> Participant DD: *"....having joined the team, recently, made observations and I found that everyone is an expert at their own field. And it was just ehh, well built parts of vehicle that. So this team is excellent".*

The status of functionality of inter-professional collaboration cited by the participants reflected a more or less contradiction to what Canadian Health Service Research Foundation (2006:i) has characterised as an efficient team. An efficient team was said to have a clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises. The active participation of all members was another key feature. Successful teams recognized the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility. On that base, the participants reflected the most functional and less functional teams in their health facilities.

The participant's view on the functionality of the team in the Maximum psychiatric ward where it was facilitated by the visiting psychiatrist is supported by Mitchell et al (2012:3) as they reflected that the appropriate team structure varies by situation, as determined by the needs of the patient, the availability of staff and other resources. The presence of the psychiatrist necessitated the conduction of the grand ward round where approximately all core members of the mental health team were in attendance. The status of functionality in other hospitals was consistent with the findings of Macfalane (2005:29) who indicated that collaborative mental health care was particularly underdeveloped in rural and remote

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communities. The status of functionality at Vhembe district can thus be described as varying from being functional to less functional.

According to Schnell (2007:1), one can simply tell how healthy and organization is by attending a meeting and observing how open the debate is (Available online: ericschnell.blogspot.com/2007/.../five-characteristics-of-functional-team....).

Participants from three hospitals found the meetings to be too much infrequent. Multi-disciplinary team meetings varied according to particular hospitals. Time for preparation of the ward round was also not adequate. Such an extent of functionality was illustrated by the following statements:

> Participant DH:*"...we are supposed to have a meeting every Tuesday at 8H00. But due to mini meetings which happens around this hospital, we tend to have a meeting probably once in a month. And I don't think is efficient".*
> *Participant NH:"And we also do have the MDT meetings which are supposed to be happening at least once a month. But sometimes we have one, twice in three months or twice in four months.I can't remember when last did we have one, it's for a long time".*

According to the National Cancer Action Team (2010:8), MDT members are supposed to have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings. The amount of time they spend in those meetings should have been negotiated locally and reflective of the workload that varies according to individual discipline circumstances. Otherwise, the functionality of the inter-professional collaboration in terms of the meetings varied according to the individual hospitals.

In addition to the preceding paragraph, participants were not satisfied with the frequency of meetings. They expected the discussions and or meetings to be held frequently. Instead, in one facility, the team discussions were depended on the visiting psychiatrist. That meant that on their own, they were not holding those team discussions. The frequency was elaborated by the following statements:

> Participant NH:*"There is only ward round that is happening in the Maximum Security Ward and they discuss those patients and patients from prison and patients from*

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other referring hospitals. But we don't have such. We only wait for the visiting Psychiatrist to talk about the issues regarding the patient in the chronic division"

Participant NH:*"....because January we never had any meeting. And February, if it was not this research, I'm betting, it was not going to happen, the MDT".*

Dissatisfaction on the frequency of meetings was supported by Sfetcu (2013:8) who highlighted that for a team to function, it was essential for the members to meet "face to face" regularly, since all working groups function better when a considerable "face to face" interaction is possible. National Cancer Association (2012:12) as well as Salas, Cooke and Rosen (2008:540) recommended for weekly team meetings where most members are present. Frequent team meetings contribute to collaboration and increased awareness of services available to patients (Simpson et al. 2001:3). Through those regular meetings, the team will be able to review assessment and plan of care, review and update criteria for and progress toward hospital discharge. This process ensures that the team reaffirms with regularity the applicability of the shared goals as well as the clarification of intent and prevention of misunderstandings. Yet, participants were not satisfied with the meeting frequency.

Participants in one facility were able to schedule two ward rounds per week whilst the rest were spot checks where the doctor only focus on challenges that could not wait for the following ward round. Yet some hospitals failed to schedule MDT meetings leaving the inter-professional collaboration functionality less efficient. Apart from scheduling the ward round, others felt that they needed more time to prepare for the required reports. Variety on the functionality of inter-professional collaboration in terms of scheduling meetings is substantiated by the following statements:

Participant OD:*"I wanted to say that in terms of the plan, such as the rounds, certain dates. We have two days that are set for major ward rounds. And the other three days, which are spot checks".*

Participant NH:*" ...because January we never had any meeting. And February, if it was not this research, I'm betting, it was not going to happen, the MDT".*

The participant's view regarding the scheduling of meetings was shared by Mitchell et al (2012:5) when they clarify the values that characterize the most effective members of high-functioning teams in health care. Discipline was cited as one of those values whereby team members carry out their roles and responsibilities even when it seems inconvenient.

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Discipline allows teams to develop and stick to their standards and protocols as well as the meeting schedule. Failure to schedule the meetings was impacting on the functionality of inter-professional collaboration. Two hospitals were still faced with a challenge of convening meetings and share information as members of the MDT, hence Daly (2004:79) recommended regular multi-professional team meetings to enforce verbal communication and activate the team's collaboration.

Sub-theme: 4.3.2.3.2: Mental health team members failing to collaborate in decision making

Participants from different hospitals varied in terms of collaboration. In one hospital, a participant was concerned and alienated by the mental health care user who would be discharged without the involvement of other team members. One hospital was having a functional MDT and collaboration was considered to be excellent and members respected each other as experts in their own fields. The functionality of inter-professional collaboration in terms of collaboration was substantiated by the following statements:

> Participant OH:*"...the patient is being discharged without other professionals knowing or sometimes you are invited in the ward round. And you find that you don't participate at all because there is nothing needed on your side. And you end up wasting time by attending the ward round without you having an input to make regarding different patients".*
>
> Participant OE: *"That perspective of saying let us sit down, dedicate at least an hour, it will improve patients relations and how far are you, where are we going, how is the patient to the community. We are lacking that in this facility at the moment".*
>
> Participant DD: *"....having joined the team, recently, made observations and I found that everyone is an expert at their own field. And it was just ehh, well built parts of vehicle that. So this team is excellent".*

The participant's view of some feeling alienated was supported by Simpson et al. (2001:13) indicating that the opportunity to participate in decision-making, and become a stakeholder in the final outcome of the program, is an important environmental support to inter-professional collaboration. The National Cancer Association (2010:12) as well as Canadian Health Service Research Foundation (2006:i) emphasised the need for consensus on the MDT meetings,agenda, and abiding to deadlines on tasks assigned. They stressed the need for a clear purpose; good communication; co-ordination; protocols and procedures; and effective

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mechanisms to resolve conflict when it arises. Active participation of all members considered a key feature. Professional and personal contributions of all members promote individual development and team interdependence, hence the need to work on the functionality of inter-professional collaboration.

Sub-theme 4.3.2.3.3: Poor quality of multi-disciplinary team meetings

Where MDT meetings are held, participants were concerned about the quality thereof in terms of what was discussed, the extent of deliberations, and the outcomes of those discussions. Participants were concerned that what they discussed in those meetings were petty issues that had little to do with patient care. The deliberations were not going down into details. The decisions taken in those meetings were not taken seriously and would end up being on the agenda time and again leaving the meetings being more of a talk show. Sometimes the meetings ended up being a place where members would be blaming one another impacting on the quality thereof. Participants felt that inter-professional collaborationhad lost its focus and was discussing issues that were not benefiting the patient. The quality of those meetings is demonstrated by the following statements:

> Participant OH*: "....in the very same meetingswe are supposed to share so many things with regard to patient care. But we end up talking about some few things far from patient care. I don't know how to elaborate more on that but you will find that there are some petty things as to whoever send the patient to tuk-shop was supposed to have written security book. She didn't do that. The dietician was supposed to prescribe this. She didn't prescribe that. But we don't go into details as to how best can we help that particular patient".*
>
> Participant OH:*"...we were supposed to come with different challenges with regard to helping the patients who are not maybe getting discharged or who are fully rehabilitated and are not welcome at home. How can we help each other with regard to that. But we normally don't do that. We just discuss this. I don't know if I call them petty things".*

The view of the participants regarding inter-professional collaboration in terms of the quality of the meetings was supported by Canadian Health Service Research Foundation (2006:i) who outlined the principles for an effective and or functional team. Teams were said to work most effectively when they have a clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises. The

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active participation of all members is another key feature. Successful teams recognize the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility.

National Cancer Association (2010:12) warned that if members know the expected information from the locally agreed minimum dataset, they would be able to prepare and be ready to share the required information or would have delegated that to another member if they cannot attend prior to and/or at the meeting, hence enhancing the quality of the MDT meetings.

Sub-theme4.3.2.3.4: Negative attitudes of mental health care team members undermining each other.

An attitude of an individual influences one's response to objects or situations to which it is related (Pickens 2005:43). The functionality of inter-professional collaboration was affected by the attitudes of the members of the mental health team. Participants felt that there was disrespect from other team members. The blame was mostly on the nurses who considered themselves better than the others. Such attitudes are captured in the following statements:

> Participant SE:*"...we undermine one another. Nurses see themselves as the people who are better than the other profession. I can see that. So, its very bad. And it destroys the team".*
>
> Participant OH:*"...people they undermine other professions. They don't take others serious".*
>
> Participant NE:*"...if he is a mental health care user, he or she is admitted in the medical ward, or in the surgical ward, you may find that the nursing staff they don't care about doing follow up for the patient to get all the antipsychotics as she ought to".*

That participant's view of negative attitudes was supported by Grant, Finnocchio, and the California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration (1995:1) who highlighted the barriers of inter-professional collaboration. Amongst other barriers, reluctance to accept suggestions from team members representing other professions; and lack of trust in the collaborative process impacted on the functionality of inter-professional collaboration.

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According to the National Cancer Association (2004:10), where there was no challenge of negative attitude, each MDT member had clearly defined roles and responsibilities within the team which they had signed up to and which were included in their job plans. There was also mutual respect and trust between team members with an equal voice for all members and different opinions are valued. MDT members play a role in sharing learning and best practice with peers.However, from the cited statements, it is evident that the functionality of inter-professional collaboration was affected by the attitudes of team members.

Sub-theme 4.3.2.3.5: Unavailability of other mental health team members

Participants also highlighted the impact of unavailability of some of the members of the mental health team on the functionality of inter-professional collaboration. Unavailability of certain members such as the medical practitioners, obstructed the functionality of inter-professional collaboration amongst members of the mental health team. However, the availability of the medical practitioner strengthened the functionality of inter-professional collaboration among members of the mental health team as illustrated by the following statement:

> Participant SD:*"Without a doctor, really it weighed on everyone of us. Cause, like we would try to go forward, we would do all but without the doctor, then there was no moving forward. But since, Dr X came, things have been different. According to my observations, I think the MDT is stronger than before. Is being revived a lot".*

There were various versions on the unavailability of certain team members. Putting people together in groups representing many disciplines did not necessarily guarantee the development of a shared understanding of the phenomenon under study (Wilson & Pirrie 2000:5).

According to Daly (2004:78), staff shortages can also damage interaction as groups withdraw in an attempt to limit demands made upon them. However, some health care professionals may find health care practice more attractive when they are treated as respected team members in inter-professional collaboration rather than subordinates, as in the traditional medical model (Simpson et al. 2001:13).

According to Simpson et al (2001:13), in areas that have a shortage of health care professionals, the underserved population could receive services by other members of the health care professions when physicians are in short supply. It is against this background

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that the available mental health team members were found performing the duties of the unavailable members.

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Sub-theme4.3.2.3.6: Poor communication amongst mental health team members

Communication was considered central to the functionality of inter-professional collaboration as described by the participants. It made members to be well informed of what was happening and then be able to contribute meaningfully in terms of patient care. Participants felt that if communication was dealt with, it would improve inter-professional collaboration. However, to some, inter-professional collaboration was on face to face communication, to others it was limited to written communication and whilst to others it was limited to calling for each other telephonically. The view of communication on inter-professional collaboration among members of the mental health team is substantiated in the following statements:

> Participant OD: *"I think there is no communication of some sort because when we admit our patients, when we discharge them, we need to discharge them".*
> Participant CD: *"And that is why it is important because when we hand over, we know that they are going to the clinic or to a social worker or to a nurse in the clinic or to an OTT with projects and everything but we don't know what is happening at the community".*

Participant's view of communication was supported by the Department of Health (2010:6) that emphasised that if teams are to function optimally and ensure patient safety and quality of care, communicating effectively was necessary. It also required individuals and teams access to adequate and timely information necessary to perform their role effectively and appropriately.Giving timely, sensitive, instructive feedback to other team members about their performance on the team, and respond respectfully as a team member to feedback from others are essential for team performance (IPEC Expert Panel. 2011:5).

The sentiment was further supported by Gaboury, Bujold, Boon and Moher (2009:707) who indicated that dedicated time for face-to-face communication was critical though time constraint appeared to be a constant challenge. Both verbal and written communications were considered central to the functioning of inter-professional collaboration. Regular and structured review meetings using up-to-date integrated records can prevent clinical care from drifting, hence communication (Mental Health Commission 2006:18). However, lack of

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appropriate mechanism for timely exchange of information, regular team meetings reinforced by the benefits of geographical co-location that enhanced information exchange; inclusivity in case review meetings involving users, carers, and professionals, set against an organisational background of greater transparency of information and communication were noted as barriers to inter-professional collaboration (Grant et al. 1995:1). On that basis, the functionality of inter-professional collaboration was also depended on the nature of communication among mental health team members.

Sub-theme 4.3.2.3.7: Poor management support for inter-professional collaboration

Participants also highlighted management support as a contributory factor on the functionality of inter-professional collaboration. Management was reported to be not coming to the wards to see what was happening. Instead, management would convene meetings frequently impacting negatively on functionality of inter-professional collaboration. Lack of management support was also seen when the staff had requested for certain things and they end up not being attended to. Lack of management support is illustrated by the following statements:

> Participant DH *"...problem is these managers are bored in their offices. So, they rather call meetings so that we can keep them busy.Or there is nothing to do in the wards. They don't go to the wards. I mean they are not like there."*
>
> Participant DH *"...certain things that have been written, requested from the management long ago but nothing has been done"*

This view was supported by the Mental Health Commission (2006:6) that cited lack of support for team working from key professionals and mental health managers/administrators as barriers to multidisciplinary working. The Mental Health Commission (2007:16) further indicated that it may be important to have general service managers present at specific team meetings enhancing inter-professional collaboration. According to Hollenberg and Bourgeault (2011:182) as well as Mulkins, Eng and Verhoef (2005:115), support and commitment from senior management and provision of adequate resources were found to improve inter-professional collaboration, hence the need to encourage management support.

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Theme 4.3.2.4: Barriers of inter-professional collaboration

From the main theme of barriers, seven (7) sub-themes were deduced namely lack of commitment and coordination of meetings, ignorance of the roles and functions of other mental health team members and what should be discussed, shortage of resources, poor quality of multi-disciplinary meetings, attitudes towards mental health care users, burnout and poor clinical care by mental health team members, and poor communication amongst members of the mental health team and lack of involvement in decision making and they will be the focus of discussions.

Sub-theme 4.3.2.4.1: Lack of commitment in honoring and coordination of multi-disciplinary team meetings

Two hospitals described lack of commitment on the part of the members of the mental health team as one of the barriers to the functionality of the multidisciplinary team. Lack of commitment was evidenced by lack of feedback with regard to task assigned. The feedback reflected some degree of irresponsibility as evidenced by failure to delegate or give other report so that the work could be done. Such behaviour of irresponsibility is substantiated by the following statements:

> Participant OH:*"I don't know if I can say negative attitude or burnt out because sometimes you find that we are having a meeting. Then we request the nurses to do some of the activities to implement some of the activities. Then in our next meeting, we say the report is needed, and the person will say I was on night duty or I was off, I didn't do that".*
>
> Participant OH: *"So we keep on delegating and people are not being fruitful or are not bring back the information or are not implementing. So, that's the thing, maybe people think that I am lazy to do this when the other group come...",*

Participant's view outlined above was supported by Grant et al (1995:1) who stated that lack of commitment and inadequate decision making of team members was one of the barriers to inter-professional collaboration at team level. In addition to that, without passionate debate, buy in and commitment to decisions may temper with the functionality of the team.

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Styles of teamwork, educational background, and role clarity were significantly associated with commitment (Simpson et al. 2001:12). Failure to fulfil tasks assigned has the potential to pose a barrier on the functionality of inter-professional collaboration.

Additionally, lack of commitment by the management was highlighted by the participants. Management was said to be not putting much effort as it was supposed to do. There was no assistance with follow up on tasks delegated by the MDT to the staff. Such a behaviour was posing a barrier to inter-professional collaboration and is evidenced in the following statements:

> Participant MH:*"I think the sectional managers should do something. Because in the MDT meeting we are gathering with them, but they, I think they are the one who are supposed to follow up to their subordinates especially those who have been given some tasks to do in the meeting. Management they are not putting as much effort as they are supposed to do"*

Assistance by management was supported by the Mental Health Commission (2007:16) that expressed acknowledgement of the scope for additional tensions arising between multidisciplinary teams and wider management structures. It thus propagated for unit managers to attend some of the multidisciplinary team meetings towards such support. Managerial support can be demonstrated by expressing interest in inter-professional working, acknowledging associated difficulties and investing in time for team building which is inclusive of accomplishment of tasks assigned (Barrett & Keepin 2009:29). Follow up by both the team members and management are critical for the honouring of decisions taken during the MDT meetings which impact on inter-professional collaboration.

Lack of commitment was also compounded by lack of coordination of MDT meetings. In three out of four hospitals, participants voiced the lack of coordination as enforced by the shortage of mental health professionals and management that would have convened other meetings at the times for MDT presenting a barrier to inter-professional collaboration. By the time the administrative meetings are over, MDT meeting time would have passed. Such lack of coordination is substantiated by the following statements:

> Participant DH:*"And when we move out of the management meeting, all the meetings are dead, even the MDTs. You can't attend the MDT because there was a management meeting every Tuesday we are having a management meeting".*

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Participant OH: *"...if I go twice to the district meeting and Provincial meeting Monday and Friday, the social worker is going on Tuesday and Thursday, the doctor forum is on Wednesdays, so, it's very much difficult to meet and discuss matters pertaining to patient care".*

Effective inter-professional collaboration according to Millward and Jeffries (2001:276) requires efficient management and coordination. In the hospital organization, the work of doctors is administered separately from that of nurses, and professional boundaries exist in the coordination of work as a whole, all of which set challenges for the smooth functioning of inter-professional collaboration.

This view of lack of coordination was thus supported by CHSRF (2006:i) indicating that teamwork was influenced by an organizational culture. A clear organizational philosophy on the importance of teamwork can promote collaboration by encouraging new ways of working together; the development of common goals; and mechanisms to overcome resistance to change and turf wars about scopes of practice. According to the Mental Health Commission (2006:16), optimum arrangement for staff on multidisciplinary teams needs to be managed by an arrangement which respects the needs of the team. Coordination of the MDT meetings is thus of the essence in enhancing inter-professional collaboration.

Sub-theme4.3.2.4.2: Ignorance of the roles of other mental health team members and what to be discussed

Failure to be involved in team discussions or consulted by other team members was identified as one of the barriers to inter-professional collaboration. There seemed to be ignorance on the expectations of each other's role and functions that led to other team members taking decisions having neglected the existence of the other team members. Such lack of involvement is depicted from the following participant's statements:

Participant CH: *"Before we could deal with the problem, she will be discharged and you will see her coming from home."*

Participant CD *"In O T, we do have an office, we try to implement the activities and the space but when we still need to sit down with the patient, you find he is discharged"*

This view of lack of involvement in team discussions was clarified by CHSRF(2006:i) who indicated that teams work most effectively when they have a clear purpose; good

communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises. Successful teams recognized the professional and personal contributions of all members and promote individual development and team interdependence seeing accountability as a collective responsibility.

However Mitchell et al (2012:2) have acknowledged that the incorporation of multiple perspectives in health care offers the benefit of diverse knowledge and experience. They also noted that working together in practice, could be achieved with challenges. For example, Chong, Aslani and Chen (2013:228) found that in another Australian study on chronic disease management, both health care consumers and providers cited frustrations by the inability of health care providers to work efficiently and collaboratively in providing care. Lack of integration amongst team members may hamper efforts toward shared decision making resulting in feeling alienated from team approach.

One participant gave ignorance of what should be discussed in the MDT meeting as a barrier to inter-professional collaboration. Members were said to do not know what was expected out of them or what information they were supposed to bring or what should be discussed in the multi-disciplinary team meeting. Such ignorance is illustrated by the following statement:

> Participant DH: "*...some things which I have noticed is that people don't know what to discuss in a MDT meeting, the importance of it".*
> Participant O S: *"..tshinwe tshifhinga wa wana u ri zwi tshi da kha u refera nda feila u refera a patient to the psychometrist because I did not really understand the role nda pfesesa" (Sometimes you find that when it comes to referring a patient to the psychometrist, I did not really understand the role..")*

This view of ignorance was supported by Barrett and Keepin (2009:18) who indicated that each individual required a set of knowledge, skills and attitudes to enable them to engage in collaborative working relationships. Sources of conflict within inter-professional healthcare teams can be the result of ignorance to the conceptual basis for practice of other disciplines. In order to work effectively together, team members must possess specific knowledge, skills, and attitudes such as the skill in monitoring each other's performance, knowledge of their own and teammate's task responsibilities (Barrett & Keepin, 2009:27). Where there was confusion and uncertainty regarding role or role overlap, the inter-professional group would benefit from the development of formal or informal inter-professional working protocols.

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Sub-theme: 4.3.2.4.3: Shortage of resources

Shortage of resources which among others included human, transport and or infrastructure were identified as barriers to inter-professional collaboration. Participants cited shortage of human resources as one of the barriers to inter-professional collaboration as evidenced by one team member who would be faced with a significant number of cases and units to attend to. Sometimes when one member was busy with ward round or team discussions, he or she would be called to go to theatre to assist with the operation as an anaesthetist. The caseload that one was expected to carry might have been more than what one could afford leaving him or her unable to contribute or collaborate effectively in the team discussions. Such a shortage was substantiated by the following statements:

> Participant OD: *"It's happening but with the room of challenges that the hospital, you find that there is only one psychologist, which is highly difficult for her to come and see patients in this unit, go to this unit, and go to that ward, go to that ward. So, it also brings a whole lot of challenges to us because we might have a time where she might be part of it but due to the fact that she is only person who is alone in the department, it becomes very challenging to her and always she will be having time constraints if ever we are having a meeting, we must try as much as possible to take it faster".*
>
> Participant OD:*"And the days where they have to do like home visits, so they are not in the premises of the hospital, you find that doctor is conducting the ward round. And the doctor would want the OT to be there. So there is an exception that there would be times where the doctor would do ward round without other health care providers like the psychologist".*

Resources need to be available to meet the needs of consumers, families, and caregivers in all health care settings. Shortage of health care providers and an absence of funding to support collaborative activities pose a barrier to inter-professional collaboration (Bosco 2005:i). This participant's view of shortage of human resources is further supported by CHSRF (2006:15) as well as Bosco (2005:i) when they outline the policy and system barriers of inter-professional collaboration. Those barriers included amongst others, limited health human resource planning which was aggravated by a shortage of healthcare providers. Leadership is needed to ensure that mental health human resources are available and accessible to help facilitate collaborative mental health care. Key recommendations in the removal of these barriers include amongst others the implementation of an effective collaborative mental health human resource planning (Bosco 2005:i). It thus implies that

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efforts need to be made with regard to the shortage of mental health professionals towards the enhancement of inter-professional collaboration.

There has been an exception in one hospital where there was no qualified clinical psychologist but a trauma counsellor or a psychometrist. One participant cited the scope of professional practice and or competency gap as a barrier to contribute effectively in the mental health team. Such a barrier was supported by the following statements:

> Participant TH: "Like we don't have a clinical psychologist here. There are some cases which I cannot attend. So, it is not easy maybe to refer a forensic patient to Tshilidzini to a psychologist. So, if there are psychologists here, it would be better".
> Participant TH: "I can just maybe conduct counseling sessions, debriefing to other people, maybe have groups in some instances, but there are things that I cannot do"

This view of scope of practice was supported by the Canadian Medical Association (2007:8) that indicated that in order for the team to function safely and efficiently, it is critically important that the scope of practice, roles and responsibilities of each health care professional on the team be clearly defined and understood. According to Bosco (2005:i) definition of scopes of practice for members of the mental health team can aid in the facilitation of inter-professional collaboration.

Management can support by selecting appropriate staff, that is, those who have the required authority, experience, enthusiasm, knowledge and skills for effective inter-professional working *(Barrett & Keepin 2009:29).*

Inadequate resources such as transport and or medicines were also cited by participants as barriers to inter-professional collaboration. Members of the team would have been assigned some work that demanded travelling to the patient's home for example. Due to unavailability of transport, the member would fail to do the required task and give feedback to the team as expected impacting negatively on the efficiency of the team. If Primary Health Care facilities do not have the necessary medicines, mental health team members conducting outreach services will fall short of making a meaningful contribution to inter-professional collaboration, hence a barrier. Lack of resources was reflected by the following statements:

> Participant ND:*"...the social worker has been assigned an activity. And she need to go out. Then she ask for transport, they fail to give her the transport. In the next*

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rounds when she has to give the report, she didn't do the home visit because there was no transport"

Participant: SD*"we have a proper plan or planning lets say in paper, its perfect but because of the challenges, that they have mentioned, transport, communication, we can't really, we will try but we wont give perfect services to them because there will be some loopholes in between".*

This view of logistical support for inter-professional collaboration was supported by CHSRF (2006:11) who indicated that literature underscores that strategies to improve team effectiveness need to consider the nature of the organization in which the team works and address the following three components: management / strategies to support teamwork; resources / tools; and setting (acute care, primary care, and rehabilitation care). Amongst several inhibitors to successful multidisciplinary team working is lack of appropriate accommodation and resources (Wilson & Pirrie 2000:i). There was a strong association with the notion of interdependence which went beyond merely working in the same physical space and entailed a shared purpose. The biggest problem was 'actually getting people together which presents its own problems in respect of accommodation, resources, library and Information Technology facilities (Wilson & Pirrie 2000:17).

Infrastructure was also cited by the participants as a barrier to inter-professional collaboration in that it was not conducive for collaborative working. Members found themselves crammed in one office. The following are the statements relating to infrastructural challenges to inter-professional collaboration:

Participant CE:*"One of them is the our facility. One that I said it makes inter-professional collaboration difficult is the infrastructure. As psychologists and social workers we don't have an office. So, even if I have to see mental health care users who are admitted, they are always need to be escorted to where the psychologist is running like in OPD"*

Participant TH:*"we do not even have offices. We have only one office. We are crammed in one office. Where the office is, is next to the laundry. And there is this big machine. Sometimes you hear a big noise from that side with the smell from the laundry".*

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This view of infrastructure was further supported by the findings from the qualitative interviews that revealed that the context and setting of a team have important implications for the practice of collaboration. Co-located teams often have a clear understanding of team membership and see themselves as a social entity, and they are perceived to be a social entity by others. (CHSRF 2006:12). It was further clarified and supported by the Canadian Medical Association (2007:10) that indicated that co-location of individuals in a team was not a requirement for all collaborative care but where team co-location did not exist, appropriate resources needed to be dedicated to ensure that communication was timely, effective and appropriate between providers. It therefore implied that the infrastructure need not be an absolute barrier to inter-professional collaboration among members of the mental health team.

Sub-theme 4.3.2.4.4: Poor quality of MDT meetings

Participants described some of the MDT meetings as time wasting as they kept on discussing the same issues without progress. Such repetition, participants saw it as a barrier to inter-professional collaboration as some would end up not attending. On the same breath, meetings held by the same discipline such as of the doctors, participant found them valuable further discrediting the said MDT meetings and eventually posing as a barrier. The poor quality of meetings is illustrated by the following statements:

> Participant DH:*"You can't be discussing things like you go to an MDT meeting you discuss about smoking for an hour. I mean, really I mean, it doesn't help us".*
> Participant OH:*"...very same things keep on coming up and we are not going anywhere because we keep on discussing one thing time and again, you know".*

The view on the quality of MDT meetings was supported by Borrill et al (1999:6) who indicated that the quality of team working was powerfully related to effectiveness of health care teams in terms of clearer objectives, level of participation, level of commitment to quality, and level of support of innovation. According to the Ministry of Health (2012:3), the quality of MDT meetings is improved by the availability of terms of reference; referral pathways; case presentations; meeting coordination and administration; documenting meetings outcomes; conducive meting environment; technological equipment for meetings; monitoring of meetings; patient being informed of the meetings resolutions; and communication processes for the patient's general practitioner, clinical teams and others. It

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thus become necessary that the quality of MDT meetings be looked into towards the enhancement of inter-professional collaboration.

Sub-theme 4.3.2.4.5: Negative attitude or stigma towards mental health care users

A sign of disgrace or discredit which sets a person apart from others impacting on social relations is considered to be stigma. When the stigma is acted upon, it is considered to be discrimination. Participants from all the four participating hospitals highlighted the stigma amongst some of the mental health professionals, particularly the doctors as one of the barriers to inter-professional collaboration. Patients could spend even three weeks without being seen by the doctor in an acute unit. Even if nurses would have reported a sick patient to the Clinical Manager, they might be promised that Doctor X would be sent and yet the same doctor would end up not coming. When the doctor arrives in the ward, he would just stand reflecting some degree of not willing to assist. When the doctor assesses the patient, he or she would not do an effective work. He would miss symptoms like an elevated blood pressure and still refer the patient to the mental health unit. The stigma was found to be coupled by an attitude. When the doctor's attention is drawn to the omission, the doctor would quote that he or she had been to school for seven years and as such he or she did not expect to be lectured by the other professional. Participants described the stigma towards mental health care users as a barrier to inter-professional collaboration among mental health professionals. Such stigma is displayed in the following statements:

Participant NE:*"....mental health, it has the stigma that has been put on us. Is only those who are interested who will probably come in and work here. You can find it even amongst doctors, if you say you work in psych, there is an assumption that there is something wrong with you..."*

Participant NE:*"...we used to spend, I remember in December, we spent three weeks without ward rounds in the ward. Patients would spend three weeks without being seen by the doctor. As a nurse I would do all my part, the psychologist did her part, the OT did her part, the social worker did her part and there is no doctor...".*

Participant NE: *"We will report that the patient is presenting this and this and this. And these are the vital signs. He would say ok. I will send doctor so and so to come to you. And doctor so and so is not coming".*

Participant NE: "The stigma, also it has to do with our attitude. Some would just say some negative things like " I went to school for seven yrs" so you can't dictate on what to do".

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The participant's view of attitudes impacting on inter-professional collaboration is supported by Orchard, Curran and Kabene (2005:4) who indicated that the sources of conflict within inter-professional healthcare teams can be the result of: ignorance to the conceptual basis for practice of other disciplines; poor communication among members of different disciplines; chauvinistic attitudes; distrust; and lack of confidence in other disciplines.

Though members of the mental health team have areas of overlapping competencies, they are expected to share varying degrees of responsibilities. Such overlapping of roles (blurring of roles) may result with some members feeling under or over utilized with a potential for conflict or burnout (Hall 2005:191). However, Volmer, Mäesalu and Bell (2008:402) found that mental health professionals did not differ from the general public on their desired social distance from individuals with mental health conditions.

Participants further described a negative attitude on the part of management toward mental health that resulted in them not being given the necessary support. Participants would make requisitions for resources and end up not being considered. Such an attitude is displayed in the following statement:

> Participant ND: *"It's true. According to the ward that is having a lot of short falls. Really, but we always make requisitions to the relevant section. There are lot of issues. But to the mental health care ward, is the worst. I don't think there is any other ward which is like that".*

The participant's view of management support is supported by the findings of Wilson and Pirrie (2000:16) who revealed varied views. Some institutions were described as 'vaguely supportive' of inter-professional collaboration whilst in others, staff was generally unsure of the degree to which their institution supported their endeavours. There was no evidence that policy makers supported team working.

Otherwise, managerial support can be demonstrated by expressing interest in inter-professional collaboration by acknowledging the associated difficulties and invest time for team building and the necessary resources (Barret & Keepin 2009:29). The sentiment expressed reflects the role attitudes can play on the functionality of inter-professional collaboration appealing for measures to be put in place.

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Sub-theme 4.3.2.4.6: Burnout and poor clinical work by mental health team members showing less determination to do their work.

The condition of someone who has become very physically and emotionally tired after doing a difficult job for a long time is called a burnout (On line library). Participants from two participating hospitals described situations that reflect burnout as one of the barriers to the functionality of inter-professional collaboration. They reflected lack of interest in attending the meeting, tired of being in the same venue always, and of being emotionally traumatised by the nature of the work such as seeing horrific pictures of crimes committed by mental health care users. The situation was leading to members developing negative attitudes towards one another after every MDT meeting appealing for timeout and or debriefing. Such burnout is illustrated by the following statements:

Participant MH: "I'm telling you that boardroom is not interesting. That's why in MDT meetings people are sleeping. Because they just go there to the meeting because a meeting was called. They are not interested".

Participant NH: "Because we, sometimes when the documents come with police officers here, we find that in the rounds they are opening those documents and photos, horrifying photos".

Participant NH: "We also need debriefing because maybe sometimes we are, what , we are starting to be negative because those things are affecting us....because from 2009 working here looking at those documents its damaging us. Definitely damaging us".

This view of burnout is supported by Rook (2011:1) who found that mental health professionals are prone to burnout as a result of conflicts between a quixotic professional mystique and the harsh realities of working in the mental health field. Leadership impacts on teamwork, teamwork impacts on structure, structure influences burnout, and burnout influences attitudes towards mental health care users.

Findings suggest that in so far as burnout as well as conflict and containment rates on the ward are concerned, a better investment might be made by striving to improve teamwork. The challenge is upon the team members themselves to reduce their own vulnerability to burnout and negative attitudes towards patients by participating in and facilitating open, creative communication; listening and responding to fellow team members; contributing to and supporting a shared vision; and supporting consistency and a commonly agreed structure to ward life for patients (Bowers, Nijman, Simpson & Jones 2000:147).

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Participants further reflected the attitude impacting on the quality of clinical work as revealed in the nature of assessment done where other team members end up faced with patients who were supposed to have been managed differently. Poor clinical work ends up being a barrier to effective IPC and such is illustrated by the following statements:

> Participant NE: *"And in some patients you may find that they take the vital signs, they check the blood pressure and find that the blood pressure is high or temperature. You find that the doctor ignores everything. He just write psychosis usually neurologics admit psychiatric ward."*
>
> Participant ND:*"Maybe is a mental health care user, is also a diabetic and also hypertension, they overlook the diabetic and hypertension. They will just throw the patient into psychiatric ward. Maybe he didn't come for psychiatric illness only. You will find that he is not having the psychiatric problems. They just send him here."*

The view on the quality of clinical work impacting on inter-professional collaboration was supported by Barrett and Keepin (2009:19) who have shown that a thorough holistic assessment of client needs was required in order to provide a comprehensive approach to care. However, when considering the relationship between competence and collaboration, the complexities of health and social care are such that service users' needs were unlikely to be met by professionals working in isolation. In order to enhance inter-professional collaboration, practitioners needed to share information in a way that was understandable, encouraging discussion, and enhancing participation in decision-making amongst team members (CIHC 2010:13). Failure to do so would be the mental health care user who suffers (Mitchell 2011:1).

Sub-theme 4.3.2.4.7: Poor communication and lack of involvement of other mental health team members.

Conflicts emanating from poor communication were also cited as another barrier to effective inter-professional collaboration by the focus group discussion participants. Other team members ended up fighting rather than attending to the mental health care problems impacting on the efficiency of inter-professional collaboration. Evidence of poor communication as a barrier is illustrated below:

> Participant CE: *"Yes! And we treat the casualties of the language rather than dealing with the problem."*

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Participant NE: *"Some would just say some negative things like " I went to school for seven yrs" so you can't dictate on what to do. So, we end up fighting, we end up communicating again that the patient can be sent to the correct ward"*

Participant CD: "But because of poor communication because the nurses there at the clinic is not falling under us, we are also not phoning her that in case of this problem, she must do this. Or even send the patient to the hospital. Most of the patients end up relapsing due to poor communication"

Effective communication and sharing of information were essential to successful multidisciplinary team working and were the basis for many recommendations and policies promoting collaborative working (Department of Health 2010:4). Competence in communication will contribute to effective inter-professional collaboration enabling those involved to articulate their own perspectives, listen to the views of others and negotiate outcomes thereof *(Barrett & Keepin 2009:21)*. From the statements captured above, it is evident that inter-professional collaboration was having challenges emanating from poor communication. Poor communication was not confined to the hospital setting but also in terms of the amount of communication provided for the clinics to mitigate the challenges faced by the clinic staff (Canadian Collaborative Mental Health Initiative 2005:22).

Theme 4.3.2.5: Measures to improve inter-professional collaboration.

As measures to be put in place in order to mitigate the challenge of inter-professional collaboration, twelve (12) sub-themes were deduced inclusive of policy development, inclusion in the job-description, in-service training, taking responsibility, making use of quality multi-disciplinary team meetings, respect for one another, involvement of primary health care staff in the multi-disciplinary team meetings, conducting team building activities, attitudinal change towards mental health, and provision of resources (supplies) or management support and will be the focus of discussion.

Sub-theme 4.3.2.5.1: Policy development on inter-professional collaboration

Participants cited the need to put inter-professional collaboration in the policy documents as a strategy to enhance implementation. Some of the documents amongst others include job description. Statements affirming such position include:

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Participant NS: "khamusi ya ri clearly indicated kha dzi policy dza nthu, kha dzi policy dza sibadela" *(Maybe it should be clearly indicated in the hospital policies)*

Participant NS: "every job description ya muthu ya sumbedzisa u pfi one of the mandate of this hospital, this is how we do things", *(inclusion of inter-professional collaboration in the job description)*

This position of putting inter-professional collaboration in the policy documents was endorsed by Belling, Whittock, McLaren, Burns, Catty, Jones, Rose and Wykes (2011:23) when they affirmed mental health teams as a key component of UK policy for integrated service delivery, providing continuity of care by harnessing the mix of professional skills drawn from medicine, psychology, social work, nursing, and occupational therapy into multidisciplinary teams. WHO (2004:68) propagated the use of mental health teams mitigating the shortage thereof in the development of the Mental Health Policy. However, it might not be easy to document such a policy on inter-professional collaboration for all the members of the mental health team.

Sub-theme 4.3.2.5.2: In-service training on inter-professional collaboration

With regard to measures that need to be put in place to improve inter-professional collaboration, three out of four participating hospitals recommended in-service training clarifying each team member's roles. They believed that training could mitigate the negative attitudes cited as barriers to inter-professional collaboration. The need for in-service training was highlighted through the following statements:

Participant NH: *"...it's important to emphasise or to re-emphasise the importance of the MDT meetings. I think if we re-focus, we re-direct our energy to the MDT meetings, we are going to reach somewhere. We are definitely going to reach somewhere."*

Participant MH: *"....we erase the attitude by saying maybe we educating to one another by saying. Maybe the first meeting would be to say the role clarification is to say, this role and this role, this person's role is this one, and this person's role is this one. And clear out the attitude."*

This view of in-service training was supported by Mitchell et al (2012:5) who indicated that when team members come from different backgrounds with specific knowledge, skills and behaviors established by standards of practice within their respective disciplines, it was essential that team members develop a deep understanding of and respect for how discipline-specific roles and responsibilities can be maximized to support achievement of the team's shared goals. Training

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of current and future practitioners in the practice of inter-professional collaboration was deemed significant to the desired results by Macfarlane (2005:14). Wilson and Pirrie (2000:4) also found that roles in multidisciplinary teams were rarely static highlighting the need for continued training.

The Mental Health Commission (2006:45) further supported the need for in-service training indicating that induction periods were needed for new staff even if they have come from another team. Training should include skills in delivering the main interventions used by the team; team building, team working and peer support; familiarisation with the principles and philosophy of the team and with all operational policies. It is evident that though in-service training, most of the cited barrierscould be addressed towards enhanced inter-professional collaboration.

The Canadian Collaborative Mental Health Initiative (2005:ii), having acknowledged a number of barriers to inter-professional collaboration among mental health professionals which among others included lack of understanding about the expertise of other mental health providers, lack of knowledge and skills in collaborative mental health care, and negative attitudes towards teamwork and collaboration, whilst reviewing literature, it found that lack of inter-professional education among mental health professionals was playing a contributory role. It believed that inter-professional education could increase awareness and understanding of the roles of other health professionals, as well as fostering more positive attitudes towards teamwork and collaborative care.

The World Health Organization (2010:8) also added its view on the matter. For health workers to collaborate effectively and improve health outcomes, two or more from different professional backgrounds needed to be provided with opportunities to learn about, from and with each other. Inter-professional education was essential to the development of a "collaborative practice-ready" health workforce, one who worked together to provide comprehensive services in a wide range of health-care settings

It is for this reason that in-service training on inter-professional collaboration became necessary towards implementation thereof.

Sub-theme 4.3.2.5.3: Taking responsibility to collaborate inter-professionally

In order to improve inter-professional collaboration, all four participating hospitals recommended the need to take individual responsibility. With the available human resource, participants felt

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that something could be started. They felt that current approach could be reviewed and individuals encouraged taking responsibility for inter-professional collaboration. The need to take responsibility was evidenced by the following statements:

> Participant NH: *"But I think for us to, maybe to can deliver advanced services, to our patients, it needs everyone in the inter-professional collaboration to be determined. Determination I think it will be the solution. But we will have to, we should have to have team building, self care and whatever."*
>
> Participant CE: *"Maybe you would say you don't have an OT, or a social worker or psychologist we could talk a different language but the fact that we are here, time cannot avail itself to us. It is us who can make it and make sure that we do have time."*

This view of taking responsibility to make the inter-professional collaboration work was supported by the Mental Health Commission (2006:17) as well as Grant et al (1995:2) indicating the significance of team members who had a personal commitment to the approach of collaboration. However, such commitment according to Simpson, Rabin, Schimitt, Taylor, Urban and Ball (2001:12) was significantly associated with the style of teamwork and role clarity.

Participants also recommended in terms of taking responsibility that if there could be someone given the responsibility to coordinate and or convene the MDT meetings, there could be progress in terms of inter-professional collaboration. Delegation of responsibility to someone for MDT activities ensures that nothing is left for chance. Delegation of responsibility is captured in the following statements:

> Participant NH: *"Lets have a person who is solely dealing with convening MDT meetings. If its clinical, it has to be clinical. If its nursing, it has to be nursing. And it needs to be spotted on."*
>
> Participant NH: *"..let's have a person who should steer the whole process of the MDT. To say that we are starting with our meetings, this is the programme, and on this date we are going to meet".*

The view of delegating the responsibility of team leadership was supported by the Mitchell et al (2012:18) indicating that roles and responsibilities needed to be clearly defined and explicitly assigned. Team members needed to anticipate and embrace flexibility where necessary. According to the Ministry of Health, New Zealand (2012:4), the team leader would ensure that members adhere to the clinical protocols; all issues relevant to each patient's future

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management were presented and discussed; and that all members participated in the meeting as appropriate to their specialties.

Sub-theme 4.3.2.5.4: Making use of quality multidisciplinary team meetings

In order to improve inter-professional collaboration, participants recommended the use of MDT meetings to ensure a platform for team members to make inputs according to their area of expertise on the case at hand. They further recommended preliminary discussions in preparation for the formal MDT discussions so as to enhance inter-professional collaboration. The recommendation for MDT meetings or discussions is evidenced by the following statements:

> Participant OH: *"Our patients are given leave of absence. They are given leave of absence maybe because the nurses are saying this patient is behaving well in the ward. But when they say the social workers report, the social worker also can say no, in giving a patient leave of absence. The occupational therapist also play a role for example in anger management or whatever. Those programmes, I think if we were having those meetings, having case presentations, of patients"*
>
> Participant NH*"...previously we used to have meetings before the doctor comes. I don't know what how to call those meetings. But we used to have the meetings before the doctor comes discussing about patients."*

The view of having MDT meetings for patient care where team members agreed on modes of operation was supported by Mitchell et al (2012:18) who indicated that a high-functioning team agrees upon shared goals for delivery of patient-centered care with clear roles and responsibilities as well as commitment to shared accountability. Daly (2004:79) recommended team meetings to enforce verbal communication and activate the team's collaboration. The most common meetings, according to Deane and Gournay (2008:19) were found to be the treatment team meetings where the mental health care users progress get reviewed. Borril et al (2000:172) found the team meetings being important for effective team working.

Further support to that view was from the Mental Health Commission (2006:24) that highlighted that though mental health professionals may have well-developed clinical skills within their own area of expertise; it should not be assumed that they have all of the skills needed to collaborate effectively with others as part of a team. The need to have team meetings and agree on goals and decision making processes become significant.

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In addition to the use of MDT meetings, focus should be on the quality thereof cutting down on irrelevant and insignificant issues as well as reducing the frequency of management meetings was also recommended for the functionality of the inter-professional collaboration. Meetings need to be focused on core issues. The plight was endorsed by the following statements:

> Participant OH:*"... I think some of the meetings must be cut off, especially those which we are discussing none important things. We have to be left with meetings which are more focused on patient care and things that will help us to go ahead. Cut off those little meetings"*
> Participant NH: *"If we discuss things which are not in line with patient care, and then the very chairperson is going to direct us to say we are not going to discuss this. So, if we re-start again, today to say we are going to have these meetings, I think that is going to kick-start all the programmes."*

The view of cutting down the irrelevant meetings and focused discussions was supported by the National Cancer Action Team (2010:12) that indicated that for an effective MDT meeting, there had to be a structured agenda/patient list which would have been circulated prior to the meeting if members agree this would be useful. A locally agreed minimum data set of information about patients to be discussed should be collated and summarised prior to MDT meeting. Members should know what information from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information. Preparation for the MDT meeting is of the essence in terms of the quality thereof.

Sub-theme 4.3.2.5.5: Respect for one another treating each other as health professionals

Two out of two participating hospitals recommended respect for one another as individual professionals who have a role to contribute towards the team approach. Such a need for respect is further substantiated by the following statements:

> Participant NH *"....and undermining one another is not ok. If I am a nurse, I am a nurse. I need to take a social worker as my colleague. Because sometimes when the social worker comes into the ward, I would say, no I am not a social worker. I am not a social worker. Though we are team members. I am not a social worker. I am not here to protect you."*

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Participant NH: *"....if we take ourselves as team members, who contribute to the whole, we are going to reach somewhere."*

The view of respecting one another was supported by Grant et al (1995:2) who recommended that in order to overcome some of the barriers to inter-professional collaboration; members need to respect each other's skills and knowledge. According to the Mental Health Commission (2006:23) as well as EICP Initiative (2012:1), each member ought to have confidence that other team members were capable of fulfilling their responsibilities and provide the best possible care for the mental health care user. Collaboration required recognition of complementary roles and a respect for each discipline's scope of knowledge and uniqueness of functions (Orchard et al 2005:2; Canadian Medical Association 2007:7; Grant et al. 1995:2 as well as CIHC 2010:14).

According to O'Daniel and Rosenstein (2008:2) as well as Grant et al (1995:2), effective teams were characterised by mutual trust and respect underlying all successful collaborative endeavors. At the same time, collaborative care honored the diversity that was reflected in the individual expertise each profession brought to care delivery (Inter-professional Education Collaborative Expert Panel 2011:18). Respect for one another became the core of inter-professional collaboration.

Sub-theme 4.3.2.5.6: Written feedback (communication)

Written communication or feedback to the clinic that referred the patient to the team was also found to be essential for inter-professional collaboration. It was found to be enhancing continuity as other team members will be informed on what has been done or what could have contributed to the patient's problems. The need for written communication is evidenced by the following statements.

Participant CD: *"....maybe some notes or at least some background on those notes for the clinic, clinic notes so that when they come with them so that here , we can see where the patient have been."*

Participant CD: *"...and we should liaise with the clinics that we refer to. That is there is medication. If not, then management should arrange that that clinic should receive the information for individuals. So that they take it home."*

The view of written communication amongst team members was supported by Mitchell et al (2012:16) as well as Lewis (2002:166) who indicated that in health care, in the digital age, team

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communication was not limited to in-person communication, such as in team meetings. It covered a wide range of interactions, including interpersonal communication, communication technology, medical education, health policy and mass communication. It took many forms, from a brief informal talk between colleagues to formalised written documents between professionals. It incorporated all information channels—progress notes and electronic health records, telephone conversations, e-mail, text messages, faxes, and even "snail mail." The essence of verbal and written communication is in the sharing of information.

Sub-theme 4.3.2.5.7: Scheduling time for MDT *meetings*

All four participating hospital focus group discussions recommended the scheduling of time for MDT meetings that is feasible in terms of duration and individual team member's circumstances for the functionality of inter-professional collaboration. The assertion is affirmed by the following statements:

> Participant CE:*"Time won't come to us. We are all here. It is us who must make it available. And condition ourselves. And dedicate ourselves in our services in terms of mental health care users."*
>
> Participant CD:*"...time cannot avail itself to us. It is us who can make it and make sure that we do have time."*
>
> Participant CD: *"So, in those forums, they can have those few minutes to discuss, information session giving. And then we schedule our meetings in such a way that they don't clutch with anything. And we ensure that in those meetings things happen."*

The view of scheduling meetings or making time available for MDT was supported by Sfectu (available on line: www.ncbi.nlm.nih.gov/pubmed/23557141) who indicated the necessity for MDT to organize several meetings a week, and at least once a week where all members are present. Without such a meeting, multidisciplinary mental health teams are doomed to failure. Without setting time aside for inter-professional meetings, collaboration becomes a talk show. However, Melissa, Blazeby, Strong, Carroll, Nessand Hollingworth (Available online at: http://www.resource-allocation.com/content/11/1/7) found the frequency of meetings varying from daily to once every three months and the average number of disciplines in each MDT was 5 ranging from 2 to 9.

Allnes and Knoedler (2011:8) as well as the National Cancer Action Team (2010:8) recommended that meetings should be locally negotiated and scheduled when the majority of

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the team members can be able to attend having accommodated the varying caseloads of the team members. According to Kim, Lowe, Srinivasan, Gairy and Sinclair (2010:18) time should include preparation time with the resource person. It is thus significant that the scheduling of MDT meetings that would have accommodated individual team members needs be given priority for the success of inter-professional collaboration.

Sub-theme 4.3.2.5.8: Conducting team building activities

One hospital out of four hospitals recommended team building activities for the functionality of the inter-professional collaboration. Some of the activities included debriefing sessions and having time out as a team and go somewhere for joint activities. The activities were found to have a positive impact on the individual attitudes towards the functionality of inter-professional collaboration. The need for team building activities is affirmed by the following statements:

> Participant NH: *"We also need debriefing because maybe sometimes we are, what , we are starting to be negative because those things are affecting us. We need what the doctor was saying. Going out and debriefing sessions within ourselves. We also need what we call team building. And team building, since I came here, it's only done in the hospital. If you want people to have a fresh approach like now is still the beginning of the year, at least let's go out. Lets go somewhere to resort. It also helps with inter-relationship between us as co-workers. I'm telling you that boardroom is not interesting."*
>
> Participant MH *"I think that teambuilding can improve the attitude, as professionals to have positive attitudes towards each other, I think that can motivate us as the multi-disciplinary team."*

The participant's view of conducting activities aimed at team building was supported by the Mental Health Commission (2006:40) that indicated that a formal programme of team building should be undertaken at the earliest stage of team formation to enable the team to develop a common vision and principles of operation. Team-building efforts could strengthen interpersonal relations throughout the hospital and increase commitment to the institution. (Jack, Canavan, Ofori-Atta, Taylor & Bradley 2013:1).

The team building activities cited by the participants such as going to a resort might impact on the team approach but are likely to pose additional barriers such as funding. However, it should be noted that the participating hospital that recommended team building activities, in

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terms of the demographic data, was the specialised hospital and whose focus group discussion participants where all having more than five years of experience. Challenges relating to the quality of MDT meetings, lack of management support and burnout were raised by that very hospital. However, the team building activities do not necessarily refer to those that demand additional funding.

According to Deane and Gournay (2008:19), how inter-professional collaboration was being handled, might have an impact on building the team spirit without involving additional funding. Those team building activities include modelling respect seeking 'consultations' with team members about cases at individual level; supporting strategies to recognise each team member's special skills or training; strengthening team identity especially around shared philosophies, vision, and values; trying to connect team values to broader organisational values highlighting both individual and team success; clarifying the client groups that the team is delivering services to along with the range of services that are to be provided; encouraging participation by all team members in information sharing through to decision making in treatment team meetings; encouraging presentation at conferences or professional meetings of the team; pursuing internal recognition of team within the organisation such as writing a letter praising team achievements; and establishing team goals or targets and be structuring of regular feedback about the team's progress.

Team building activities are thus critical for the enhancement of inter-professional collaboration among mental health team members.

Sub-theme 4.3.2.5.9: Involvement of PHC staff in the multi-disciplinary team meetings

Participants from one hospital expressed the need to work or collaborate with the primary health care health professionals in order to enhance inter-professional collaboration seeing that they were a significant stakeholder that they referred the mental health care users to. The other reason was that primary health care was already having an infrastructure for collaborating with in order to meet the needs of the mental health care users. They felt that if primary health care was involved at least once a month in the MDT meetings, it could make a difference in the functionality of inter-professional collaboration. The affirmation of primary health care involvement was evidenced by the following statements:

Participant CD: *"...or they come and join us in the hospital once in a month and we have a meeting in terms of planning goals forward."*

Participant CD:*"Maybe because we have got sub-district mental health coordinator, and coordinators in each and every clinic, in nursing, we have found that we have psychiatric nurses in those facilities. And when ehh, they have got meetings, psychiatric nurses will have meetings and hospital psychiatric nurses. So, there is that forum. Where in their forum they can have time where if you talk about ehh, a sub-district which is under a hospital, they have time they can discuss their patients."*

The participant's view of involving the Primary Health Care is supported by the Mental Health Commission (2006:10) that indicated that mental health care users should be seen in the context of their family, work and leisure pursuits, as members of their neighborhood and the wider community. Where interdisciplinary collaboration was present in primary health care, the Canadian Pharmacists Association (2007:s6) alluded that patients have access to the "right service, provided at the right time, in the right place, and by the right health professional." Geographic barriers are minimized and services are available close to where people live, work, and learn. On that basis, there was a need to establish community based alternatives to hospital treatment and to ensure coordinated health and social care for the severely mentally ill.

However, the appropriate team structure, according to Mitchell et al (2012:3), varies by situation, as determined by the needs of the patient, the availability of staff and other resources, and more. Yet, a single type of collaborative mental health care arrangement according to Macfarlane (2005:29), does not exist, nor should exist, for all communities. Communities differ in terms of needs, resources, and practice patterns. On that basis, variables should be identified for the choice of collaborative mental health care arrangement.

Sub-theme 4.3.2.5.10: Providing management support

Participants held opposing views in terms of management support. Some felt that management should attend the MDT meetings so that they could be able to understand the team member's needs whilst others felt that unit managers need not attend the MDT meetings as they were alleged to be sitting in their offices. Those who felt that managers should attend the MDT meetings, they felt that they would be able to understand the needs of the mental health professional team members and provide them with the required resources. There was an appeal for scheduled meetings in advance to enhance attendance. Those different opinions are reflected in the statements cited underneath:

Participant MH: *"Challenges could be the management to put effort, to do their part as well. If possible, they should be able to arrange meetings at least once a month and join the MDT and hear our views about them. What is that they can do and change our facility."*

Participant MD:*" I think they (management) were supposed to also come on board to know exactly what feeling with regard to more travelling than patient care itself".*

Participant MH: *There are people who are dedicated, who can attend all those meetings and give inputs because we don't need managers. They are now sitting in offices. Come back from a meeting they sit in offices.*

The participant's view of management support was endorsed by Wilson and Pirrie (2000:vi) who indicated that inter-professional collaboration usually exist within an institutional framework which might or might not support multidisciplinary team working. They further indicated the main factors supporting multidisciplinary teamwork as committed individuals who play a key role in team development, staff with a common sense of purpose or vision and who work together to achieve it, clearly negotiated team roles, and explicit support for such developments at the organisational level.

On the contrary, Barret and Keepin (2009:25) stated that it was important for professionals to be afforded sufficient discretion to enable them to contribute effectively to decision making within the team and confidently in the knowledge that management will support decisions and authorise the required resources.

It is for this reason that management support to inter-professional collaboration be further explored within the confines of the facility circumstances and adjusted accordingly.

Sub-theme 4.3.2.5.11: Attitudinal change towards mental health

Participants expressed the need for attitude change towards mental health care users. They recommended that mental health care users be cared for and treated like any other patients. Care for mental health care users should be prioritised like in other programmes. The view was illustrated by the following statements:

Participant NE: "To embrace our ward just like mental health care userss just like any other patients as in the general wards. Address the issues which are there according to the priorities".

Participant NS: "Ngauri, ehh, so ko wisher u ri this, vhathu kha ri relathelane to one another .ndi sokou vhona u nga ri arali ra prioritiser wa psych, sa service yo no fana na dzinwe *(I wish people could relate to one another prioritising psych like other services)"*

The participant's view on the need for attitude change to enhance inter-professional collaboration was supported by Barret and Keepin (2009:18) who indicated that each individual requires a set of knowledge, skills and attitudes to enable them to engage in collaborative working relationships, as well as support from relevant personnel within their employing organisation. The starting point for attitudinal change is an acknowledgment by managers and leaders that a change is needed in how business is done and how inter-professional collaboration functions.

However, according to Brown, Ohlinger, Rusk, Delmore and Ittmann (2003:111:E847). It should be noted that the process of changing attitudes is slow and difficult. When the culture changes, the results might not be suited to all individuals who were part of the original culture and some people may want or need to leave. This might entail the review of the appropriateness of the mission statement, meeting formats, communication tools and needs, or conflict resolution skills.

It therefore implies that in an effort to change the health professional's attitudes, it might not be easy appealing for patience and understanding in order to enhance inter-professional collaboration.

Subtheme 4.3.2.5.12: Provision of resources for inter-professional collaboration

In order to improve inter-professional collaboration, participants recommended the provision of both material and human resources. The provision of resources is illustrated in the following statements:

> Participant MD: "*..and should also ensure that the hospital have medications. And the clinic that we are referring patients to there is medications"* Participant NS: "Zwi amba u ri the whole hospital must see u ri hu vhe na human resource ya u ri hu na mushumo munzhisa vha khou zwivhona". *(The hospital must ensure that there is human resources as there is a lot of work)*

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The provision of both material and human resources was supported by Macfarlane (2005:14) who pointed out that resources, both financial and human, are critical ingredients for inter-professional collaboration. Availability and use of resources such as information technology (that is electronic records, teleconference / videoconference clinical consultations, staff education and training, and telehealth / telemental health) were increasing and shortages of mental health professionals were posing significant challenges (Macfarlane 2005:18).

It should be noted that all four FGDs participants had cited shortage of resources as one of the barriers to inter-professional collaboration. Measures to improve inter-professional collaboration should then take the challenge of shortage of resources into consideration. In an effort to do so, it should be realised that the World Health Organization and its partners have recognized that inter-professional collaboration in education and practice was an innovative strategy that will play an important role in mitigating the global health workforce crisis(WHO 2010:7). It is for this reason that measures being put in place should strengthen inter-professional collaboration towards positive health outcomes

4.4. SUMMARY

This chapter addressed the analysis of data obtained from the four Focus Group Discussions. The framework approach of data analysis was used in this study. Through this approach, the researcher used a systematic procedure for analyzing the qualitative data. The procedure comprised the following steps: familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation. Data were presented in tabular forms, according to themes, categories and sub-categories, which resulted from the data analysis.

Five major themes were identified from the data analysis namely: Understanding of inter-professional collaboration, benefits of inter-professional collaboration, functionality of inter-professional collaboration, barriers of inter-professional collaboration, and measures to improve inter-professional collaboration.

The research findings were elaborated by further explanation of the themes and sub-themes. Quotation of comments by focus group participants were made where appropriate. Descriptions of related literature that aligns or contradicts the views of the FGD participants were also made.

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The findings, concerning FGD participants about inter-professional collaboration among mental health team members are summarised in table 4.5.

Table 4.5. Summary of data analysis of inter-professional collaboration amongst mental health team members within Vhembe district.

Research question	Findings from the study
What is the view on the nature of inter-professional collaboration by mental health team members?	**Theme 1: Understanding of inter-professional collaboration** • Team approach working together as a collective • Holistic approach looking at the needs of the patient and addressing them in totality • Situational team approach depending on the needs of the patient. • Community involvement engaging those that are in the community.
What are the benefits of inter-professional collaboration as viewed by mental health team members?	**Theme 2: Benefits of inter-professional collaboration.** • Efficiency in the management of the mental health care user. • Information giving imparting knowledge to both the mental health care user and the mental health professional. • Holistic approach addressing the diverse needs of the mental health care user • Strengthened support for the mental health care user.
To what extent is the functionality of inter-professional collaboration among members of the mental health team?	**Theme 3: State of functionality of** inter-professional collaboration • Variety in the use of the team approach. • Variety in the holding of multi-disciplinary team meetings • Infrequent referral of mental health care user to other team members

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	• Poor quality of multi-disciplinary team meetings • Failure to schedule multi-disciplinary team meetings • Team members failing to collaborate amongst each other. • Negative attitudes of team members under-mining each other • Unavailability of other core mental health team members • Poor communication amongst mental health team members • Poor management support
What are the barriers to the application of inter-professional collaboration among mental health team members?	**Theme 4: Barriers of** inter-professional collaboration **among mental health team members.** • Lack of commitment in honouring and coordination of multi-disciplinary team meetings. • Ignorance of roles and functions of other mental health team members and what to be discussed in the multi-disciplinary team meeting • Shortage of human resource particularly of mental health team members. • Scope of practice of available team members where some of the core team members are not available • Shortage of resources (i.e. human, material resources or supplies and infrastructure that is not fit for purpose) • Poor quality of multi-disciplinary team meetings • Negative attitudes or stigma attached to mental health • Burnout and poor clinical work by mental health team members • Poor assessment of mental health care users • Poor communication and lack of involvement among mental

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	health team members
What measures can be put in place to improve inter-professional collaboration among mental health team members?	Theme 5: Measures to improve inter-professional collaboration • Development of policies on inter-professional collaboration • Inclusion of inter-professional collaboration in the job description. • In-service training on inter-professional collaboration • Taking responsibility to collaborate inter-professionally. • Application of the team approach conducting multi-disciplinary team meetings. • Respect for one another treating each other as mental health professionals • Use of quality multi-disciplinary team meetings • Focusing on the quality of multidisciplinary team meetings. • Conducting team building activities amongst mental health team members • Involvement of Primary Health Care staff in the multi-disciplinary team meetings. • Providing management support to multi-disciplinary team meetings. • Attitudinal change towards mental health. • Provision of resources or supplies for inter-professional collaboration

The next chapter (chapter 5) will cover conclusions, limitation and recommendations arising

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CHAPTER 5

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

In the previous chapter, data analysis and research findings were discussed. This chapter focused on drawing conclusions. It also described the limitations of the study, and presented recommendations for improving inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.

5.1.1. Purpose

The purpose of this study was to explore and describe the nature of inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo, South Africa and generate recommendations for improvement.

5.1.2. Research questions

Based on the research findings discussed in chapter 4, the conclusion will be used to answer the research questions which were formulated in section 1.5 as follows:

- What are the views of mental health team members regarding the nature of inter-professional collaboration at Vhembe district of Limpopo, South Africa?
- As members of the mental health team at Vhembe district of Limpopo what do they think are the benefits of inter-professional collaboration?
- How is the functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa?
- As they collaborate among members of the mental health team at Vhembe district of Limpopo, what did they find to be the barriers?
- In their opinion, what measures could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa?

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5.1.3 Objectives of the study

The objectives of this study were:

- To explore and describe the understanding of the mental health team members at Vhembe District of Limpopo with regard to the nature of inter-professional collaboration.
- To describe the benefits of inter-professional collaboration from the perspective of the members of the mental health team at Vhembe District of Limpopo Province, South Africa.
- To describe the state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.
- To explain the barriers experienced by the mental health team members at Vhembe District of Limpopo Province in South Africa as they collaborate inter-professionally.
- To recommend measures that could be put in place to improve inter-professional collaboration among members of the mental health team at Vhembe District of Limpopo Province, South Africa.

5.2. CONCLUSION

The research questions were evaluated against the research findings to determine whether they have been answered.

5.2.1. The understanding of inter-professional collaboration by mental health team members at Vhembe district of Limpopo Province, South Africa.

Participants from all four selected hospitals described their understanding on the nature of inter-professional collaboration among mental health team members mainly as the working together or a collective addressing the needs of the mental health care user holistically or in totality and such view was supported by Collin et al (2011:1) as well as MHC (2007:8).

Some of the participants expressed their understanding of such collaboration as being depended on the needs of the mental health care user and was not limited to the hospital environment but also to the community involving the mental health care providers in the primary health care facilities (Barr et al. (2005:5).

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5.2.2. The benefits of inter-professional collaboration as viewed by mental health team members at Vhembe district of Limpopo Province, South Africa.

Participants expressed the benefits of inter-professional collaboration as enhancing efficiency in the management of the mental health care user; information giving imparting knowledge to both the mental health care user and the mental health team members; holistic approach addressing the diverse needs of the mental health care user; and strengthening support for the mental health care user. The efficiency view was supported by Patkar, Acosta, Davidson, Jones, Fox, and Keshtgar (2011:1) whilst the view of getting informed was shared by WHO (2010:7) as well as Koszyks (2013:1). Benefits to both service users and providers working on the team were supported by MHC (2007:11).

5.2.3. The state of functionality of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.

On the state of functionality of inter-professional collaboration, FGD participants varied according to their health facilities. Donald Frazer hospital FGD expressed its inter-professional collaboration as being functional whilst the other three, namely, Elim hospital, Siloam hospital, and Hayani hospital expressed that they had some challenges such as failure to schedule MDT meetings, poor quality MDT meetings, lack of logistical support, etc. The same sentiment was supported by Mitchell et al (2012:3) when they reflected that the appropriate team structure varies by situation depending on the needs of the patient, the availability of staff and other resources. It has also been highlighted that collaborative mental health care was particularly under-developed in rural and remote communities (Macfalane 2005:29).

The status of functionality of inter-professional collaboration was expressed in terms of: the extent of implementing a team approach; holding MDT meetings; the frequency of referring mental health care users among mental health care team members; the quality of MDT meetings; scheduling the MDT meetings; extent of collaboration among mental health team members; attitudes among mental health team members; availability of the core mental health team members; quality of communication among mental health team members; and management support.

Such a view was endorsed by the National Cancer Action Team (2010:8) with regard to dedicated time for MDT meetings, Mitchell et al (2012:5) as well as Daly (2004:79) on scheduling regular meetings, the National Cancer Association (2010:12) as well as CHSRF

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(2006:i) on the need for joint decision making, Daly (2004:78) on staff shortages, and Mental Health Commission (2006:6) on the lack of support from key professionals and mental health managers. However, it was acknowledged that putting people together in groups representing many disciplines did not necessarily guarantee the development of a shared understanding of the phenomenon under study (Wilson & Pirrie2000:5).

5.2.4. The barriers to the implementation of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.

FGDs varied in their expression of the barriers to inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa. Barriers cited included: lack of commitment by mental health team members in honouring scheduled multi-disciplinary team meetings; ignorance by some of the mental health team members not knowing what should be discussed in the multi-disciplinary team meetings; shortage of some of the core mental health professionals; scope of practice for the available mental health team members where some of the core members were not available; inadequate supplies for mental health team members to make use of in the provision of care to the mental health care users; poor coordination of multi-disciplinary team meetings; infrastructure that is not fit for purpose for some of the mental health team members; negative attitudes or stigma attached to mental health; burnout amongst some of the mental health team members showing less determination to do their work; poor quality of clinical work rendered by some members of the mental health team; poor communication amongst mental health team members; and ignorance of the roles and functions of other mental health team members.

The participant's view on the barriers was supported by Grant et al. (1995:1) with regard to lack of commitment, Barrett and Keepin (2009:29) on the lack of managerial support; Barrett and Keepin (2009:18) on ignorance of what to be discussed; Bosco (2005:i), CHSRF (2006:15) as well as Bosco (2005:i) on the shortage of health care providers and absence of funding to support collaborative activities; Bosco (2005:i) on the inadequate scopes of practice for members of the mental health team; Millward and Jeffries (2001:276) on the lack of coordination of MDT meetings; Borrill et al (1999:6) on the poor quality of team meetings; Curran and Kabene (2005:4) on the ignorance of other team members roles; and Barrett and Keepin (2009:19) on the quality of clinical work done on the patient.

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All four participating hospitals cited the shortage of mental health team members, negative attitudes of mental health team members, and lack of management support as barriers to inter-professional collaboration reflecting the strength of the views thereof.

5.2.5. Measures that could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa

In order to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, focus group discussion participants made varied recommendations within the hospitals. Recommended measures included:

- development of policies on inter-professional collaborationfor mental health team members;
- inclusion of inter-professional collaboration in the job description of the mental health team members;
- in-service training on inter-professional collaboration for mental health team members;
- taking individual responsibility to be incorporated to strengthen inter-professional collaboration in the workplace for all role players;
- respect for one another as mental health professionals;
- focusing on the use of quality of multi-disciplinary team meetings;
- conducting team building activities;
- involvement of primary health care providers;
- attitudinal change towards mental health; and
- Providing management support.

The participant's view with regard to measures that could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa is supported by Belling, Whittock, McLaren, Burns, Catty, Jones, Rose and Wykes (2011:23) with regard to the development of a policy; Mitchell et al (2012:5) as well as Mental Health Commission (2006:45) on on-service training; Mitchell et al (2012:18) on MDT meetings; Grant et al (1995:2); O'Daniel and Rosenstein (2008:2) as well as Grant et al (1995:2) on mutual respect; Allnes and Knoedler (2011:8) as well as the National Cancer Action Team (2010:8) that recommended regular meetings; Mental Health Commission (2006:40) on team building; Mental Health Commission (2006:10) as well as

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Wilson and Pirrie (2000:vi) on management support; and Macfarlane (2005:14) who called for both financial and human resources.

All four FGDs recommended the taking of individual responsibilities and scheduling the MDT meetings as measures to improve inter-professional collaboration among mental health team members.

The recommended measures can be further categorised into four main categories namely commitment to the use of a team approach; conducting in-service training on inter-professional collaboration, ensuring the use of scheduled quality multi-disciplinary team meetings; and management support.

- Commitment to team approach will entail taking responsibility to collaborate, changing attitudes towards mental health, and interact with respect for one another.
- Conducting in-service training on inter-professional collaboration will include pertinent policies, clarification of roles and functions of mental health team members, use of scheduled MDT meetings, the need to ensure communication with respect and change of attitudes towards mental health
- Ensuring the use of scheduled quality MDT meetings will entail scheduling those meetings having considered the individual health professional circumstances, involving primary health care providers, focusing on the quality of meetings, and conducting team building activities.
- Management support will entail development of policy on inter-professional collaboration, inclusion in the job description of mental health team members, and providing both human and logistic support for inter-professional collaboration.

From the above recommendations, it is for this reason that commitment to inter-professional collaboration is considered to be the key towards implementation. In-service training on inter-professional collaboration becomes the enabling tool towards efficient inter-professional collaboration. MDT meetings serve as one of the tools for inter-professional collaboration. Management support is necessary for the enabling environment for inter-professional collaboration

In support to that view, WHO (2010:28) has alluded that institutional mechanisms can shape the way people work appealing for management support believing in sharing responsibility for health care service delivery among team members. Management need to ensure that

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there is adequate time and space for inter-professional collaboration and delivery of care being enforced through policies that recognize and support collaborative practice.

On the same breath WHO (2010:28) acknowledges that though collaborative practice ready health workforce is an essential mechanism towards shaping the effectiveness of inter-professional collaboration, it cannot guarantee the provision of optimal health services. It needs other practice level mechanisms such as institutional supports, working culture and environment. The appeal is for health workers not to just be professional but also inter-professional (WHO 2010:36).

5.3. LIMITATIONS OF THE STUDY

The generalisability of the research findings is limited by the fact that only 19 mental health professions participated in the focus group discussions conducted at Vhembe district of Limpopo Province, South Africa. Only FGDs were used to collect data. Being a qualitative study, the findings arising from the study may not be generalized beyond the mental health units of the hospitals where the study analysed. The results of this study only portray the views of mental health care providers and not those of the caregivers / parents or of the mental health care users themselves.

5.4. RECOMMENDATIONS

5.4.1. Recommendation for improving inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.

Based on the above discussion, it is for this reason that the following recommendations are made towards the improvement of inter-professional collaboration as follows:

- In-service training on inter-professional collaboration should be conducted for mental health team members. It could clarify the roles and functions of mental health team members, the benefits of inter-professional collaboration, what should be discussed during MDT meetings, and the significance of respect for one another as mental health professionals.

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- Developing a facility policy on inter-professional collaboration. It will enhance the need to apply a team approach in the management of mental health care users as well as inclusion of inter-professional collaboration in the job-description of mental health team members.
- Coordinating the MDT meetings ensuring that they are scheduled far in advance for mental health team members to incorporate them in their programmes. The coordination should be done in collaboration with the mental health team members to enhance ownership, responsibility and commitment towards honouring the scheduled meetings.
- Focusing on the quality of MDT meetings ensuring that team members know in advance the case (s) to be presented so that they are able to prepare accordingly. Cutting down on irrelevant and insignificant but core issues. Reducing the frequency of other meetings that might interfere with the scheduled MDT meetings.
- Conducting team building activities inclusive of, among others:
    - modeling respect seeking 'consultations' with team members about cases at individual level;
    - supporting strategies to recognise each team member's special skills or training;
    - strengthening team identity around shared philosophies, vision, and values;
    - connecting team values to broader organisational values highlighting both individual and team success;
    - encouraging participation by all team members in information sharing through decision making in treatment team meetings;
    - encouraging presentation at conferences or professional meetings of the team;
    - pursuing internal recognition of the team within the organisation (e.g. writing a letter praising team achievements); and
    - establishing team goals or targets and structuring regular feedback about the team's progress.
- Providing management support monitoring the multi-disciplinary team meetings and resolutions being taken and enforce implementation thereof. Accommodating the multidisciplinary team meetings and avoiding clashes with management meetings. This will enhance attendance of the multi-disciplinary team meetings. Attending to logistical challenges being encountered by mental health team members and provide support accordingly. Providing for internal recognition of performance made by the mental health team members.

5.4.2. Recommendations for further studies

- Future researchers should conduct quantitative studies to establish other areas of need in terms of inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province, South Africa.
- Conduct research to establish the extent to which academic institutions within Vhembe district were incorporating inter-professional education.

5.5. CONCLUDING REMARKS

The purpose for this study was to explore and describe the nature of inter-professional collaboration barrier among mental health team members at Vhembe district of Limpopo Province in South Africa.

Mental health professionals were drawn from Siloam hospital, Elim hospital, Donald Frazer hospital and Hayani hospital, as FGDs participants.

The participants understood inter-professional collaboration among mental health team members as working together as a collective, holistic approach, situational and inclusive of primary health care.

They perceived the benefits of inter-professional collaboration as being efficiency in the management of a mental health care user, holistic addressing the diverse needs of the mental health care user, and information giving empowering both the mental health care user and the mental health care provider.

Health facilities varied with regard to their state of functionality of inter-professional collaboration among mental health team members. One health facility described its inter-professional collaboration as being functional whilst the remaining three health facilities expressed challenges. Functionality of inter-professional collaboration was described in terms of the use of the team approach, holding of MDT meetings, frequency of referrals, quality of MDT meetings, scheduling MDT meetings, attitudes of team members towards one another, availability of other core mental health team members, communication amongst mental health team members, and management support

Participants perceived lack of commitment in honouring MDT meetings, ignorance in knowing what to be discussed in the MDT meeting, shortage of human resource particularly

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of mental health team members, scope of practice of available team members where some of the core team members are not available, inadequate material resources or supplies, poor coordination of MDT meetings, infrastructure that is not fit for purpose, poor quality of MDT meetings, negative attitudes or stigma attached to mental health, burnout mental health team members showing less determination to do their work, poor clinical work of mental health care users, and poor communication amongst mental health team members as barriers to inter-professional collaboration.

Based on the understanding of inter-professional collaboration described above, the benefits, the status of functionality of inter-professional collaboration and the barriers thereof, it was evident that there were some challenges that needed measures to be put in place.

Key measures that could be put in place to improve inter-professional collaboration among mental health team members at Vhembe district of Limpopo Province in South Africa include in-service training; taking responsibility to collaborate inter-professionally; reviewing the use of MDT meetings; conducting team building activities among mental health team members; and providing management support.

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ANNEXURE A

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RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF THE RESEARCHER/ INVESTIGATOR:

Makhwanya T.E

PROJECT TITLE: Inter-personal collaboration among member of the mental health team at Vhembe district of Limpopo province, South Africa

PROJECT NO: SA/10/PDC/04

SUPERVISORS/CO-RESEARCHERS/CO-INESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Makhwanya T.E	University of Venda, Department of Advanced Nursing Science (Student)	Investigator: Student
Prof. M.L. Netshikweta	University of Venda, Department of Advanced Nursing Science	Supervisor
Prof.V.O. Netshandama	University of Venda, Department of Advanced Nursing Science	Co-Supervisor

ISSUED BY:
UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS COMMITTEE

Date Considered: 08 March 2013
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee .....
Name of the Chairperson of the Committee: PROF. G.E. EKOSSE

University of Venda

University of Venda
Private Bag X5050,Thohoyandou,0950, LIMPOPO PROVINCE,SOUTH AFRICA
TELEPHONE (015) 962 8504/8484/8313 FAX (015) 962 8439

" A quality driven financially sustainable, rural-based Comprehensive University"

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ANNEXURE A

University of Venda
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RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF THE RESEARCHER/ INVESTIGATOR:

Makhwanya T.E

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PROJECT NO: SA/10/PDC/04

SUPERVISORS/CO-RESEARCHERS/CO-INESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Makhwanya T.E	University of Venda, Department of Advanced Nursing Science (Student)	Investigator: Student
Prof. M.L. Netshikweta	University of Venda, Department of Advanced Nursing Science	Supervisor
Prof.V.O. Netshandama	University of Venda, Department of Advanced Nursing Science	Co-Supervisor

ISSUED BY:
UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS COMMITTEE

Date Considered: 08 March 2013
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee .....
Name of the Chairperson of the Committee: PROF. G.E. EKOSSE

University of Venda

University of Venda
Private Bag X5050,Thohoyandou,0950, LIMPOPO PROVINCE,SOUTH AFRICA
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ANNEXURE B: PERMISSION LETTER

The Head of Department
Provincial Department of Health
P/Bag 9302
POLOKWANE, 0699

Dear Sir / Madam

RE: REQUESTING PERMISSION TO CONDUCT RESEARCH

This letter serves as an application to conduct research on " Inter-professional collaboration amongst members of the mental health team at Vhembe District, of Limpopo Province"

I am presently studying for a Master Curationis degree at the University of Venda. The study will be conducted at the Vhembe District. The study is conducted under the supervision of Professor L. Netshikweta and Professor V. O. Netshandama, of the said university.

The purpose of this study is to explore and describe inter-professional collaboration amongst members of the mental health team within the Vhembe District of Limpopo Province.

To achieve this purpose, mental health team members working in hospitals within the Vhembe District of Limpopo Province will be recruited to participate in the study.

The discussion will be audiotaped, transcribed verbatim and verified with them and by an independent expert. The taped information will be erased on completion of transcribing the tapes to ensure confidentiality. Their anonymity will be safeguarded by omitting the use of thenames in the report. Information related to the discussions will only be accessible to me and the supervisors. No data will be linked to their names.

It is on that basis that permission to collect the said data is hereby requested. For any information on the participation, contact the researcher at: Cell no 084 690 0606.

Thank you

.....

Makhwanya Tshililo Edwin (Researcher)

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ANNEXURE C

University of Venda
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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

12 April 2013 Ref:4/2/2

Makhwanya T.E
University of Venda
P/Bag X 5050
0950

Dear Makhwanya T.E

Inter-professional collaboration among members of the mental health team at Vhembe district of Limpopo province, South Africa

- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The researcher is expected to avoid disrupting services in the course of his study.
- The researcher/s should be prepared to assist in interpretation and implementation of the recommendation where possible
- The institution management where the study is being conducted be made aware of this.
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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ANNEXURE D1

P O Box 2145, SIBASA, 0970 0846900606:
Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Siloam Hospital
P O Nzhelele
0920

Dear Sir

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

This letter serves as an application to conduct pilot research on " Inter-professional collaboration amongst members of the mental health team within the Vhembe District, in Limpopo Province"

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It is on that basis that permission to collect the said data is hereby requested. For any information on the participation, contact the researcher at the following numbers: Cell 084 690 0606.

NB: This study is also a sub-topic of the main study: UNDERSTANDING MENTAL HEALTH IN VHEMBE DISTRICT" which the Department of Health in collaboration with the University of Venda have embarked upon.

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Permission to do has been secured from the Provincial Department of Health.

Thank you

.....
Makhwanya Tshililo Edwin
Researcher

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ANNEXURE D2

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Elim Hospital
P O ELIM

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

This letter serves as an application to conduct pilot research on " Inter-professional collaboration amongst members of the mental health team within the Vhembe District, in Limpopo Province"

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Permission to do has been secured from the Provincial Department of Health.

© University of Venda

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

© University of Venda

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Donald Frazer Hospital
P O VHUFULI

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

This letter serves as an application to conduct pilot research on " Inter-professional collaboration amongst members of the mental health team within the Vhembe District, in Limpopo Province"

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It is on that basis that permission to collect the said data is hereby requested. For any information on the participation, contact the researcher at the following numbers: Cell 084 690 0606.

NB: This study is also a sub-topic of the main study: UNDERSTANDING MENTAL HEALTH IN VHEMBE DISTRICT" which the Department of Health in collaboration with the University of Venda have embarked upon.

Permission to do has been secured from the Provincial Department of Health.

© University of Venda

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

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P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO

Hayani Hospital

P O SIBASA

0970

Dear Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

This letter serves as an application to conduct pilot research on " Inter-professional collaboration amongst members of the mental health team within the Vhembe District, in Limpopo Province"

I am presently studying for a Master Curationis degree at the University of Venda. The study will be conducted at the Vhembe District. The study is conducted under the supervision of Professor L. Netshikweta and Professor V. O. Netshandama, of the said university.

The purpose of this study is to explore and describe inter-professional collaboration amongst members of the mental health team within the Vhembe District of Limpopo Province.

To achieve this purpose, mental health team members working in hospitals within the Vhembe District of Limpopo Province will be recruited to participate in the study.

The discussion will be audiotaped, transcribed verbatim and verified with them and by an independent expert. The taped information will be erased on completion of transcribing the tapes to ensure confidentiality. Their anonymity will be safeguarded by omitting the use of thenames in the report. Information related to the discussions will only be accessible to me, research assistant and the supervisors. No data will be linked to their names.

It is on that basis that permission to collect the said data is hereby requested. For any information on the participation, contact the researcher at the following numbers: Cell 084 690 0606.

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NB: This study is also a sub-topic of the main study: UNDERSTANDING MENTAL HEALTH IN VHEMBE DISTRICT" which the Department of Health in collaboration with the University of Venda have embarked upon.

Permission to do has been secured from the Provincial Department of Health.

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

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ANNEXURE E

ANNOUNCEMENT

RECRUITMENT OF RESEARCH PARTICIPANTS

The criteria for participation:

- A member of a mental health team
- 2 years experience as a registered mental health practitioner

Researcher: Mr Makhwanya T E

Supervisors: Professors Netshikweta, L and Netshandama, V O

Study title: "**Inter-professional collaboration amongst the members of the mental health team within the Vhembe District in Limpopo Province, South Africa"**

The purpose of this study is to explore and describe inter-professional collaboration amongst members of the mental health team within the Vhembe District of Limpopo Province.

To achieve this, members of the mental health team are needed to participate in this study. They will be engaged in a focus group discussion on the above-mentioned topic.

The discussion will be audio taped, transcribed verbatim and verified with participants and an independent expert. The taped information will be erased on completion of transcribing the tapes to ensure confidentiality. Your anonymity will be safe guarded by omitting the use of names. Information related to the discussion will only be accessible to me (researcher) and the supervisor. No data will be linked to your name.

You are hereby invited to participate in this study. You are of course under no obligation to participate in this study, but if you do so, you have the right to withdraw at any stage of the research.

For any information on your participation, contact the researcher at: No: 084 690 0606

Thank you

.....

Mr Makhwanya T E

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ANNEXURE F

INFORMATION SHEET

Dear participant

RE: REQUEST FOR CONSENT FROM PARTICIPANTS

I am a district mental health coordinator at the office of the Department of Health, Vhembe District of Limpopo Province and a master's student at the University of Venda, in the School of Health Sciences. I am presently engaged in a research study entitled: "**Inter-professional collaboration amongst the members of the mental health team within the Vhembe District of Limpopo Province, South Africa"**

This study is to be conducted at your hospital under the supervision of Professors Netshikweta, L and Netshandama, V O.

The purpose of this study is to explore and describe inter-professional collaboration amongst members of the mental health team within the Vhembe District of Limpopo Province.

To achieve this, members of the mental health team are needed to participate in the study. They will be engaged in a focus group discussions on the above-mentioned topic.

The discussions will be audio taped, transcribed verbatim and verified with the participants and by an independent expert. The taped information will be erased on completion of transcribing the tapes to ensure confidentiality. Your anonymity will be safe guarded by omitting the use of names. Information related to the discussion will only be accessible to me (researcher) and the supervisors. No data will be linked to your name.

You are hereby invited to participate in the study. You are of course under no obligation to participate in the study, but if you do so, you have the right to withdraw at any stage of the research.

For any information on your participation, contact the researcher at the following number:
Mobile No: 084 690 0606

Thank you

.....

Mr Makhwanya T E

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ANNEXURE G

CONSENT FORM

I, hereby voluntarily consent to participate in the following project:

I realise that:

1. The study deals with the nature of **Inter-professional collaboration among the members of the mental health team at Vhembe District of Limpopo Province, South Africa"**

2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage;

3. The Department of Health Head Office Limpopo has approved that individuals may be approached to participate in the study.

4. The experimental protocol, i.e. the extent, aims and methods of the research, has been explained to me.

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation;

7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research provided that anonymity is assured.

8. Any questions that I may have regarding the research, or related matters, will be answered by the researchers;

9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the research team.

10. Participation in this research is voluntary and I can withdraw my participation at any stage;

I ..... voluntarily consent to participate in the study. I understand that my participation is voluntary and that I may withdraw at any time.

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Signed at this day of 2012

....

Facilitator DATE

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ANNEXUREH

FOCUS GROUP DISCUSSION INTERVIEW SCHEDULE

Introduction and role as a research assistant

- Greet the participants
- Self introduction and
- Thank the participants for accepting the request to participate in the focus group discussion
    - Please note that I am the research assistant or a moderator who is a clinical psychologist at Louis Trichardt hospital,
    - I will be directing the discussion ensuring that you are not affected by the presence of the researcher who happens to be your District Mental Health Coordinator which would bias the study findings.

Stating the purpose of the session

- We have brought you together so that we can learn from one another about what is going on with regard to inter-professional collaboration among yourselves as members of the mental health team.
    - We want to know what you are seeing, even if it looks bad.
    - That is the only way we are going to learn.
    - Of course we also want to know where things are going well on the matter.
    - Our focus is on your experiences on inter-professional collaboration among yourselves as members of the mental health team in this facility.
    - Through the discussion we hope to obtain the current picture of inter-professional collaboration among members of the mental health team with a view to improving the standard thereof.

Permission to conduct the study

- Please note that we have secured permission to conduct the study from the following:
    - The Research Committees at the University of Venda
    - The Department of Health, Provincial Office and Hospital Management, as well as from
    - Yourself as participants on recruitment by the Researcher making use of the information letters you were given and the signing of consent form

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Note taking, recording & logistical issues

- Please note that during the discussion I will also be taking some few notes and recording the discussion so as to minimise disruptions during our discussion.
- The researcher, your district mental health coordinator will be serving as a house keeper ensuring that we have our logistical needs attended to e.g. refreshments after the FGD

Privacy and confidentiality of participants

- Please note that anything you say here will be held in strict confidence by:
  - Not reflecting your names in the report but the assignment of codes thereof
  - In case you feel that certain information you are about to say does not need to be recorded, you will signal to our note taker so that he stops the digital recorder.
  - On completion of transcribing the tapes, recorded information will be erased to ensure confidentiality.

Withdrawal from the study

- You are of course under no obligation to participate in the study, but if you do so, you have the right to withdraw at any stage of the research.
- Otherwise, the discussion is likely to take not more than 2hrs.
- Before we could proceed, I will request you to introduce yourself in terms of your occupation.
- NB: We do not have to address each other by our names but professions to enhance our privacy.

Ground rules

- Again before we could embark on our discussion, lets first establish our ground rules that will enhance our interaction:
  - One participant at a time and avoidance of side conversation
  - Treating each other with respect and not to criticise what others have to say.
  - .....
  - .....

Research content discussion

Introducing the topic: Our topic for the session will be:

"Inter-professional collaboration among ourselves as members of the mental health team"

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Content questions (each participant to respond to it with follow ups if necessary)

- What is your view of inter-professional collaboration among members of the mental health team?
  - .....
  - .....
- In your opinion, what are the benefits or importance of inter-professional collaboration among members of the mental health team?
  - .....
  - .....
  - .....
- When do you engage in inter-professional collaboration?
  - .....
  - .....
- What are the constraints or barriers to inter-professional collaboration among members of the mental health team?
  - .....
  - .....
- What measures can be put in place to improve inter-professional collaboration among members of the mental health team?
  - .....
  - .....

Concluding the pre-exercise

- From our discussion, we have noted the following ……(Recap key findings)
  - .....
  - .....
  - .....

Thanking the participants

- In conclusion I would like to thank everybody for your participation in the discussion.
- Hopefully there will be some refreshments for us as we go out

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ANNEXURE I

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Siloam Hospital
P O SILOAM

Dear Sir

RE: APPOINTMENT TO COME AND CONFIRM RESEARCH FINDINGS

Your hospital will recall that I, Mr Makhwanya T E, came with the Clinical Psychologist from Louis Trichardt and conducted a focus group on "Inter-professional collaboration amongst mental health team members within Vhembe district" as part of my studies.

Based on the methodology, I am expected to confirm the research findings with the focus group participants. (Psychometrist, AvancedPasych Nurse Ramovha, Occupational therapist and Social worker ThomaniGomba).

It is against this background that an appointment is hereby made to come and see the participants on Wednesday the 22nd January 2014 at 14H00

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

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ANNEXURE H1

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Elim Hospital
P O ELIM

Dear Madam

RE: APPOINTMENT TO COME AND CONFIRM RESEARCH FINDINGS

Your hospital will recall that I, Mr Makhwanya T E, came with the Clinical Psychologist from Louis Trichardt and conducted a focus group on "Inter-professional collaboration amongst mental health team members within Vhembe district" as part of my studies.

Based on the methodology, I am expected to confirm the research findings with the focus group participants. (Clinical psychologist Mphago M, Dr Mathai, Advanced Pasych Nurse Chuma, Occupational therapist and Social worker).

It is against this background that an appointment is hereby made to come and see the participants on Wednesday the 22nd January 2014 at 10H00

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

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ANNEXURE H2

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Siloam Hospital
P O SILOAM

Dear Sir

RE: APPOINTMENT TO COME AND CONFIRM RESEARCH FINDINGS

Your hospital will recall that I, Mr Makhwanya T E, came with the Clinical Psychologist from Louis Trichardt and conducted a focus group on "Inter-professional collaboration amongst mental health team members within Vhembe district" as part of my studies.

Based on the methodology, I am expected to confirm the research findings with the focus group participants. (Dr Mmbara, Clinical Psychologist Dzialwa, AvancedPasych Nurse Lukhwareni, Occupational therapist and Social worker).

It is against this background that an appointment is hereby made to come and see the participants on Wednesday the 24th January 2014 at 09H30

Thank you

.....

Makhwanya Tshililo Edwin

Researcher

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ANNEXURE H4

P O Box 2145, 0846900606:
SIBASA, 0970 Makhwanyate@gmail.com
Makhwanya Tshililo Edwin

To: CEO
Hayani Hospital
P O SIBASA
0970

Dear Sir

RE: APPOINTMENT TO COME AND CONFIRM RESEARCH FINDINGS

Your hospital will recall that I, Mr Makhwanya T E, came with the Clinical Psychologist from Louis Trichardt and conducted a focus group on "Inter-professional collaboration amongst mental health team members within Vhembe district" as part of my studies.

Based on the methodology, I am expected to confirm the research findings with the focus group participants. (Dr Rathando, Trauma Counsellor Sinthumule, Forensic Psychiatric Nurse Rambuda, Occupational therapist and Social worker).

It is against this background that an appointment is hereby made to come and see the participants on Wednesday the 24th January 2014 at 09H30

Thank you

.....

Makhwanya Tshililo Edwin

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LIBRARY

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	3.7. *Negative attitudes* of team members' undermining each other.
	3.8. *Unavailability* of other team members affecting inter-professional collaboration
	3.9. Poor *communication* amongst mental health team members
	3.10 *Poor management support* for inter-professional collaboration
4. Barriers of inter-professional collaboration	4.1. *Lack of commitment* in honouring and coordination of multi-disciplinary team meetings
	4.2. *Ignorance* of the *roles and functions* of mental health team members and in knowing what is to be discussed in the multi-disciplinary team meetings
	4.3. *Shortage of resources (i.e. human resources, material resources and infrastructure that is not fit for purpose)*
	4.4. *Poor quality* of multi-disciplinary team meetings
	4.5. *Negative attitudes* or stigma attached to mental health
	4.6. *Burnout* and poor clinical work by mental health team members.
	4.7. *Poor communication* and lack of involvement among mental health team members
5. Measures to improve inter-professional collaboration	5.1. Development of *policies* on inter-professional collaboration
	5.2. Inclusion of inter-professional collaboration in the *job description* of mental health team members
	5.3. *In-service training* on inter-professional collaboration
	5.4. *Taking responsibility* to collaborate inter-professionally
	5.5. Use of quality multi-disciplinary team meetings
	5.6. *Respect* for one another treating each other as health professionals
	5.7. Conducting *team building* activities amongst mental health team members
	5.8. *Involvement of PHC* staff in the multidisciplinary team meetings
	5.9. *Providing management support* to multi-disciplinary team meetings
	5.10. *Attitudinal change* towards mental health
	provision of resources for inter-professional collaboration

The results of the study are discussed along the themes and the sub-themes that were derived from the data. Applicable direct quotes are supplied to substantiate relevant results. Appropriate research reports are also cited to support findings.

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During this stage, the researcher began sifting pieces of data that were considered relevant to the purpose of the study. The researcher coded and categorized these data chunks, while reading and rereading the transcripts, as a means of developing themes. The researcher developed a detailed index of the data, which categorized the data into manageable chunks for subsequent retrieval and exploration. This was followed by systematically annotating the transcripts with numerical codes, supported by short text descriptors to elaborate the index heading.

The researcher re-arranged the data according to the appropriate part of the thematic framework to which they related; forming tables. The tables contained statements of views and experiences. The researcher used the tables to provide explanations for the findings.

Each theme was described in detail, including their associated categories and sub-categories. The researcher provided "thick" descriptions of what was discussed in the focus groups, and quotes from the FGD participants that illustrated specific themes.

In the discussion section of the research report, the researcher provided commentaries about the knowledge generated by the study's result, including the participant's views regarding the nature of inter-professional collaboration among mental health team members at Vhembe district of Limpopo, South Africa.

The researcher also discussed specific implications of the findings for mental health care, tying the implications to existing literature, to enhance the credibility of the interpretations of the findings.

4.3. DATA ANALYSIS AND DISCUSSION

The findings are presented in two sections, namely Section A and B. Section A contains a discussion on the biographical data of the participants and section B focuses on the themes and sub-themes that emerged from the data. In section 4.3.1 the demographic data of the FGD participants are presented in quantitative terms in order that the readers can know who these participants were. This might be important for contextualizing some qualitative data presented and discussed.