EXPERIENCES OF PROFESSIONAL NURSES RELATED TO CARING FOR
CHRONIC MENTALLY ILL PATIENTS AT RURAL PRIMARY
HEALTHCARE CLINICS

BY

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Submitted in partial fulfilment of the requirements for the degree of
Magister Curationis
In
Advanced Psychiatric Nursing Science
In the
Faculty of Health Sciences at the
Nelson Mandela Metropolitan University

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December 2014
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DECLARATION:

In accordance with Rule G5.3.3, I hereby declare that the above-mentioned treatise/dissertation/thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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ACKNOWLEDGEMENTS

Firstly I would like to thank the Lord Almighty for giving me strength, courage and wisdom to complete this document, with God all things are possible.

I would also like to thank my family for their undying support and believing in me throughout my studies;

My kids, Ayavuya and Kholo for having to share their mother’s love and time with the studies, I love you;

My partner, Xolani for the love and support throughout my studies;

My sisters Lulama, Yoliswa and cousin sister Akhona for believing in me and for helping me look after my kids during my studies and of course for guiding me through technology skills, you guys have touched my heart in so many ways, thank you so much.

Lastly I would like to thank my supervisor Prof J. Strumpher for her perseverance and patience with me, my research coordinator Dr D. Morton for his help and guidance and my colleagues and friends who have been there for me and helping me where neccessary. Without your support I would n’t be where I am today, thank you all.

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ABSTRACT

Since the de-institutionalisation of chronic mentally ill patients, there has been an increase in the number of relapsed chronic mentally ill patients who become acutely mentally ill and need to be re-admitted for acute care in psychiatric institutions. Professional nurses working at rural primary healthcare clinics find it difficult to care for these individuals because they lack the necessary knowledge and skills. Chronic mentally ill patients who have been admitted to acute care facilities are stabilised by rendering care, treatment and rehabilitation and then released into the care of the professional nurses working at rural primary healthcare clinics. These patients live in the community and have to make use of the primary healthcare clinics nearest to their homes to provide them with their prescribed medication and care. Furthermore the patients’ mental conditions do not always remain stable, possibly because of a knowledge deficit, at times about their mental status. Patients may become non-compliant, resulting in the recurrence of symptoms, and thus need to be re-admitted to the acute care facility. However, the problem leading to re-admission is not clear for all admissions. It may be that patients do not make use of the primary healthcare clinics. It also seems that the professional nurses in the primary healthcare clinics are unfamiliar in dealing with chronic mentally ill patients living in rural communities. The aim of this study was therefore, to explore and describe the experiences of these professional nurses in caring for chronic mentally ill patients living in a rural community.

The researcher used qualitative, explorative, descriptive, and contextual research design. The research population consisted of professional nurses working at primary healthcare clinics. Non-probability purposive sampling was used to identify participants for inclusion in the study. Data collection was conducted using one-on-one, semi-structured interviews, observations and field notes and interviews were tape-recorded and transcribed. Data analysis was conducted using Tesh’s method of content analysis to identify themes and sub-themes. A literature control was done to compare the findings to the current published research. Trustworthiness was ensured by using Gubas’s model (1985) of trustworthiness. A pilot study, conducted by interviewing a
small sample prior to the start of the main study, determined whether the sampling and interviewing techniques of the researcher as well as the research questions were adequate for data collection. The researcher ensured that the study was of a high ethical standard by taking into consideration values that guide the principles of autonomy, beneficence, non-maleficence and justice.

The findings of the study was categorised into three main themes and 13 sub-themes. The main themes were as follow: Professional nurses experience problems when they have to take care of psychiatric patients attending rural primary healthcare clinics. This theme had six sub-themes which were discussed in details in chapter three. The second theme was that professional nurses experience that psychiatric patients in rural communities experience problems which affected their well-being. This second theme has got five sub-themes which were discussed further in chapter three. The last theme was that professional nurses have positive experiences when caring for psychiatric patients in rural communities. This theme has got two sub-themes as well discussed further in chapter three.

Key words: mental illness, primary health care, professional nurse, community, chronic mentally ill patients and experiences.
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CHAPTER 1:- OVERVIEW OF THE STUDY

1.1. INTRODUCTION

According to the Mental HealthCare Act (No.17 of 2002), all mentally ill individuals should be treated in the least restrictive environment possible and should be living in the community and not in an institution. Bauman (2007:3) states that the majority of people with mental illness should be treated in the community for most of the time during the period of their illness or until their condition has stabilised. These community-based patients receive care from professional nurses working at rural primary healthcare clinics in the community.

As a professional nurse working in a psychiatric institution in the catchment area for rural communities, the researcher observed an increase in the re-admission rate of chronic mentally ill patients who had been stabilised on medication in an acute psychiatric unit before being discharged to their home in their respective communities. These patients were told to visit the local rural primary healthcare clinic to collect their medication and receive care for their mental condition. Until a few years ago, professional nurses working at rural primary healthcare clinics had not been responsible for the care of mentally ill individuals who are either acutely or chronically ill. They are now responsible for taking care of the patients living in their catchment areas.

As there seems to be a large number of patients becoming acutely mentally ill while in the care of professional nurses working at rural the primary healthcare clinics the researcher will be looking at the experiences of the nurses caring for these patients in the Amathole rural communities. The current research study will focus on the care of chronic mentally ill patients living in the community while attending rural primary healthcare clinics for care and support. Professional nurses working at rural primary healthcare clinics will be asked to describe their experiences of such care.
1.2. LITERATURE REVIEW & BACKGROUND

Mental illness is defined by the DSM-1V as a clinically significant behavioural or psychological syndrome or pattern of behaviour that occurs in an individual and is associated with present distress, or disability (Baumann, 2007: 561). Patients described as “chronically mentally ill “are a clinically diverse population with different diagnoses and a varied pattern of symptoms of illness and they present a variety of needs and treatment programmes. The professional nurses at rural primary healthcare clinics should know the prognosis and phase of illness of these patients, as well as about contributing factors such as substance abuse and other mental disabilities and any psychosocial issues that give a variant of presentation of the condition. (Morris, Yates & Andrews, 1997, cited in Henderson, Willis, Watters & Toffoli, 2008:34) In short, professional nurses should know how to treat and care for chronic mentally ill patients.

According to the World Health Organisation (WHO 2011:8), the mental health plan components are shifting services and resources from mental hospitals to community mental health services. Their study revealed that 76% of the countries surveyed clearly revealed shift of services and resources from mental hospitals to community mental health facilities, and 88% emphasized the integration of mental healthcare into primary healthcare services (Mental Health Atlas, 2011:8).

Countries such as England and Australia have successfully integrated mental healthcare services as part of primary healthcare. Henderson, Willis, Watter and Toffoli, (2008:162) conducted a study in Australia that showed that the National Mental Health Strategy of Australia launched in 1992 had shifted the delivery of mental health services from stand-alone psychiatric hospitals to general hospitals and community services, creating greater demands for these services and changes in the strategy of service delivery. This resulted in the intensification of community nursing work because patients were discharged earlier discharge from in-patient services and the admission rate into the community health service increased. In their study Olasoji & Mhaule (2010:106) showed that Australia’s primary healthcare has been recognised as an essential health system, able to deliver health to the population in a timely and equitable manner.
McMillan (2008:6) cites the World Health Organisation (WHO) report that England specialises in integrated care of people with mental health problems to improve outcomes at reduced costs in mental healthcare delivery. The mental health services in England have undergone a transformation of treating chronically mentally ill patients from mental healthcare institutions in the past decade, and are providing community-based mental health services instead of treating people in mental healthcare institutions. Although both Australia and England propose to treat patients in the communities, they have systems in place where mentally ill patients in the community receive care from mental health professionals; indeed, McMillan (2008:5) stated that, according to the World Health Organisation report, England has one of the highest ratios of mental health nurses in Europe.

Studies concerning mental healthcare delivery have been carried out in sub-Saharan Africa. In his study, Zolnierekc (2008:565) reported that Mozambique, a developing country located on the south-eastern coast of Africa was able to reduce the relapse and re-hospitalisation rate of people with chronic mental illness by integrating mental healthcare into general healthcare at primary care level. In this programme, accessibility seemed to be the critical issue, particularly in rural areas where there were fewer health workers, such as professional nurses. A number of traditional healers had been successfully trained to identify persons with mental disorders in the community and bring them to the attention of healthcare.

Since 1994, mental healthcare in South Africa has been aimed at developing appropriate and accessible mental health services for all people in South Africa (Baumann, 2007:3). In line with international trends, the primary objectives of South Africa’s mental health policy are the development of comprehensive community-based mental health services. This means that the majority of people with mental illness should be treated in their respective communities for most of the time during the period of their illness (Baumann, 2007:3). However, according to van Staden & Ncayiya (2010:68), there are limited community psychiatric services in most rural areas, areas which are poorly developed. Szabo (2005:103) stated that reservations about the capacity of the mental healthcare in South Africa include insufficient staff, inadequately
supervised facilities, or unavailability of mental health professionals to provide services in alternative facilities or programmes. A further problem is staff finding it difficult to overcome fragmentation of continued rehabilitation options after discharge. Finally, the budget allocation for the implementation of the policies and the process of monitoring these policies is inadequate (Szabo, 2005: 103).

According to Muller and Flisher (2006:18), South African health services emphasize and facilitate the on-going living, support, care and empowerment of chronically mentally ill patients and their caregivers in the community. They do this through policies and resource allocation. They further state that services in South Africa focus on prioritising and investing resources in developing and providing information about mental health and contact numbers and addresses of the available support groups in their local area, if there are any available in order to help chronic mentally ill patients to get services that they need (Muller & Flisher, 2006:18).

In the Eastern Cape Province, the Provincial government’s 2010 healthcare plan made sure that transaction from hospital-based services to community clinic services was completed (Baumann, 2007:3). The plan involved the integration of mental health services with general health medicine. During the integration of mental healthcare into primary healthcare, there are service difficulties and problems for chronic mentally ill patients, such as a history of relapse and re-admission to institutions, becoming uncomfortable with treatment, becoming non-compliant to treatment, and experiencing self-care deficit problems (Burns, 2008:3). Unfortunately, there are no statistics of re-admissions of chronic mentally ill patients available in the Eastern Cape Province. The following are the factors associated with the relapse and re-admission of chronic mentally ill patients:

- Patient-related factors, which include substance abuse, forgetfulness, anxiety about side effects, inadequate knowledge, lack of insight, lack of motivation and fear of social stigmatisation.

- Health-related factors, such as poor patient/healthcare provider relationship, poor services, poor access to services and poor staff training.
• Socio-economic related factors, such as illiteracy and a low level of education.

• Treatment-related factors which include polypharmacology, complex treatment regimens and, among South Africans, cultural and social attitudes, and belief systems are regarded as common reasons for non-adherence to treatment (Kazadi, Moosa & Jannen, 2008:52).

Burns (2009:3) states that government policy requires that chronic mentally ill patients should not be institutionalised. According to Kazadi et al. (2005:56), effective management of chronic mentally ill patients would reduce relapse if psychosocial approaches such as case management, assertive community treatment, foster homecare, day treatment centres and rehabilitation centres were added to anti-psychotic drug therapy. These services do not function in a rural health care setting. This study also shows that clinics focus mainly on pharmacotherapy with little psychosocial support because they lack human and material resources. This means that there are still challenges in the mental healthcare delivery system in rural primary healthcare settings, which if attended to, would improve the care for chronic mentally ill patients. While primary healthcare services are supposed to prevent illness and promote healthcare, and professional nurses working in the primary healthcare services are exposed to numerous in-service education courses, they are trained in the management of chronic mentally ill patients. Some of the professional nurses are comprehensively trained, but do not have experience in caring for chronic mentally ill patients.

1.3 PROBLEM STATEMENT AND RESEARCH QUESTION

Re-admission rates are not available as no accurate statistics are kept and, unfortunately, there are no international statistics in the re-admission ratios of chronic mentally ill patients available for other countries, so comparisons are difficult. Nevertheless, the increase in re-admissions of chronic mentally ill patients living in the community has been noticed despite the aim to deinstitutionalise these patients and encourage them to live in the community without being re-admitted to the hospital.
Further, it has been noticed that for a number of patients the time period between being released into the community and being re-admitted has shortened dramatically. Admission information from Fort England Hospital where all these chronic mentally ill patients are admitted for acute care, treatment and rehabilitation from their respective primary healthcare services shows an increase in the number of re-admissions. Specific numbers on re-admissions were difficult to obtain but the trend was noticed by nursing staff.

The numbers at Fort England Hospital showed that the number of re-admissions was high between 2008 and 2009. Those numbers decreased in 2010 and increased again in 2011. Although the numbers fluctuate, the percentage of re-admissions is still more than one-third of the total admissions. The researcher believes that the re-admission rate is far too high. Ideally, these numbers should decrease to even lower levels in the future if the primary healthcare nurses could prevent the chronic mentally ill patients from being re-admitted into tertiary level institutions. They should be able to help them comply better with their anti-psychotic medication and cope well with its side-effects.

According to the researcher’s knowledge and experience as a psychiatric nurse working in a tertiary psychiatric institution, professional nurses working at rural primary healthcare clinics are responsible for caring for chronic mentally ill patients in rural communities. Some of the problems were noted from the patients, families and from the primary healthcare nurses. This study intends to throw light on the problems, some of which include:

- Non-compliance which is not identified by the primary healthcare nurses;
- Side-effects of psychotropic medication which is not properly managed at the primary healthcare clinic;
- Interpersonal problems with families that are not addressed;
- Substance abuse by chronically ill patients;
• Recurring relapse as the patients lack most of the necessary support systems they need;

• **Cost of travelling**

Professional nurses working at rural primary healthcare services should be looking to solve the above problems; they seem to lack the knowledge, experience and skills to handle chronic mentally ill patients. Professional nurses working at rural the primary healthcare services may or may not be trained in psychiatric nursing. This means that they may or may not be familiar with how to care for psychiatric patients and cannot recognise the needs of the patients. The burden on professional nurses is increased because of the increased number of psychiatric patients living in the community. There are now fewer beds in long-term care facilities due to de-institutionalisation.

According to professional nurses working at rural primary healthcare services, nurses experience the care of chronic mentally ill patients as frustrating for a number of reasons: they are scared of them, they do not have the skills to be able to identify problems, they are unable to deal with the problems, and they may not know where and when to refer these patients if a problem occurs. Further, they are unable to identify patients who are relapsing, are not familiar with the action of psychotropic medication, and do not know how to recognise or manage the side-effects.

The researcher will ask the following questions:

- how do professional nurses working at rural primary healthcare clinics experience caring for chronic mentally ill patients?
- what recommendations can be made to assist professional nurses working at rural primary healthcare clinics related to caring for chronic mentally ill patients?

### 1.4 RESEARCH OBJECTIVES
Brink (2006:79) defines research objectives as clear, concise, declarative statements that are written in the present tense. The researcher will focus on the following research objectives:

- to explore and describe the experiences of professional nurses related to the care of chronic mentally ill patients at rural primary healthcare clinics in the Amathole District Municipality;
- to make recommendations that can assist professional nurses related to caring for chronic mentally ill patients at rural primary healthcare clinics in the Amathole district municipality.

1.5 DESCRIPTION OF CONCEPTS

The following concepts will be used in the study and will thus be described in detail:

**Mental Illness**
According to Sadock and Sadock (2010:1), mental illness is an illness with psychological and behavioural manifestations. It is associated with significant distress and impaired functioning caused by biological, psychological, genetic, physical or chemical disturbances. In this study, mental illness refers to the illness of patients who have psychological, behavioural or some impairment in any area of their functioning. These patients have been treated and cared for in the psychiatric institutions where they were diagnosed with mental illness and later discharged back into the community.

**Primary HealthCare**
Primary healthcare encompasses any health clinic that offers the first entry into the health system. These clinics usually provide initial assessment and treatment for common health conditions and refer those requiring more specialised diagnosis and treatment to facilities with staff with a higher level of training and resources (Mental Health Atlas, WHO, 2011:1). In this study, the professional nurses working at rural primary healthcare services should be able to provide preventive, promotive, curative
and rehabilitative services to all the chronic mentally ill patients who are under their care in their respective communities, including mental health nursing care, as needed. They can refer the most serious mental illness conditions to tertiary facilities when the need arises. The terms primary healthcare clinics and primary healthcare services will be interchangeable utilised in this study.

**Professional Nurse**

A professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and is capable of assuming responsibility for such practice (Nursing Act, No. 33 of 2005). In this study it is supposed that professional nurses working at rural primary healthcare clinics should be competently and independently caring for the chronic mentally ill patients as they are released into their care. A primary healthcare nurse is a professional nurse who is working at a primary healthcare clinic. The terms professional nurse and primary healthcare nurses will be interchangeable utilised in this study.

**Community**

Community is defined as all the people living in a specific locality, inclusive of its inhabitants or body of people having a religion, a profession and other qualities in common (Thornicroft & Szmuckler, 2001: 155). In this study the community that the researcher will be conducting research in is the rural areas of the Buffalo City in the sub-district in Amathole municipality.

**Chronic mental ill patients**

Patients described as "chronically mentally ill "are a clinically diverse population with different diagnoses and a varied pattern of symptoms of illness and they present a variety of needs and treatment programmes (Baumann, 2007: 561). When mental illness is chronic it means that a person has been mentally ill over a long period of time, mental illness has already described earlier. In this study chronic mentally ill patients are those patients who have been mentally ill and have been living in the community and utilising primary healthcare clinics for continuation of nursing care. The terms
chronic mentally ill patients and psychiatric patients will be interchangeable utilised in the study.

**Experiences**

Experiences are the events or knowledge shared by all the members of a particular group in society that influence the way they think and behave (Oxford advanced learner’s dictionary, 2010:514). In this study the experiences will be those of the professional nurses working at rural primary healthcare clinics related to caring for chronic mentally ill patients.

**1.6 RESEARCH DESIGN**

Mouton (cited in de Vos, Strydom, Fouche & Delport, 2005:132) defines a research design as a plan of how the researcher intends to conduct the research. It focuses on the product, formulates a research problem as a point of departure and focuses on the research design. Similarly, Burns and Grove (2009:218) define the research design as the blueprint for conducting a study and point out that it maximizes the researcher's control over factors that could interfere with the validity of the findings. A research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2009:218). In this study, the researcher will use the qualitative, explorative, descriptive, and contextual approaches to the research study. These designs will be discussed in details in Chapter 2.

**1.7 RESEARCH METHODS**

Research methods refer to the steps, procedures and strategies for gathering and analysing data in a research investigation (Polit & Beck 2006:504). In this study, qualitative research methods will be used in order to answer the research question and meet the objectives of the study. The research population and the sampling method to be used will be described, as well as the method of data collection, data analysis,
literature control, and the pilot study, thus ensuring the rigour of the study. The above-mentioned will be discussed in detail in Chapter 2.

1.7.1 Research Population and Sampling

A research population refers to the individuals who possess specific characteristics the researcher is interested in. It can be a set of entities that represents the measurements of interest to the practitioner or researcher (de Vos et al., 2005; 204). The research population in this study are the professional nurses working at rural primary healthcare clinics in Amathole District in the Buffalo City sub-district.

A purposive sampling method will be used to identify persons who may participate in the study. According to Potton (cited in Speziale & Carpenter, 2007:94), purposive sampling is used in selecting the data participants for the study from whom information will be obtained. These concepts will be discussed in detail in Chapter 2.

1.7.2 Method of Data Collection

According to Polgar and Thomas (2000:107), data collection are all the investigations, and the information collected through the application of a variety of techniques, such as interviews, questionnaires, observations, direct physical measurement and the use of standardised tests. In this study, data will be collected by using interviews and field notes. Interviews will be conducted in a semi-structured way. The methods of data collection will be discussed in detail in Chapter 2.

1.7.3 Data Analysis

All the transcribed interviews, as well as the field notes will form the database, which will be analysed. Data analysis reduces, organises, and gives meaning to the data (Burns & Grove, 2009:44). Before starting to analyse or process the data, the researcher must
examine them for their completeness and accuracy (Polit & Beck, 2006:55). All transcripts will be analysed using Tesh’s method of data analysis (Creswell, 2003:192), which will be discussed further in Chapter 2. In this study, the researcher will appoint a person independent of the study and who does not contribute to or participate in the study to do the coding as an independent coder.

1.8 LITERATURE CONTROL

The literature control takes place when the results from a qualitative study are verified against existing literature (de Vos et al., 2005:18). A literature control will be used in verifying findings after the data collection phase of the study (de Vos et al., 2005:265) and after the findings of the research have been formulated.

1.9 PILOT STUDY

A pilot study is a preliminary, small-scale study (Brink, 2006:166) conducted prior to the main study on a limited number of participants from the population at hand. Bless and Higson-Smith (2000:155) (cited in de Vos, 2005: 206) provide what is perhaps the most encompassing definition of the pilot study: they describe it as a small study conducted prior to a larger piece of research to determine whether the methodology, sampling instruments and analysis are adequate and appropriate. In qualitative research the pilot study is done to test the questions on the interview schedule as well as the researcher’s ability to conduct a research interview. The researcher will select one participant who meets the inclusion criteria. The pilot study will be discussed in more detail in Chapter 2.

1.10 TRUSTWORTHINESS

In this study the researcher will ensure the trustworthiness and quality of the study, as Holloway and Wheeler (2002:250) stated that all types of inquiry are open to scrutiny by
their readers. The researcher must consider the truth-value of the research and demonstrate that it is credible and valid for professional practice.

In this study, the researcher will use Guba’s model of trustworthiness to ensure the methodological soundness and adequacy of the study. Holloway and Wheeler (2002:254) state that Guba ensures trustworthiness of the study through the use of dependability, credibility, transferability and confirmability. These concepts will be discussed further in Chapter 2.

1.11 ETHICAL CONSIDERATIONS

According to Pera and van Tonder (2005:40), ethics refers to standards and behaviours expected of an individual. Ethics explores the basis on which people, individually or collectively, decide whether actions are right or wrong. Ethics also explores whether something ought to be done, or whether people have the right to do something. The researcher will use the principles of autonomy, beneficence and non-maleficence, justice and the strategies such as confidentiality, informed consent, anonymity and privacy to ensure the high ethical standards of the study. All these principles and strategies will be discussed in details in Chapter 2.

1.12 STRUCTURE AND FORMAT OF THE RESEARCH REPORT

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Research findings

Chapter 4: Conclusions, limitations, and recommendations
1.13 CONCLUSION

Research has shown that the integration of mental healthcare services into primary healthcare clinics is facing some problems, though it was aimed at treating the chronic mentally ill patients in less restrictive environments. Nevertheless, this transformation still faces some challenges as far as service delivery is concerned. The end of the report will provide recommendations and some guidelines aimed at improving the standard of service delivery for chronic mentally ill patients at rural primary healthcare clinics. In this chapter an overview of the study was discussed; Chapter 2 will outline research methods.
CHAPTER 2: RESEARCH METHODOLOGY

2.1 INTRODUCTION

In the previous chapter, the researcher described current literature on the topic that was relevant to the study. She also described the design and planned methodology of the study. In this chapter the methodology utilized in the study will be discussed in detail. Methodology refers to the principles and ideas on which the researcher bases the procedures and strategies in the study (Holloway & Wheeler, 2002:4). In this study the researcher used a qualitative approach. According to de Vos et al. (2005:74), a qualitative approach refers to the research that brings out the meaning of a participant’s description of events, experiences or perceptions of a phenomenon. This chapter dealt with the research methodology, together with a detailed description of data collection, analysis and trustworthiness of the study.

2.2 RESEARCH OBJECTIVES AND HOW I PLAN TO USE THEM

Brink (2006:79) defines research objectives as clear, concise, declarative statements that are written in the present tense. The researcher focused on the following research objectives:-

- to explore and describe the experiences of professional nurses related to the care of chronic mentally ill patients at rural primary healthcare clinics in the Amathole district municipality;
- to make recommendations that can assist professional nurses related to caring for chronic mentally ill patients at rural primary healthcare clinics in the Amathole district municipality.
2.3. RESEARCH DESIGN

Mouton (cited in de Vos et al., 2005:132) defines a research design as a plan of how the researcher intends to conduct the research. It focuses on the product, formulates a research problem as a point of departure, and focuses on the research design. Burns and Grove (2009:218) define the research design as the blueprint for conducting a study. They further state that the design maximizes the researcher’s control over factors that could interfere with the validity of the findings. A research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2009:218). In this study, the researcher used the qualitative, explorative, descriptive and contextual approaches. These concepts are discussed below.

2.3.1 Qualitative Research Design

According to Brink (2006:13), a qualitative research design focuses on the qualitative aspects of meaning, experience and understanding. The study is seen as a human experience from the viewpoint of the research participants in the context in which the action takes place. A qualitative research design is a systematic, interactive, subjective approach used to describe life experiences and it gives those who participated meaning into that which is explored (Burns & Grove, 2009:22). This type of research is conducted in order to describe and promote the understanding of the reader’s concept of experiences such as pain, caring and comfort (Burns & Grove, 2009:25). The researcher used this research method to describe and promote her understanding of the life experiences of professional nurses working at rural primary healthcare clinics of their experiences of caring for chronic mentally ill patients living in a rural community.

2.3.2 Explorative Design

An explorative design is used to satisfy the researcher’s curiosity and desire for a better understanding and may lead to insights about the phenomenon (Babbie & Mouton, 2001:80). Explorative studies are designed to increase the knowledge of the field of study (Burns & Grove, 2009:359). This study was explorative because the researcher
wanted to gain more insight into the problems faced by professional nurses working with chronic mentally ill patients at rural primary healthcare clinics in the Eastern Cape of South Africa.

**2.3.3 Descriptive Design**

According to Neuman (2011: 38), a descriptive design presents a setting or a relationship. Burns and Grove (2009: 237) supported this by stating that the purpose of a descriptive study is to provide a picture of the situation as it is. In this study, the researcher gave a detailed description of the research method, findings and literature control as it is necessary to ensure trustworthiness. Analysis, themes and sub-themes indicating participant’s experiences are described in detail.

**2.3.4 Contextual Design**

A contextual design is used when the researcher desires to understand events, actions, and processes in the concrete, natural context in which they occur (Babbie & Mouton, 2001:272). If one understands events against the background of the whole context and how such a context confers meaning to the events concerned, then one can truly claim to “understand” the events (Babbie & Mouton, 2001:272). The context of this study was the primary healthcare clinics where the primary healthcare nurses were working. They were responsible for the care of chronic mentally ill patients who attend the clinics for treatment of their condition. This study took place in the rural community of the Buffalo City sub-district, Amathole district municipality.

**2.4. RESEARCH METHODS**

Research methods refer to the steps, procedures and strategies for gathering and analysing data in a research investigation (Polit & Beck, 2006:504). In this study qualitative research methods were used in order to answer the research question and meet the objectives of the study. The research population and the sampling method that was used, as well as the method of data collection, data analysis, literature control, and pilot study to ensuring the rigour of the study are discussed below.
2.4.1 Research Population and Sampling

A research population refers to the individuals in the group who possess the specific characteristics the researcher is interested in (de Vos et al., 2005:204). The population of this study was the professional nurses working at rural primary healthcare clinics in a specific rural environment.

A purposive sampling method was used to identify persons who could participate in the study. According to Potton (cited in Speziale & Carpenter, 2007:94), a purposive sampling is used in selecting the data-rich cases for the study from whom information will be obtained. These are individuals from whom one can learn a great deal about the issues of central importance to the purpose of the research, hence the term, purposive sampling. In this study, non-probability purposive sampling was used, meaning that the odds of selecting a particular individual were unknown, because the researcher did not know the population size or the members of the population (de Vos et al., 2005:204). In this study the researcher selected the population from four of the clinics at Amathole, district municipality.

The inclusion criteria for the participants for this study were the following:

- a professional nurse registered under Nursing Act no 33 of 2005 with South African Nursing Council according.

- a professional nurse who had been working at the rural primary healthcare clinics for at least one year or longer.

- a professional nurse who has experience in caring for chronic mentally ill patients.

The researcher obtained, from their operational managers, a list of all professional nurses working in four of the clinics in the Amathole, Buffalo City sub-district municipality who were providing mental health care to chronic mentally ill patients in the rural communities. The operational managers were approached by the researcher to act as gatekeepers between her and the participants. The gatekeepers were tasked to
approach each professional nurse who had been chosen to participate, explain the study to her and obtain provisional consent to participate in the study. Contact information was given to the researcher who then made contact with the prospective participants; she contacted, explained and obtained provisional informed consent from participants. Informed consent was obtained from each participant by explaining the study and what would be required from the participant (see annexure A). The sample size could not be determined before the start of the study. Data saturation was used to indicate the size of the sample that will be characterised by a repetition of the same themes, ideas and concepts. When data saturation occurred, the researcher concluded interviewing.

2.4.2 Method of Data Collection

Data was collected after the researcher received permission to conduct the research from the Department of Health (see annexure D). Permission was also obtained from the district offices of the Buffalo City sub-district municipality to conduct research in that sub-district (see annexure E). According to Polgar and Thomas (2000:107), data collection are consists of all the investigations and information collected through a variety of techniques such as interviews, questionnaires, observations, direct physical measurement and the use of standardised tests. In this study, data was collected by conducting interviews and taking field notes.

Data gathering refers to the planning and implementation of sampling, which includes population, sample size and types of sampling methods and the role of the researcher, research methods for data gathering (Botma, Greef, Mulaudzi & Wright, 2010: 199). Botma et al. (2010:199) further state that this means the kind of data, such as transcribed interviews, records and videos and how the data will be collected. In this study, data was collected using semi-structured interviews and field notes. These two data gathering methods will now be discussed.

2.4.2.1 Semi-Structured Interviews

A semi-structured interview is conducted according to an interview guide that focuses on certain themes and that may include suggested questions (Kval e& Brinkmann,
According to Kvale and Brinkmann (2009:27), a semi-structured interview attempts to understand themes of the lived everyday world from the participants' points of view. It is ‘semi-structured’ because it is neither an open, everyday conversation nor a closed questionnaire. The semi-structured interview comes close to an everyday conversation, but as a professional interview, it has a purpose and involves a specific approach and technique (Kvale & Brinkmann, 2009:27).

In semi-structured interviews, the researcher has an interviewing schedule or guide with a set of questions. Kvale and Brinkmann (2009:27) define the interview guide as a guide that focuses on certain themes and includes suggested questions. The interview guide, however, ensures that the researcher collects similar types of data from all participants (Holloway & Wheeler, 2002:82). Open-ended questions are asked to allow the participants to express themselves freely (de Vos et al., 2005:297) and the researcher is completely involved in perceiving, reacting to, interacting with, reflecting and attaching meaning to the answers. Recording the data collection process was done using an audio tape recorder (Burns & Grove, 2009:508).

The sequencing of the questions was not the same for every participant as it depended on the process of the interview and the response of each individual. The interviewing technique encouraged participants to do most of the talking so that they were able to tell their stories. Minimal verbal responses and interview techniques such as probing, paraphrasing, reflection and clarification encouraged communication (de Vos et al., 2005:297). The researcher established rapport by listening attentively, showing interest, understanding and respect for what the participants were saying (Botma et al., 2010:208) in an attempt to gain a detailed picture of participants' experiences of a particular topic. The semi-structured interviews gave the researcher and the participants more flexibility to answer freely (de Vos et al., 2005:296).

In this study the researcher handed over the interview guide to the participant and they read it together before the interview started. The interviews were conducted in 30-45 minutes. The research questions were as follows:
Overall question:

Tell me about your experiences related to taking care of chronic mentally ill patients who visit your clinic?

Follow-up questions:

What are some of the problems you encounter in caring for chronic mentally ill patients in your clinic?

How have you been prepared to care for these chronic mentally ill patients?

What information do you think rural primary healthcare nurses need in order to help them take better care of these chronic mentally ill patients?

All the interviews were recorded using an audio-tape recorder. After completion of the interviews, the recordings were transcribed verbatim. The transcribed interviews were analysed and coded so that no names appeared on them. Copies of the interviews were kept in two different locations to ensure that the research data stayed available to the researcher and for auditing purposes when necessary. The data collection process was continued until data saturation. An example of an interview can be found in annexure C.

2.4.2.2 Observations and Field Notes

Observation is a fundamental method of gathering data for qualitative studies (Burns & Grove, 2011:88). Field notes are written accounts of the things the researcher hears, sees, experiences and thinks about in the course of gathering and analysing data. The researcher should include both empirical observation and interpretations, writing down the emotions, preconceptions, expectations and prejudices so that the researcher can include them in the final report (de Vos et al., 2005:98).

Descriptive and reflective personal field notes were used, as described by Burns and Grove (2011:89) who state that a researcher should make detailed handwritten notes while observing. In this study these notes reflected on events that occurred during the interview; the researcher made her own interpretation from descriptive notes.
• **Descriptive notes**

Descriptive notes, according to Botma et al. (2010:218), include the portraits of the participants, a reconstruction of the dialogue, a description of a physical setting and accounts of particular events or activities and reflective notes including the researcher's personal thoughts, speculations, feelings, problems, ideas, impressions and prejudices. In this study these notes reflected on events that occurred during the interview.

• **Reflective notes**

Botma et al. (2010:218) state that reflective notes included methodological notes which are the reflections of strategies and methods used in the observations, that is, what did and did not work, what worked well, and they document thoughts about new strategies. Reflective notes record what the researcher thought about her actions and what the participants were telling her. In this study the researcher used reflective notes to ensure that her conduct during the interview was congruent with the proposed research design.

• **Theoretical and personal notes**

Theoretical or personal notes are about researcher’s thoughts about how to make sense of what was going on. Lastly, personal notes involve comments about the researcher’s own feelings and perceptions and they can reflect on ethical dilemmas (Botma et al., 2010:218). In this study the researcher used these notes to make sense of what was going on at rural primary healthcare clinics and to comment on her feelings.

After completing each interview, the researcher sat down immediately and jotted down her impressions. These notes helped the researcher to remember and explore the process of the interview (de Vos et al. 2005:298). Field notes were either used as part of the data or for verification purposes (Botma et al., 2010:216). Recording the observations on the audio tape recorder was also useful.
2.5 DATA ANALYSIS

All the transcribed interviews, as well as the field notes formed the data base for analysis. Data analysis reduces, organises, and gives meaning to the data (Burns & Grove, 2009:44). Before starting to analyse or process the data, the researcher must examine them for their completeness and accuracy (Polit & Beck, 2006:55). Qualitative data analysis involves the integration and synthesis of narrative non-numeric data that is reduced to themes and categories with aid of a coding procedure, meaning that categories are identified and described as themes and sub-themes (Brink, 2006:557). According to Polgar and Thomas (2000:294), coding is a qualitative method of analysis of materials such as interviews where categories are formed and their inter-relationship examined. All transcripts were analysed using Tesh’s method of data analysis (Creswell, 2003:192), which includes the following steps:

- The researcher gets sense of the storyline by reading through all the transcripts carefully, highlighting some words and jotting down ideas as they come to mind.
- The researcher selects one interview, the most interesting one, and focuses on the underlying meaning, jotting down thoughts in the margin.
- The step above is repeated for several transcripts, and a list made of all the topics written in the margin.
- Similar topics are clustered together into major topics, unique topics and ‘leftovers’.
- Abbreviated topics as codes, new categories and codes can emerge.
- The most descriptive wording is found for topics which are categorised and grouped to reduce the total list of categories.
- Each category is abbreviated and put into alphabetical order.
- A preliminary analysis of each category is carried out.
- A final check for existing data that might need to be recorded is carried out.

In this study, the researcher appointed a person who was independent of the study and who had neither made a contribution nor participated in the study to do the coding as an independent coder. The researcher handed over copies of clean; unmarked transcribed
interviews and the copy of analysing techniques used to the independent coder (see annexure F). The coder and the researcher coded interviews independently and identified categories, and then the coder and the researcher met to discuss identified themes. The identified themes were used to make recommendations to assist professional nurses in caring for chronic mentally ill patients at rural primary healthcare clinics.

2.6 LITERATURE CONTROL
A literature control was performed after the findings of the research had been formulated in order to verify the findings of the data collection phase of the study (de Vos et al., 2005:265) and to verify the results of the qualitative study against the existing literature (de Vos et al., 2005:18). Themes and sub-themes were clearly identified, as were differences and similarities in the findings.

2.7 TRUSTWORTHINESS
All types of inquiry are open to scrutiny by their readers (Holloway & Wheeler, 2002:250) and the researcher must consider the truth-value of the research and demonstrate that it is credible and valid for professional practice. In this study, the researcher used Guba’s model of trustworthiness to ensure the methodological soundness and adequacy of the study. According to Holloway and Wheeler (2002:254), Guba ensures trustworthiness of the study through the use of dependability, credibility, transferability and confirmability. These concepts are defined and the strategies discussed below:

2.7.1 Credibility
De Vos et al. (2005:364) describe credibility as the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in a manner that ensures that the subject was accurately identified and described. Holloway and Wheeler (2002:254) also state that credibility means that the participants recognise the meaning
that they themselves give to a situation or condition, and the ‘truth’ of the findings in their own social context. The researcher’s findings should be compatible with the perceptions of people under study. According to Botma et al. (2010:233), truth value is obtained by using the strategy of credibility and the criteria of prolonged engagement, the reflexivity of the researcher, member checking and authority of the researcher. These strategies are those that the researcher used and are described below.

- **Prolonged Engagement**

Prolonged engagement is the investment of sufficient time in data collection activities to have an in-depth understanding of the culture, language and views of the participants and to test for misinformation; it may also be useful in building trust and rapport with participants (Polit & Beck, 2006:332). In this study the researcher spent most of the time collecting data to avoid misunderstandings and wrong information and to build relationships of trust. The researcher herself had been involved in caring for chronic mentally ill patients for 13 years.

- **Reflexivity of the Researcher**

According to Holloway and Wheeler (2002:263), reflexivity means that the researcher will critically reflect on his or her own preconceptions and monitor the relationship with the participants and his or her own reactions to the accounts and actions of participants. In this study the researcher did this by reflecting on her own role, relationships and assumptions about the research. The researcher also took field notes during the interviews so that she could add them in the collected data.

- **Member Checking**

In member checking the researcher checks the understanding of the data with the people who are being studied throughout the interviews and observations (Holloway & Wheeler, 2002:257). The researcher did this by summarising, repeating and paraphrasing the participant’s words. In addition, the researcher carried out follow-up interview with the participants to review the data collected with them, giving them the transcriptions of their interview and her own interpretation of their words and the field
notes that were collected. The participants were asked if they still agreed with what had been said and whether they wanted to add more information.

- **Authority of the Researcher**

The researcher has worked in a psychiatric institution for 13 years. The researcher has studied for a specialist qualification and has a supervisor who is an expert in both qualitative research and psychiatric nursing. The researcher also completed a module on research methodology.

2.7.2 Dependability

Dependability is the alternative to reliability in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by an increasingly refined understanding of the setting (de Vos et al., 2005:364). Dependability is met once the researcher has demonstrated the credibility of the findings. The question to ask, then, is how dependable these findings are. Speziale and Carpenter (2007:49) state that the findings of a study are dependable if they are consistent and accurate. This means that the reader would be able to evaluate the dependability of the study by following the decision-making process of the researcher. Dense description, code-recode, triangulation and peer examination were the strategies the researcher used to ensure the dependability of the study and these are discussed in detail below.

- **Dense Description**

Dense description refers to rich, thorough description of the research setting and the transactions and processes observed during the study (Polit & Beck, 2006:336). Creswell (2013:252) refers to this as a thick description and describes it as that which will allow readers to make decisions regarding transferability. Disclosure of the quality enhancement strategies the researcher adopted to convince qualitative report readers were established. (Polit & Beck, 2012:600). In this study the researcher described the participants, research processes and setting under which the study was conducted in details so that readers would be able to transfer the information to other settings to determine whether findings could be transferred.
• **Code-recode**
In code-recode there are strategies for enhancing quality during the coding and analysis of qualitative data and these include investigator triangulation which is an independent coding and analysis of at least a portion of the data by two or more researchers (Polit & Beck, 2012:599). In this study the researcher made use of an independent coder to analyse and code raw data. The researcher also coded the data and repeated coding it again and again to develop themes and sub-themes.

• **Triangulation**
Triangulation is a process whereby a topic under study is examined from different perspectives, meaning that findings of one type of method can be checked out by reference to another (Holloway & Wheeler, 2002:261). The aim of triangulation is to overcome the intrinsic bias that comes from single-method, single-observer and single-theory studies and it helps to capture a more complete and contextualised portrait of key phenomena (Polit & Beck, 2012:590). In this study the researcher gathered information by using interviews, observation, field notes and a literature review to ensure triangulation. Data analysis was also triangulated by the researcher, an independent coder and the supervisor, all of whom analysed the data.

• **Peer Examination**
Peer examination means that colleagues who are competent in qualitative research or who are experts in the clinical field of mental health nursing are asked to give their opinions on the findings, listen to the researcher’s concerns and discuss them (Holloway & Wheeler, 2002:259). In this study the researcher gave a draft copy of the themes and sub-themes as well as recommendations to the peers at the end of the research to review and explore various aspects of the inquiry.

**2.7.3 Transferability**
Transferability is when the findings in one context can be transferred to similar situations or participants. The knowledge acquired in one context may be relevant in another (Holloway & Wheeler, 2002:255). However, the research population in a
qualitative study is usually very small, thus preventing generalisation of the findings to an outside population. Therefore, findings cannot be transferred. However, Speziale and Carpenter (2007:49) state that transferability refers to the probability that the study findings have meaning to others in a similar situation, in which case the methodology must be described well enough to allow another researcher or reader to apply the information to her/his own situation or to a group similar to the research population. Dense description and peer examination were the strategies that the researcher used and already discussed in dependability.

* **Dense description**

As already discussed.

### 2.7.4 Confirmability

This is the fourth criteria in Guba’s model of trustworthiness. De Vos et al. (2005:347) state that confirmability captures the traditional concept of objectivity and tests whether the findings of the study can be confirmed by another study. When confirmability exists, readers can trace data to their original sources (Holloway & Wheeler, 2002:255). Independent coding was used to ensure the neutrality of the study. Triangulation, peer examination, (both strategies as described in dependability) reflexivity and audit trial, were also strategies that the researcher used.

- **Reflexivity**

Reflexivity is done to test the bias of the researcher by creating an opportunity for self-reflection(Creswell in Boatmen al., 2010:231). Reflexivity involves awareness that the researcher as an individual brings to the inquiry a unique background, set of values and a social and professional identity that can affect the research process (Poli t& Beck, 2012:589). In this study the researcher brought her psychiatric professional knowledge and values as her unique background about chronic mentally ill patients.
• **Audit trial**

Audit trial is a systematic collection of materials and documentation that would allow an independent auditor to come to conclusions about the data. (Polit & Beck, 2012:591). They further stated that there are six useful classes of data that are needed to create an audit trial, and these are: raw data; data reduction and analysis; process notes; materials relating to researcher’s intentions and dispositions; instrument development information and data reconstruction products. In this study the researcher will keep all the documentation including field notes so that when needed, these documentations would be available for auditing.

2.8. **ETHICAL CONSIDERATIONS**

According to Pera and van Tonder (2005:40), ethics refers to standards and behaviours expected of an individual. Ethics explores the basis on which people, individually or collectively, decide whether actions are right or wrong. Ethics also explores whether something ought to be done, or whether people have the right to do something. A discussion of the principles and strategies used to ensure the high ethical standards of the study follows.

2.8.1 **The Principle of Autonomy**

According to Pera and van Tonder (2005:152), individuals should have the freedom to conduct their lives as autonomous agents, without external control, coercion or exploitation, especially when they are asked to participate in research. Further, autonomous individuals are capable of making informed decisions about the study and this should allow them to accept or decline an invitation to participate. The Department of Health, Education and Welfare of the United States (1979: [4]) considers this principle as ‘the respect for the person’, where patients should be treated as autonomous beings, and whereby those who have diminished autonomy are protected. So in this study, the researcher undertook to respect each participant’s freedom and decisions.
2.8.2 Beneficence and Non-Maleficence

The researcher needs to secure the well-being of the participants, who have a right to protection from discomfort and harm, physically, emotionally, spiritually, socially or legally. This raises the question whether the benefits outweigh the potential risk (Brink, 2006:32). Benefits refer to direct advantages, such as access to better services, increased knowledge, skills, and improved access to healthcare services.

Non-maleficence is closely related to autonomy. It infers that no harm should come to the participants. It is the responsibility of the researcher to protect the participants within reasonable limits, from any physical or psychological discomfort that may emerge from the research project (de Vos et al., 2005:58).

2.8.3 Justice

Justice refers to the healthcare practitioner’s responsibility to enforce justice with equal distribution of benefit to all people, preventing one person from benefitting to the detriment of another, or allowing the exploitation of another person (Muller, 2009:63). According to Brink (2009:33), the researcher must select with fairness the study population in general, and the participants in particular, and she should select the participants for reasons directly related to the study problem. Further, the researcher must ensure that all the actions are legal. The researcher took into consideration the right to fair selection and treatment of the participants.

2.8.4 Strategies used to ensure Research Principles

The strategies used in this study to ensure high ethical standards are described below.

- **Confidentiality**

Confidentiality means that information from individuals and the institution with which they are associated will not be divulged against their will. Information will be kept confidential, for example, the names of the participants will be kept anonymous. Pera and van Tonder (2005:154) state that confidentiality means no information provided by
a candidate should be divulged in any way except for research purposes. In this study, all the information was kept confidential and is used for research purposes only. Only the researcher, supervisor and the coder had access to original information and the coder was not given the names of the participants. The coder was given transcribed interviews and she identified themes and sub-themes for coding purposes.

- **Informed consent**

Informed consent means that the respect for a person requires that participants should be given the opportunity to choose what should or should not happen to them according to their degree of capability (Belmont Report, 1997:7). According to de Vos et al. (2005:59), obtaining informed consent implies that all possible or adequate information on the goal of the investigation and the procedures will be followed during the investigation. The gatekeepers contacted possible participants and informed them of the process. The researcher sent letters informing the participants (see annexure A) and before signing the informed consent, the researcher discussed it with the participants to ensure that they understood it clearly. The possible advantages, disadvantages and dangers, to which respondents may be exposed, as well as the credibility of the researcher, must be made clear to potential participants or their legal representatives. The researcher also obtained permission to conduct the research from the ethics committee of the Eastern Cape Department of Health (see annexure D) and from the Amathole, Buffalo City sub-district municipality (see annexure E).

- **Anonymity**

Anonymity in reporting data has been ensured. The use of quotes from the transcripts was conducted using pseudonyms, and participants were informed about this. The researcher assured them that their quotes would not be recognised. In this study the participants were a small group, the researcher met them and conducted interviews so the researcher was aware of their identity, but the researcher did not make it known who the participants were.
• **Privacy**

According to de Vos et al. (2005:61), privacy is that which is normally not intended for others to observe or analyse. The right to privacy is the individual's right to decide when, where, to whom, and to what extent his or her attitudes, beliefs and behaviour will be revealed (de Vos et al., 2005:61). Interviews were conducted in a private venue such as an office where there were no interruptions. In addition, the tape recordings and transcribed interviews were kept locked safe to ensure privacy.

• **Veracity**

Veracity means obtaining an accurate flow of information that is comprehensive and takes account of the participant’s understanding and it is important in order to gain participation in research study and informed consent (Holloway & Wheeler, 2002:53). In this study the researcher explained the procedure to the participants, how the interviews would be conducted and how the findings would be written. The participants were told that they could withdraw from the study at any time.

• **Use of deception**

Deception can involve either deliberately withholding information about the study or providing participants with false information (Polit & Beck, 2006:89). In this study the researcher gave participants all comprehensive information about the study and the participants were not manipulated into participating in the study.

**2.9. CONCLUSION**

In this chapter the researcher described the methodology that was used in the study and how it was used. Because the study is qualitative in nature, qualitative research methods were used. In Chapter 3, the collected data, its analysis and the findings of the study are discussed.
CHAPTER 3: RESEARCH FINDINGS

3.1 INTRODUCTION

In Chapter 2 described the research design and method: the researcher contacted the primary healthcare clinics with a request to the nursing staff to participate in the study. After getting permission and informed consent, the researcher conducted the interviews, transcribed them and analysed the data. The researcher approached an independent coder, and using Tesh’s method of data analysis identified themes and sub-themes which were discussed with both the independent coder and her supervisor. The researcher and her supervisor agreed on the three themes discussed in this chapter.

3.2 DESCRIPTION OF THE RESEARCH PROCESS

The Faculty Research and Technology Information Committee, and the Department of Health of Eastern Cape from Buffalo City sub-district of Amathole district municipality (see annexure D and E) granted permission to conduct the study and made arrangements to carry it out. The researcher conducted a pilot study first by interviewing one professional nurse who met the inclusion criteria. The interview was transcribed and sent it to the supervisor for approval. Once the supervisor had approved the interview, she gave the go-ahead to conduct the interviews. The researcher made appointments for interviews and contacted five clinics, approaching the operational managers of these clinics who were asked to act as gatekeepers between the researcher and the participants. Four of the clinics gave permission to participate and one indicated no interest in participating in the study.

All the prospective participants signed the informed consent forms before the researcher conducted interviews with eight professional nurses. The interviews were transcribed immediately after each interview was completed. The pilot interview was
added to the database, bringing the total number of interviews to nine. There were no problems setting up appointments, with the exception of one clinic which kept rescheduling the appointment dates. The researcher had difficulty getting signed informed consent forms from one of the clinics which eventually refused to participate in the study. All participants in the remaining clinics were willing to participate and met the inclusion criteria. The interviews were conducted in the offices of the clinics to protect the privacy of the participants. The characteristics of the participants are described in the following table.
Table 3.2.1 Characteristics of the participants

<table>
<thead>
<tr>
<th>Participants</th>
<th>Age</th>
<th>Gender</th>
<th>Qualifications</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse One</td>
<td>59 years</td>
<td>Female</td>
<td>General nursing, midwifery, community nursing care, and nursing administration</td>
<td>14 years</td>
</tr>
<tr>
<td>Nurse Two</td>
<td>40 years</td>
<td>Male</td>
<td>General nursing, psychiatric nursing care, clinical nursing management</td>
<td>9 years</td>
</tr>
<tr>
<td>Nurse Three</td>
<td>32 years</td>
<td>Female</td>
<td>General nursing</td>
<td>8 years</td>
</tr>
<tr>
<td>Nurse Four</td>
<td>55 years</td>
<td>Female</td>
<td>General nursing, community nursing care, midwifery</td>
<td>11 years</td>
</tr>
<tr>
<td>Nurse Five</td>
<td>46 years</td>
<td>Female</td>
<td>General nursing, community nursing care, midwifery, psychiatric nursing care,</td>
<td>21 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>administration</td>
<td></td>
</tr>
<tr>
<td>Nurse Six</td>
<td>31 years</td>
<td>Female</td>
<td>General nursing, community nursing care, midwifery, psychiatric nursing care</td>
<td>3 years</td>
</tr>
<tr>
<td>Nurse Seven</td>
<td>50 years</td>
<td>Female</td>
<td>General nursing: midwifery, community nursing care, psychiatric nursing care,</td>
<td>17 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>management</td>
<td></td>
</tr>
<tr>
<td>Nurse Eight</td>
<td>59 years</td>
<td>Female</td>
<td>General nursing: midwifery, psychiatric nursing care, community nursing care</td>
<td>13 years</td>
</tr>
<tr>
<td>Nurse Nine</td>
<td>25 years</td>
<td>Male</td>
<td>General nursing, community nursing care, midwifery, psychiatric nursing care</td>
<td>2 years</td>
</tr>
</tbody>
</table>

Nine professional nurses participated in the study. Their ages differed from 25 – 59 years of age, with a mean age of 44 years. Seven of the participants were females with only two male nurses who participated. Their experience in nursing differed from 21 years to only 2 years, with a mean time span of experience of 10.8 years. This means that most of the participants had a lot of experience in dealing with nursing issues. One of the participants had a single qualification in general nursing but most of them were well qualified with three or more nursing qualifications. Six of the participants had a qualification in psychiatric nursing which should have qualified them to deal with problems chronically mentally ill patients presented with.
<table>
<thead>
<tr>
<th>MAIN THEMES</th>
<th>SUB-THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THEME 1</strong> Professional nurses experience problems when they have to take care of psychiatric patients attending rural primary health care clinics.</td>
<td><strong>SUB-THEMES</strong> 1.1 Professional nurses at primary health care are unable to properly assess and manage mental illness symptoms that patients present within the clinic. 1.2 Chronic mentally ill patients on on-going treatment are unable to consult a doctor every six months to have their prescriptions up-dated. 1.3 Professional nurses at rural primary health care clinics reported that at times there are not enough staff available to deliver full services. 1.4 Professional nurses are unsure about how to take care of the needs of chronic mentally ill patients because: 1.4.1 They did not receive any training in caring for psychiatric patients; 1.4.2 No workshops to update their knowledge are held.</td>
</tr>
<tr>
<td><strong>THEME 2</strong> Professional nurses experience that psychiatric patients living in rural communities experience problems which affect their well-being.</td>
<td><strong>SUB-THEMES</strong> 2.1 Limited family involvement. 2.2 There are specific factors that prevent psychiatric patients from attending rural primary healthcare clinics regularly. 2.3 Patients do not adhere to their treatment regimen. 2.4 Patients lack knowledge regarding their illness and treatment. 2.5 When acutely mentally ill patients become aggressive, police are asked to intervene.</td>
</tr>
<tr>
<td><strong>THEME 3</strong> Professional nurses have positive experiences when caring for psychiatric patients in rural communities.</td>
<td><strong>SUB-THEMES</strong> 3.1 Clinics always have stock of the chronic medication prescribed for the chronic mentally ill patients. 3.2 Community healthcare workers assist professional nurses to trace patients who default on their treatment so that patients can continue complying with their medication.</td>
</tr>
</tbody>
</table>
3.4 DESCRIPTION OF THEMES AND SUB-THEMES

The following themes and sub-themes were identified and will be described as follows:

3.4.1 Theme 1: Professional nurses experience problems when they have to take care of psychiatric patients attending rural primary healthcare clinics

Decentralisation of all health care, not just mental health care, became the cornerstone of the World Health Organisation’s policy as expressed in the recommendations of the International Conference on Primary Health Care at Alma-Ata (Robertson, Allwood, & Gagiano, 2001:418). The World Health Organisation developed a policy incorporating mental health care into the general primary healthcare services and declared that primary health care was the way to go in order to ensure health for all by the year 2000 (Uys & Middleton, 2010:11). The South African Department of Health supported this policy (Uys & Middleton, 2010:11) and, as a result, for the past 20 years chronic mentally ill patients have been de-institutionalised and chronic mentally ill patients living in rural areas received care at primary healthcare clinics.

The participants in this study, who are professional nurses working at rural primary healthcare clinics, reported that they experienced the care of chronic mentally ill patients as problematic. Professional nurses at rural primary healthcare clinics were unable to properly assess and manage the mental illness symptoms that patients presented at the clinic, for several reasons: chronic mentally ill patients who were on ongoing treatment were unable to consult with a doctor every six months to have their prescriptions up-dated; at times there were not enough staff available to deliver a full service; they were unsure about how to take care of the needs of chronic mentally ill patients because they had not received training in caring for these patients and no workshops on mental health issues to update their knowledge had been held; when patients were referred to clinics, they received files with information only on the patients and no guidance on how to treat them. Finally, physicians visited each clinic only a few times a year, so mentally ill patients were seldom assessed by these physicians. This
broad theme was divided into four sub-themes and these sub-themes will now be discussed.

3.4.1.1 Sub-theme 1.1: The primary healthcare nurses are unable to properly assess and manage mental illness symptoms that patients present within the clinic.

Patients with mental illness may present with a range of symptoms associated with mental illness, such as psychotic symptoms, aggressive behavior, mood disturbances or emotional discomfort. These may be known psychiatric patients or an individual presenting with mental illness for the first time. Chronic mentally ill patients may also become non-compliant with prescribed treatment and present with aggressive and violent behavior. Psychiatric patients including chronic mentally ill patients present with behaviors that are listed above and that the professional nurses working in primary healthcare clinics had not been trained to manage. Because of their inability to diagnose mental illness symptoms, the primary healthcare nurses had difficulty helping patients and might even refer these patients incorrectly.

“Usually they come with the police, like family called the police and the police will come with the client to the clinic, so in that case we give treatment. If it’s an injection we inject them, then from there we send them back home but if that person is very, very violent usually we write a letter to the hospital. Then we send them, that’s where they look at him, we work with. Is it Fort England? Yes.”

The following quotes showed that some of the participants were unable to assess and manage symptoms of mental illness leaving them uncertain about when and where to refer patients. Only one participant mentioned 72-hour assessment in all the interviews and most mentioned that they would contact another clinic or the doctor from a psychiatric institution for advice.

“We phone the psychiatric doctor at Fort England hospital for the advice and we give [the] client haloperidol 50mg imi stat, and if the patient is still violent we send them to Nompumelelo hospital for 72-hour assessment.”
“I deal with a client and when I have a problem, I phone the other clinic or the doctor to say that I’ve got this problem, I was never prepared for psych patients.”

The investigation conducted by Ganasen, Parker, Hugo, Stein, Emsley and Seedats (2007:25) of nurses' knowledge of mental illness and their attitudes in community clinics found that the majority (94%) of nurses were not able to correctly diagnose the disorders presented in a case study and nurses seemed to favor psycho-therapeutic treatments over psychotropic drugs as they believed that the drugs caused brain damage and dependency (Ganasen et al., 2007:25).

As referral is part of managing the patients, it is most effective when the patients and the family know where to go, whom to meet, the reason for the referral, and what to expect when they got there (Keltner, Shcwecke & Bostrom, 2007:160). In this study participants seemed to be unable to assess symptoms of mental illness properly so that they could refer patients correctly. Instead, some contacted professional nurses in other clinics for advice, or contact either the physician or the psychiatrist from the psychiatric institution in their catchment area for guidance. Some of the other primary healthcare nurses referred the patients to the nearest hospital. A nurse must be knowledgeable about the resources to which he or she has access to refer families and patients (Keltner et al., 207: 160).

In a study conducted in Uganda it was found that, although a referral system existed in the district, it was never adhered to, as patients would seek help where they expected the services and they would bypass the available levels of care (Ssebunnya, Kigozi, Kizza & Nyannabangi, 2010:130). In that case, patients were not using the primary health care for their treatment, but were bypassing all other levels and seeking help from secondary and tertiary services, unlike in the Eastern Cape, where patients go to the primary healthcare where they may be medicated only and sent back home when they may actually need referral for 72-hour assessment and treatment. However, the primary healthcare nurses do not have enough knowledge to be familiar with the services.
3.1.4.2 Sub-theme 1.2: Chronic mentally ill patients who are on on-going treatment are unable to consult with a doctor every six months to have their prescriptions updated.

Doctors do not visit the rural primary healthcare clinics as expected. Psychiatric patients are supposed to visit the primary healthcare clinic on a monthly basis to receive their prescribed treatment when they are supposed to be issued with the prescribed medication. According to the law, a prescription for chronic medication must be renewed every six months and a physician, usually a general practitioner, is supposed to visit rural primary healthcare clinics at least once a month. One of the physicians’ duties is to examine chronic mentally ill patients and review prescriptions. Legally, each patient should be seen by a doctor every six months in order for a physician to issue a new prescription for medication, but there was a shortage of doctors and patients were not seen by them. The outcome was that, after a period of time, the prescriptions had expired and were no longer valid. The primary healthcare nurses reported that they had to issue the patients with medication on prescriptions which had already been expired. The primary healthcare nurses had to ensure that medication was available and that all prescriptions met minimum criteria and, although it was possible to refer patients to a psychiatric hospital for prescription review only, it was expensive for patients as they had to travel and did not always have money for transport.

“Another problem with my facility, or should I say a clinic, with our clinics and around all the clinics, we do have a challenge with the prescriptions, they are supposed to be reviewed at six months, ever since Nompumelelo Psychiatric Department was closed, so we do have that problem. There are clients whose scripts are not reviewed.”
“The doctor will come and write a script for one month then the patient will stay after that with expired scripts because the doctor does not come often. That is a problem; now we use expired scripts.”

“I think we have a problem with the visiting doctor, the patients must be seen by the local doctor which I think he only came three times this year to this clinic.”

In this study all participants verbalised that, at times, they were using expired prescription charts for the psychiatric patients. It appeared that doctors seldom visited the clinics, so there were long periods when patients were seen by a medical doctor or a psychiatrist from the nearest psychiatric institution. There was a doctor (medical doctor) who was supposed to visit the clinics to assess the psychiatric patients on a monthly basis, but that doctor visited only a few times a year and possibly only specific clinics.

In the study conducted by Ssebunnya et al. (2010:130) in Uganda, there were only a few doctors who had a minimal interest in mental health and rest had no interest in it. Another study conducted in the Western Cape by van Heerden (2008:5) found that there was only specialist psychiatrist for all the rural districts so the patients were seldom seen by the psychiatrist. Van Heerden’s study supports the current study that chronic mentally ill patients living in rural areas do not have access to proper care as prescribed by a psychiatrist or even a medical practitioner.

Unlawful practice was perpetuated when patients are issued chronic medication on a script that has actually expired. The primary healthcare nurses were aware that patients needed medication to stay compliant, therefore they made an ethical decision to keep on issuing the medication on an old prescription for the good of the patients. According to Muller (2009:59), ethics is a highly specialised field of study that deals with the dynamics of what is right or wrong in human behavior. Ethics is generally understood to be a system of action-guiding principles and rules which function by specifying the type of conduct that is permitted, expected or required, and forbidden. When primary
healthcare nurses issued medication on expired scripts, it was legally wrong but ethically acceptable.

3.4.1.3 Sub-theme 1.3: Professional nurses at rural primary healthcare clinics report that at times there are not enough staff available to deliver full services.

Primary healthcare clinics in rural areas were under-staffed. Each clinic had only two or three professional nurses allocated to the clinic. At times it happened that when one professional nurse is on leave or sick, there would be only one to two professional nurses available to prove the full service to all the patients using the facility. The professional nurses were supposed to do home visits and to conduct in-service training at clinic level to empower one another, but they point out that they do not because of staff shortages.

“In my clinic I don’t think they all know because we don’t have in-service trainings [sic], especially as we are short staffed so we don’t have in-services [sic].”

These professional nurses also pointed out that they were supposed to accompany the patients when they had to meet the psychiatrist to fully present the patient but, because they were short-staffed, were unable to do so.

“There is a shortage of staff now. There is only an operational manager and one professional nurse and these patients need to be escorted by a professional nurse to the doctor. As a result we use community healthcare workers to do home visits when there is a problem.”

Most participants mentioned that they made use of community healthcare workers to do home visits because they were short-staffed. In some of the clinics, the community healthcare workers seemed to be allocated to do home visits with the patients who were staying at the same village as they do. In other clinics, the primary healthcare nurses
asked the community health care workers to trace the patients should the patients had defaulted on treatment.

“Those patients who do not come to the clinic, we just trace them. We have community healthcare workers in the clinic that we can use to trace the patients.”

These quotes supported the fact that staff shortages made it difficult or impossible for staff members to attend activities such as in-service education, accompany patients to see the doctor in a local hospital, and carry out home visits. This means that chronic mentally ill patients got a limited service as they only saw nurses at clinics when medication was issued.

The study conducted in Uganda by Ssebunya, et al. (2010:130) found that staffing levels for mental health in the district were far below optimal, with only one mental health nurse in the district. In the study conducted by van Heerden (2008:4) in the Western Cape, some of their challenges of the community centres and district hospitals were that they were poorly equipped, understaffed, and staff who were unwilling to take care of the mental health services at district hospitals in rural districts. In the rural areas of the Western Cape, they also experienced staff shortages, amongst other challenges.

3.4.1.4 Sub-theme 1.4: Professional nurses are unsure about how to take care of the needs of chronic mentally ill patients.

Most participants reported that they had not received any training in caring for chronic mentally ill patients. Other primary health care nurses were not qualified in psychiatric nursing, they did not have experience in dealing with psychiatric patients nor had they ever had any workshops to update their knowledge in caring for psychiatric patients. These sub-themes are discussed below.

- **They did not received any training in caring for mentally ill patients**

Participants mentioned that they were not really prepared for taking care of chronic mentally ill patients as they do not have experience in managing psychiatric patients,
nor had they attended any in-service training courses on the topic. Some of the participants mentioned that they were not trained in psychiatric nursing care:

“I don’t have psychiatric nursing but due to seeing all the sisters with psych working with clients, so I know by looking at the client’s folders and see the type of medication he is taking. So I am able to give it.”

Some of the professional nurses working in rural primary healthcare clinics received training in psychiatric nursing when they were doing their four-year comprehensive nursing course. Some of the professional nurses had taken the one-year diploma course in psychiatric nursing care, but had never worked in a psychiatric institution afterwards, which meant that they had very little experience in caring for chronic mentally ill patients. The professional nurses with qualifications in psychiatric nursing care needed refresher courses to remind them how to deal with psychiatric patients.

“I only heard about psychiatric nursing at school when I was doing my four-year course. After that I never worked in a psychiatric institution.”

“I was not sent to any course, never; as a result I deal with the client when I have a problem. I phone another clinic or the doctor to say I’ve got this problem. I was never prepared for psych patients.”

“Yes, medications, some of these medications[s], we only know them by trade names and not generic names. We need in-service of these drugs; we also need training in advanced psychiatry (psychiatric nursing care).

In the study conducted by Ssebunnya, et al. (2010:130), most of the primary healthcare nurses in Uganda admitted to never having received training in mental health care. In the study conducted by Mkhize and Kometsi (2008:107) the authors stated that mental health care is a free-standing activity in primary health care without the necessary training, support, supervision and follow-up. This conflict with the Alma Ata Declaration, which called for a primary healthcare system complete with referral systems, supervision and support (Mkhize & Kometsi, 2008:107).
No workshops are held to update their knowledge and skills.

Primary healthcare nurses were not able to care for psychiatric patients holistically as they did not have the knowledge and skills to do so. The primary healthcare nurses could not provide health education for patients as they themselves need more knowledge on psychiatric nursing care; they could only focus on anti-psychotic medication interventions but, because they could not identify side-effects of the anti-psychotic medication, their limited knowledge of psychiatric medication also caused problems. The participants expressed the need for specific knowledge on medication, side-effects and how to manage them.

“You see, we need information about medication and side effects, we really need to know especially side-effects. You will find someone coming here with stiff neck and drooling of saliva but we don’t know what to do about them.”

The participants also stated that they need specific skills on the management of aggressive patients, suicidal patients, and of patients with anxiety and psychosis. Most times when nurses were placed in primary healthcare clinics, they were sent on short courses for other programmes, such as caring for HIV patients or patients with tuberculosis, but these participants claimed that they were not sent on any mental health nursing course. It seemed that there were no courses on psychiatric nursing arranged for them to attend.

“One day he came and I attended to him. Then he was really aggressive. It was him and me there so that day, hey, I don’t know what happened but at the end I escaped. I came out and he was left inside. He was very, very rough. He wanted like ... to assault me.”

The above quote supported the assertion that primary healthcare nurses could not handle patients who acted aggressively because they lacked the necessary skills.
“Some of us only have that training of psychiatric nursing we got from school. Besides that there are no short courses, no in-service trainings in place and again in this clinic we need to do more in-service trainings, we can use the pamphlets from the medication boxes to teach ourselves.”

The study conducted by Peterson and Swartz (2002:73) showed that the training of nurses had not provided them with the necessary skills to work in a primary healthcare setting nor to understand illness as a social, biological and cultural construct. Another study conducted by Ssebunnya et al. (2010:130) in Uganda revealed that integration of mental health into primary health care required investment in the training of the staff to detect and treat common mental disorders. The nurses in Uganda also did not clearly understand mental illness. According to Burns (2008:48), treatment protocols for the management of mental disorders should be developed regionally for distribution to district- and community-level health workers and regular updates should be provided on these protocols.

**3.4.2 Theme 2: Professional nurses experience that psychiatric patients living in rural communities experience problems which affect their well-being**

Chronic mentally ill patients living in rural communities experienced problems which affected their well-being such as patients having limited family involvement or specific factors that prevented the psychiatric patients from attending rural primary healthcare clinics regularly. Some patients did not adhere to their treatment plan, while other patients lacked knowledge regarding their illness and treatment. When these patients became mentally ill and aggressive, police had to be asked to intervene. As these patients live in a rural community, they had problems arranging transport if they need it. Chronic mentally ill patients also experienced poverty because they had no income. Some also hold supernatural beliefs regarding mental illness. These sub-themes are discussed below.
3.4.2.1 *Sub-theme 2.1: Limited family involvement.*

The term ‘family’ can be described as two or more related people living together who are committed to each other (Keltner, Schwecke & Bostrom, 2007:152). They can be related to one another by a blood tie, the term can also include unrelated individuals choosing to live together and assuming the roles and functions of a family (Keltner, Schwecke & Bostrom 2007:152). When a psychiatric patient is released into the community, the family is contacted, informed of the discharge and is expected to accept responsibility for the patient. This study revealed that some families seem not to be supportive of their chronic mentally ill family members. Some of the participants mentioned that some patients may visit the clinic unaccompanied by family members. Some patients did not attend the clinic at all meaning, that they defaulted on their treatment. This could often be regarded as lack of involvement of the part of the family as they did not remind the patients of the clinic visit. Some participants mentioned the fact that it was the police and not the family who brought the patients to the clinic when they exhibited symptoms of serious mental illness. The following were the supportive statements:

“Also family involvement is poor because the family does not bring them to the clinics for follow-ups. Most of the times since I’ve worked with these patients I’ve noticed that it is the police who bring them to the clinics when they relapse mostly.”

“The relatives do not care about these clients. You see, we do give them the next visit date but they do not turn up at times.”

“I will start about the families. Families do not involve themselves in the patient’s illness, they (patients) come alone to the clinic most of the time every time, we do not have that chance to ask relatives how the patient is coping at home, if he is not psychotic sometimes, if not vandalising things at home, not dangerous.”

Though some of the families did not get involved in their relative’s illness and care, there were those who did support the patients and it was beneficial for patients when
the families were involved. The uninvolved families still took the money from their disability grant and sometimes used it for their own needs. This could compromise the patient’s health because it could make the patients angry, sometimes leading them to refuse to take their medication. The chronic mentally ill patients then relapse and must be re-admitted to acute psychiatric care.

According to Chamberlin and Rogers as cited in Mhaule and Ntswane-Lebang (2009:127), psychiatric patients need support of the families to encourage them to take medication. Families as a support system were a problem in this study as the caregivers who were supposed to support the patients did not get encouragement to do so from other family members, causing the caregivers to neglect the patients. In response, the psychiatric patients refused to take their medication as prescribed.

3.4.2.2 Sub-theme 2.2: There are specific factors that prevent psychiatric patients from attending primary healthcare clinics regularly.

The participants reported that patients were at times referred to hospitals in the nearby town to consult a doctor or a psychiatrist, but there were some factors that prevented patients from attending the clinics and hospitals for their follow-up visits and bookings. Lack of money was one of those issues as the family or the patient could not pay the taxi fare. Most of the patients were staying far away from the clinics and the hospital was also far from the villages. One participant stated that:

“In our clinic we don’t have the psychiatric doctor, there is only one doctor from Fort England hospital and [who] sees them once a month at Nompumelelo Hospital. It’s also a problem because some of them do not have money to go to Nompumelelo Hospital because it is too far from the Pikoli clinic, is about 30 km from here so maybe it’s another cause of relapse.”

An issue preventing regular clinic attendance was patients who were living far away and had to walk to the clinics. Sometimes the roads that they had to use to get to the clinic were impassable because of heavy rains and broken bridges. One participant said:
“Another thing is transport, some of them are living in far areas, they have to wait for the grant money to come, sometimes there are heavy rains and the bridge becomes full and patients become unable to come to the clinic.”

All these quotes supported the sub-theme that there were factors that prevented the patients getting to their appointments. Some of these factors, such as bad weather, staying far away from the clinic, drug and alcohol abuse were not under the control of the professional nurses. Nothing was found in the literature that supported the factors mentioned that prevented psychiatric patients from attending primary healthcare clinics, but the participants of this study raised them.

3.4.2.3 Sub-theme 2.3: Patients do not adhere to their treatment regimen.

Some patients adhere to their treatment regimen and did well.

“What I’m experiencing is that if the client is taking medication, because I do have clients who are taking treatment well, they become all right.”

The participants reported that there is lack of adherence to the treatment regimen among a large number of the chronic mentally ill patients. These patients relapsed because they forgotten to take their medication and no one at home reminded them. All of this leads to medication being taken irregularly or not taken at all. The participants felt strongly that poor adherence might also be related to substance abuse as some of their patients were using substances. The following statements support this:

“Yes, another thing is dagga; few of the patients are still using it because it results in poor adherence.”

“The problem is with those who are taking drugs; liquor, they always relapse, come with relatives aggressive.”

“Those who smoke dagga, the relatives would come and say the patient is not taking medication throughout the month and only smokes this dagga, will do piece jobs and with the money they buy dagga.”
According to Kniesel and Trigoboff (2009:391), researchers estimated that 68% of psychiatric patients adhered to medication intake while in the hospital and when in the community, only 37% or less adhered to the prescribed drug regimens. Kniesel and Trigoboff (2009:866) stated that, among the factors that contributed to medication non-adherence, were a lack of support from significant others, cultural attitudes and beliefs, substance use or abuse, side-effects from the medication and decreased motivation to collaborate in treatment.

### 3.4.2.4 Sub-theme 2.4: Patients lack knowledge regarding their illness and treatment.

The chronic mentally ill patients seemed to lack knowledge regarding their illness and treatment which might cause lack of insight into their mental illness. The following statements explained that patients had lack of insight into their mental illness and treatment:

> “Because when they come sometimes, they don’t know what is happening to them at first and then I explain further about the causes of mental illness.”

The participants verbalised that these patients did not comply with their medication because they lacked knowledge. If the patients had a good insight into their mental illness, they were more likely to comply. Poor understanding of one’s mental illness equals poor compliance. Most participants stated that although the medication was available, patients did not come and collect it. These non-complying patients may then become acutely ill and may only be seen by clinic staff when the police bring them to the clinic. If the patients had better knowledge of their illness and medication, they might adhere better to treatment and be willing to visit the clinic regularly for their medication.

> “He is very ill. I don’t know if he is relapsing or what, but sometimes he does not take his treatment. When he doesn’t take his treatment we have to call the police and everything, and then they come with him to the clinic.”
“No, it’s not that there is no treatment because we make all means that they get their treatment each time. So when someone comes their treatment is always ready for them. They get sick because they don’t come for their medication.”

Some of the inhabitants of rural areas may have a different way of defining mental illness. Some are associating it with witchcraft or supernatural causes which cause them to think differently about mental illness. As a result they refuse to comply with western medicine and using traditional medicine to cure the illness. Knowledge about mental illness and treatment can affect people’s viewpoints. As Ganasen et al. (2008:23) explain, knowledge may not simply mean that one has little or no evidence-based knowledge of mental illness or treatment, but may also mean that knowledge and beliefs held might be derived from other sources such as superstitions, cultural and personal views. These sources influence the knowledge the psychiatric patients has, and clash with the health education given by the nurses.

The study conducted in Nigeria by Ganasen, Parker, Hugo, Emsley and Seedat (2008:25) revealed that some patients and relatives believe that mental illness develops as a result of supernatural causes. Another study conducted in Malaysia by Ganansen et al. (2008:25) found that psychiatric patients who believed in supernatural causes were more likely to make use of traditional healers and were less willing to comply with western medication.

In Ethiopia, witchcraft, herbalists and holy water were favoured over medical treatment for various mental illnesses (Ganasen et al., 2008:25). This supported the view that if patients were well informed regarding their mental illness they would use their prescribed treatment (western medicine), but because their knowledge about their illness was based on their beliefs of the causes of mental illness, they used other methods of treatment, such as traditional medicine and herbs.
3.4.2.5 **Sub-theme 2.5: When acutely mentally ill patients become aggressive, police are asked to intervene.**

Chronic mentally ill patients may display aggressive behaviour. When patients become aggressive, they may be taken to the clinic by family members or by the police. These patients became aggressive because they had not been taking their medication as prescribed. Sometimes they became aggressive because they had have problems with their families and had difficulty coping with stress. The nurses at rural primary healthcare clinics were afraid of attending to patients who acted aggressively and whose behaviour was out of control. The participants reported that they had limited skills in dealing with that kind of behaviour.

Because the nurses are scared of these patients, the police are helpful in dealing with them when they are aggressive. Police intervene because they are expected to, as stated in the Mental Health Care Act, No. 17 of 2002. They can become dangerous in the community and harm others and themselves, which is why the police become involved. In some areas the police are willing to help with aggressive patients but in other areas they are not, stating that it is not their job.

“If they are violent in the community, we ask the policemen to fetch and bring them to the clinic.”

“In the community some of them are aggressive. They don’t want the people to handcuff them so they can come to the clinic. The parents will ask the family to bring them with a donkey-scotch (donkey wagon), tie them and bring them. If you leave them in the community when they are aggressive, they want to beat their families. They want to commit suicide sometimes.”

“We also have a challenge with those who are relapsing because we used to call the police. The police are saying it’s not their duty they are not supposed to take clients to the hospital. So when the client is violent we don’t know what to do, we just tell the relatives to take them to the hospital. At times it becomes difficult because they don’t have transport at times or the money for the bus fee.”
The study conducted by Muller and Flisher (2005:10) reported that mental healthcare services work to establish a collaboration and mutually cooperative relationship with the police service to ensure rights-based treatment and care for people with severe psychiatric conditions and their caregivers. Services formulate the role of police in the form of transport of users, involuntary admission and criminal justice. According to Burns (2008:48), the local South African Police Services and Emergency Medical Rescue Services personnel should receive regular training in their roles in respect of mental healthcare users and the requirements of the Mental Health Care Act, No. 17 of 2007 (Burns, 2008:48).

3.4.3 Theme 3: Professional nurses have positive experiences in the care of psychiatric patients in rural communities

Professional nurses reported positive experiences regarding the care of psychiatric patients in a rural primary health care. They stated that clinics always had stocks of the chronic medication needed by the patients, including the first-generation psychotropics medication for the chronic mentally ill patients. What was also experienced as positive was that community healthcare workers assisted professional nurses in tracing patients who had defaulted treatment so that patients could continue complying with medication. These sub-themes will now be discussed:

3.4.3.1 Sub-theme 3.1: Clinics always have stocks of the chronic medication prescribed for chronic mentally ill patients.

The participants described the supply of medication as a positive experience. It appeared that most of the clinics had no problem with ensuring that there is sufficient medication in stock. The older, first-generation antipsychotic medication was stocked for the patients whom it was prescribed. These medications listed in the Essential Drug List. There are some of the newer generation antipsychotic medications prescribed to chronic mentally ill patients that clinics are not allowed to stock. These include the atypical anti-psychotic, anti-depressants or second-generation medication such as clozapine, risperidal, olanzapine and others. When patients receive the newer anti-
psychotropic drugs (newer generation) it usually indicates that they experienced problems with the older generation anti-psychotic medication in the past and are not able to tolerate the older drugs.

The participants mentioned that they obtained the medication from the facility where the patients had been treated or from the nearest psychiatric institution. The psychiatric institution sends the prescription to the local general hospital and the clinics ensure that the medication is taken to the clinic in time for the patient’s next visit. The participants said:

“We do give them their monthly treatment. They do come to our institution monthly so that we can supply them with the treatment. Then we do order if it is out of stock.”

“There is one who came to collect his script and we did not have his medication with us. Then we get his medication from Nompumelelo dispensary monthly. We make means that there is a nurse who goes via the hospital on those return dates to get it.”

The participants reported that they were responsible for ordering their medication stock and ensured that the psychiatric patients received their monthly medication. Participants also reported that it was only a few patients who did not comply with their treatment. Nurses reported that patients did not fail to comply because of shortage of medication but rather because they did not come to collect their treatment regularly. It is important for these patients to receive a regular supply of medication to ensure compliance.

The study conducted by Ssebunnya et al. (2010:130) in Uganda reported that only a few mental health drugs, particularly anti-epileptics, were available at some of health facilities, with irregular supply at times, meaning that meant most of the medication was not available and that was a problem.
3.4.3.2 Sub-theme 3.2: Community healthcare workers assist in tracing patients who have defaulted treatment so that patients can continue complying with their treatment.

The participants raised the issue of task shifting because of staff shortages in the clinics. The professional nurses were supposed to do home visits so that they can assess patient needs at large. Because of staff shortages, task shifting had been beneficial in the sense that the patients were now reminded about their follow-up dates for clinic attendance by healthcare workers who are not professional nurses. The community healthcare workers also motivated patients to comply with treatment and clinic attendance. Those patients who defaulted treatment were reminded to come to the clinic so that they could continue with their medication. The use of community healthcare workers seemed to be of benefit all the clinics because defaulters were traced and started attending clinics again. Most participants mentioned this:

“We don’t do home visits as professional nurses. We send the health care workers to the homes of the ones who do not come to get their medication.”

“Those who do not take their medication, we try to allocate community health care workers to check at home to see if he did not take it, to call them.”

“Usually we do have community healthcare workers (Onompilo). In that case each and every village has its community health care worker, so they know each other and they know the clients. If the client did not come then they should go to the family to ask why the client did not come, is the client taking medication?”

The study conducted by Mkhize and Kometsi (2008:107) showed that volunteer health workers are employed as envisaged in the White Paper on the transformation of the health system. Volunteer health workers do not have a clearly defined career trajectory within the health care system. As the professional nurses do not have the time to do home visits, the actions of the health workers ensure continued treatment adherence.
3.5 CONCLUSION

In this chapter the researcher analysed the research findings. The themes and sub-themes were identified and discussed. The researcher used the literature control to compare the results of this study with the results of other studies, and in many cases, found similarities. The researcher made recommendations and outlined limitations in the next chapter, Chapter 4.
CHAPTER 4: RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

4.1 INTRODUCTION

In Chapter 3 research findings of the experiences of professional nurses related to taking care of chronic mentally ill patients at rural primary healthcare clinics were discussed. Literature control related to these findings was also carried out. In this chapter, recommendations are made to help professional nurses at rural primary healthcare to take care of chronic mentally patients who visit their clinics. Conclusions and limitations will also be discussed in this chapter.

4.2 RESEARCH OBJECTIVES OF THE STUDY

The researcher focused on the following research objectives of the study:

- to explore and describe the experiences of professional nurses related to caring for chronic mentally ill patients at rural primary healthcare clinics
- to make recommendations that can assist professional nurses related to caring for chronic mentally ill patients attending a rural primary healthcare clinic.

In the researcher’s opinion, the first objective was achieved in the sense that the experiences of professional nurses working in rural primary healthcare clinics related to caring for chronic mentally ill patients was explored in interviews and described in Chapter 3. After conducting interviews with the participants, the researcher identified the following three themes:

- Professional nurses experience problems when they to take care of psychiatric patients attending rural primary healthcare clinics;
- Professional nurses experienced that psychiatric patients living in rural communities experience problems which affected their well-being;
- Professional nurses had positive experiences when caring for psychiatric patients in rural communities.
The researcher now will develop recommendations based on the findings which will be described in this chapter. These recommendations are clinical, education and research.

4.3 CONCLUSIONS OF THE STUDY

Primary healthcare nurses pointed out that patients with a variety of health and social problem may visit rural primary healthcare clinics, meaning that primary healthcare nurses need to have a comprehensive knowledge base and skills to be able to deal with a variety of problems. The Department of Health ensures this need is met with regular in-service education courses. However, a number of primary healthcare nurses do not have a psychiatric nursing qualification and have not attended short course dealing with mental healthcare issues. Thus, some of the primary healthcare nurses do not have the necessary experience, skill or knowledge to take care of the chronic mentally ill patients attending their clinics. This also means that the primary healthcare nurses face problems related to caring of chronic mentally ill patients. These problems were discussed in detail in Chapter 3.

Primary healthcare nurses working in rural communities have a high work load and must sometimes function under difficult circumstances. According to Thornicroft and Szmukler (2001:144), primary healthcare services are increasingly involved in sharing the care of mentally ill patients in primary healthcare as well as chronic disease management of patients with common mental disorders which is also similar as the pattern of caring for patients with chronic disease such as chest problems and uncontrolled glucose levels. These circumstances are discussed below.

• Large number of patients

The number of nurses at primary healthcare clinics is very limited with only two or three professional nurses allocated to the clinic. As a result, they are under pressure because they care for a large number of patients. The participants of this study explained that they were unable to deliver full services to some of these patients such as home visits or taking them to the doctor at the hospital as they should have done because they had to care for other patients at the clinic as well. Further, there is no nurse who is
specifically tasked with caring for the chronic mentally ill patients only. All the professional nurses working in a clinic take care of all patients who attend the rural primary healthcare clinics for different healthcare problems at any time.

The primary healthcare clinics have community healthcare workers who can help where necessary but because of their limited scope of practice and their lack of knowledge and skills, the action they can take is limited. They are in a position to do home visits and encourage the patients to attend the clinic, but it is the professional nurse’s duty to assess mental status, observe behavior and give health education to chronic mentally ill patients. According to Muller (2009:78), the staff in the clinics makes use of the principle of “task-shifting” as a method to improve the human resource crisis, for example, the use of community healthcare workers for home visits and for following up on defaulting patients. The tasks that were traditionally performed by specialists are now being performed by the less specialised practitioners and a new group of people who are ancillary healthcare workers are doing home visits (Muller, 2009:78). This means that the home visiting duties that were supposed to be done by the professional nurses who are more able to assess or intervene with any problems now has to be done by the health care workers who are not knowledgeable in mental health care.

The primary healthcare nurses do not have enough time to give attention to the needs of the chronic mentally ill patients

- **The primary healthcare nurses have to deal with a variety of problems from physical to mental care**

All primary healthcare nurses care for all the patients who visit their clinics and who have different kinds of illnesses, from physical to mental health problems. Some of the cases that the nurses at rural primary healthcare clinics deal with are minor ailments, immunization programmes, ante-natal and post-natal care, chronic physical care, family planning, and mental illness. All these duties of the primary healthcare nurses make it difficult for the psychiatric patients to get full services when visiting the primary healthcare clinic. Nurses simply provide patients medication according to their prescription cards but no further intervention such as health education or rehabilitation.
Some of the chronic mentally ill problems they are responsible for dealing with are long-term schizophrenic patients, caring for patients with stress or suicidal tendencies, patients suffering from psychotic symptoms, many of whom do not get attention they need.

- The primary healthcare nurses are expected to provide care for chronic mentally ill patients without being prepared for the task

Because the other primary healthcare nurses are not trained to take care of the chronic mentally ill patients, the chronic mentally ill patients are neglected and no rehabilitation is done. The files of the chronic mentally ill patients were simply sent to the rural primary healthcare clinics and the nurses were expected to carry on taking care of the mentally ill patients without being properly prepared for the task. There were no short courses or workshops on caring for the mentally ill patients to prepare the nurses for this task. Some of the professional nurses working at primary healthcare clinics were never trained in psychiatric nursing care at all. The professional nurses who had been trained in psychiatric nursing had never worked in a psychiatric institution before which means they have very little experience in caring for chronic mentally ill patients. It is important that the nurses are caring for chronic mental ill patients to know how to manage patients who are presenting with aggressive behavior, hence the need for professional nurses working at primary health care for short courses or workshops in mental health. Some nurses did a four year course comprehensive program but were never exposed to psychiatric nursing except when they were still student nurses.

4.4 RECOMMENDATIONS THAT CAN ASSIST PROFESSIONAL NURSES RELATED TO CARING FOR CHRONIC MENTALLY ILL PATIENTS AT RURAL PRIMARY HEALTHCARE CLINICS

The recommendations are divided into clinical, educational and research recommendations.
4.4.1 Clinical Recommendations

Clinical recommendations are as follows:

- The psychiatric patients need to be cared for by a full multi-disciplinary team. The multi-disciplinary team includes the psychiatrist, medical doctor, professional nurses, psychologist, social worker, occupational therapist and a pharmacist. Each of these members of the multi-disciplinary team has a specific role in the care of chronic mentally ill patients. The members of the multidisciplinary team support each other by working together and discussing the care, needs and problems of these patients. The members of the multi-disciplinary team sit together in a hospital environment but, in the rural primary healthcare clinics, there are no team members present and the ones that do visit clinics do so in their individual capacity, not part of the team. The medical doctors are also infrequently seen in the clinics. They may not discuss the patients as a team, but they should, at least, support each other by other means of communication. In this study no participant mentioned any involvement on the part of other members of the multi-disciplinary team, except for the doctor who may visit the clinic once a month. The primary healthcare nurses voiced lack of support from the doctors as a problem as they had to care for chronic mentally ill patients on their own with no team support. According to Uys and Middleton (2010:73), the primary healthcare level service usually consists of supplying the patients with psychiatric medication, assessing the effectiveness of the medication and organising admissions when necessary. Another member who may function on a primary healthcare level is the social worker, who may assist in obtaining disability grants and ensuring accommodation for the patients. However, if a patient is referred to a social worker, it usually involves travelling. The narrow focus on medication without counseling leaves major needs of the patients unattended. This means that professional nurses focus on continuing with the administration of medication and no other rehabilitation activities takes place (Uys & Middleton, 2010:73). Family members also do not receive
guidance and support in their efforts to care for and rehabilitate chronic mentally ill patients.

- Polices and protocols that are essential for the management of an aggressive patient, management of a suicidal patient, crisis intervention, management and rehabilitation care of chronic mentally ill as well as medication management should be made available and accessible for professional nurses and be placed in consulting rooms at rural primary healthcare clinics. The professional nurses should at least discuss these protocols during in-service training and regular updates should be provided on these protocols. The skills development co-coordinator of the Buffalo City sub-district should make provision for the nurses at primary healthcare to have this training on mental health. According to Burns (2008:480), treatment protocols for managing mental disorders should be developed, and regular updates should be provided on these protocols.

- The Department of Health should recruit more professional nurses to work at the rural primary healthcare clinics. It is especially important to have sufficient staff in smaller clinics to relieve the primary healthcare nurses when they go on leave or are sick, to ensure that the remaining professional nurses do not have an excessive workload.

- Number of doctors and/or psychiatrists should be recruited by the Department of Health to visit the clinics regularly and be available for treating chronic mentally ill patients. There should be more doctors so that each patient can be seen by a physician at least once in six months to ensure that prescriptions meet legal requirements.

- There should be support groups for patients and families of psychiatric patients in the communities. The community healthcare nurses should start and facilitate these support groups with the help of other professional nurses or other team members, based on their knowledge. There should be more support for nurses and more visits from the management to guide and help the nurses.

- Psycho-education of patients and family members needs to be conducted both in their homes and in the clinics when they go for their follow-up dates. According to Uys and Middleton (2010:54), psycho-education means that
consumers, who are the patients and their families, are taught about mental illness, its treatment and management, so that they can cope better with community-based care. This means that the families who were identified as non-supportive earlier in the findings should be enlightened and made aware of what mental illness is and how to support their family members who are the patients.

- Open days, such as mental health awareness days, must also be held by psychiatric nurses to make the communities aware of mental illness. Family members should be taught how to take care of mentally ill patients. Mentally ill patients will benefit from these open days as they can gain knowledge about their mental illness and treatment.

- Police should be involved in crisis care of patients and some refuse to do so. Local South African Police Services personnel and ambulance crews should also receive regular training in their roles in respect of caring for mental healthcare users and the requirements of the Mental Health Care Act, No. 17 of 2002 regarding their role in care of mentally ill patients. This should be done by the district office (Burns, 2008:48). The district offices should build a positive relationship with both the South African Police Service personnel and the ambulance personnel to ensure that they will be willing to help.

- Rehabilitation of chronic mentally ill patients is also important. In rehabilitation patients are being prepared with skills and knowledge so that they can fit back into their communities.

- Support system for primary healthcare nurses caring for chronic mentally ill patients at rural primary healthcare clinics is needed. The primary healthcare nurses do not always have the necessary knowledge or skill to manage the problems presented by chronic mentally ill patients. The primary healthcare nurses have to rely on colleagues from other clinics for a support system. Some of the nurses do not have psychiatric nursing skills and knowledge, so when they are faced with a challenge or a problem of a mental health nature, they have to call a colleague from another clinic or a doctor from a psychiatric institution for advice. When one professional nurse is absent from work, another professional nurse from a clinic which has three professional nurses on duty on
that day has to go and cover in the clinic where there is no professional nurse at the time, leaving his or her clinic short-staffed as well. The primary healthcare nurse has to attend to patients who are not known to her and she may not be aware of their previous problems. Sometimes the nurses are left to work alone when a colleague is on leave, which makes it difficult for them to deliver full services to the patients.

4.4.2 Education

Education is another recommendation which will be discussed as follows:

- The primary healthcare nurses should be prepared through short courses and in-service education on how to care for chronic mentally ill patients. In-service education and short courses should be held for all professional nurses working in rural primary healthcare clinics. The topics should include mental health, assessing patients to identify symptoms of mental illness, managing individuals presenting with mental illness symptoms, administering anti-psychotic medication, managing side-effects, managing aggressive or suicidal patients, and crisis intervention. In-service training refers to the healthcare service-based training of personnel presented by their employer, the Department of Health, to improve their knowledge, skills values and attitudes, according to the demands of the clinics where they are working (Muller, 2009:350). According to Muller (2009:343), well-planned and purposeful workshops are an effective method of education. Workshops can be held with the aim of applying the theoretical principles or reaching consensus about problem solving in the clinics. According to the study conducted by Burns (2008:48), district and community health workers require regular training updates on the Mental Health Care Act of 2002 and its forms and this must be repeated six-monthly as the staff change regularly and the complexity of the Act requires refresher training (Burns, 2008:48).
The training schools for nurses should ensure that students are able to care for chronic mentally ill patients and they are being trained in the skills that are necessary to care for these patients. Barrett, Boeck, Fusco, Ghebrehiwet, Yan & Saxena,(2009:139) suggests that both basic and graduate nursing curricula should be improved by increasing the number of hours devoted to mental health and establishing psychiatric nursing as a priority in nursing education, standardising training curricula on a global level, and introducing multi-disciplinary aspects into the nursing curriculum.

Professional nurses who are not trained in psychiatric nursing care should be encouraged to go on study leave to study psychiatric nursing studies. The employer should provide study leaves for the psychiatric nursing training studies according to the human resource needs. According to Thornicroft and Szmuckler (2001:414), expecting an untrained primary healthcare nurse to administer depot medication without support and training is unacceptable, so training is necessary on how to assess the suitability of this form of medication by monitoring the side-effects and reporting any to the doctor; how to assess mental state for signs of deterioration; how to assess the effect of medication of patient and when to involve colleagues or refer the patient to the relevant places (Thornicroft & Szmuckler, 2001:414).

4.4.3 Research

The primary healthcare nurses who have experience in research activities should be encouraged to conduct research on the topics that are relevant to caring for chronic mentally ill patients.

- Research can be carried out on how families of people with mental illness experience living with chronic mentally ill patients in rural communities.

- Further, similar research can be done in other areas such as urban communities.
• Research can also be done on the experiences of chronic mentally ill patients who are living in the rural communities and who are attending primary healthcare clinics.

4.5 LIMITATIONS

The limitations are as follows:

• Interviews were conducted with nursing staff who met the inclusion criteria in only a few clinics as others were too busy to participate. The researcher was staying far away from the clinics which made it difficult for her to conduct more interviews.

• Obtaining permission to conduct the interviews and this was time-consuming and thus completing the study took longer than expected.

• Personal problems experienced by the researcher (a newborn baby, supporting another child at home with school work, being a single parent and working full time) made it difficult to complete the research project in time.

• Financial constraints also caused problems as the researcher had no bursaries, and had to wait for her salary day in order to start working on her research study.

• Although only professional nurses were included in the study, other categories were excluded including community healthcare workers and may have their own experiences related to caring for chronic mentally ill patients.
4.6 SUMMARY

The research carried out makes it clear those professional nurses in rural primary healthcare need to be knowledgeable about psychiatric conditions so that they are able to assess and manage psychiatric patients properly. In addition, psychiatric patients have problems that prevent them from attending primary healthcare clinics. However, many professional nurses have positive experiences when caring for chronic mentally ill patients. Based on the above experiences, the researcher made recommendations that will assist professional nurses to care more effectively for chronic mentally ill patients in rural primary healthcare clinics.
5. REFERENCES


Barrett, T. Boeck, R. Fusco, C., Ghebrehiwet, T. Yan, J. & Saxena, S. 2009. Nurses are the key to improving mental health services in low-and middle-income countries. *International Nursing Review*. 56. 138-141


ANNEXURE A

CONSENT FORM AND A LETTER TO THE PARTICIPANTS
Dear

RE: REQUEST FOR PERMISSION TO INTERVIEW PARTICIPANT

My name is Ms Noluthando Sam and I am a Masters degree student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. I am employed at Fort England Hospital. The research I wish to conduct for my Master's treatise is entitled: Experiences of professional nurses related to caring for chronic mentally ill patients at rural primary health care clinics. The project is being conducted under the supervision of Professor J. Strumpher at the Department of Nursing Science at the NMMU. The study is about the increased rate of readmission of the chronic mentally ill patients living in a rural community despite the aim to deinstitutionalise these patients.

I am hereby seeking your consent to interview you for the purposes of this study. I will be interviewing professional nurses working in the primary health care services. The objectives of this study is to explore and describe the experiences of professional nurses working in the primary health care services in the Eastern Cape in caring for chronic mentally ill patients living in a rural community. The second objective is to make recommendations that can assist professional nurses working in primary health care services in taking care of chronic mentally ill patients who are attending their clinics.

The data will be collected by doing a semi-structured interview, observations and field notes with each participant. Each interview will last approximately 45 minutes. The questions that you will be asked are:

- Tell me about your experience related to taking care of chronic mentally ill patients who visit your clinic?
- What are some of the problems you encounter in caring for chronic mentally ill patients?
• How have you been prepared to care for these chronic mentally ill patients?
• What information do you think primary health care nurses need in order to help them take better care of these patients?

You should not feel coerced. You may withdraw at any time and information will be managed confidentially. Quotes from the interviews may be used in the research report or in an academic article. However, the actual names of the participants will be replaced with pseudonyms. There are no direct benefits for the participants, but the improved knowledge and skills, improved patient care and job satisfaction

Upon completion of the study, I undertake to provide your clinic with a letter explaining the findings of the full research report. If you require any further information, please do not hesitate to contact me:

Cell nr: 083 506 194  Tel. nr: 046 622 7003(work)
Fax nr: 046 622 7030  Prof J. Strumpfer 041 5404 2617(work)
Ms K. Lange 041 504 2538 (REC-H)

Thank you for your time and consideration in this matter.

Yours sincerely,

Ms N. Sam
INFORMED CONSENT FORM

EXPERIENCES OF PROFESSIONAL NURSES RELATED TO CARING FOR CHRONIC MENTALLY ILL PATIENTS AT RURAL PRIMARY HEALTH CARE CLINCS

I............................................. give consent that as professional nurses working in the primary health care service will participate in the above mentioned project.

I have read the accompanying letter explaining the purpose of the research project and understand that:

- My participation is voluntary
- I may decide to withdraw at any time without penalty
- All information obtained will be treated in strictest confidence
- My name will not be identifiable and used in any written reports
- A report of the findings will be made available to me via my clinic
- I may seek further information on the project from Ms N, Sam on :-

  Cell nr: 083 506 1934  Tel. nr: 046 622 7003
  Fax nr: 046 v622 7030  Prof J. Strumpher 041 504 2617

________________________________________________________________________

Participant                                  Signature

________________________________________________________________________

Date
ANNEXURE B

REQUEST FOR A PERMISSION TO CONDUCT RESEARCH
Dr Nogela
Acting Director specialised services
BISHO
Fax: (040)608 3304

Dear Dr Nogela

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN PSYCHIATRIC HOSPITALS

My name is Ms Noluthando Sam, and I am a Masters Degree student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. I am employed at Fort England Hospital. The research I wish to conduct for my Master’s treatise is entitled: Experiences of professional nurses related to caring for chronic mentally ill patients at rural primary health care clinics. The project is being conducted under the supervision of Professor J. Strumpher at the Department of Nursing Science at the NMMU. The study is about the increased readmission rate of the chronic mentally ill patients living in the community despite the aim of deinstitutionalisation of these patients. The goals of the study is to explore and describe the experiences of professional nurses working in the primary health care services in the Eastern Cape in caring for chronic mentally ill patients living in a rural community. The second objective is to make recommendations that can assist professional nurses working in the primary health care services in taking care of chronic mentally ill patients who are attending their clinics.
I am hereby seeking your consent to do research in the rural community at Amathole District, Buffalo City sub-district in the Eastern Cape, to provide participants for this project. The participants will be expected to be willing to participate in the study and the information obtained from them will be kept confidential but will be used for research purposes only.

I have provided you with a copy of my treatise proposal which includes also copies of the consent forms to be used in the research process, information letters for the participants and the consent forms they have to complete.

Upon completion of the study, I undertake to provide the Department of Health with a bound copy of the full research report.

If you require any further information, please do not hesitate to contact me:

**Cell nr:** 0835 06 1934  
**Tel. nr:** 046 622 7003(work)

**Fax nr:** 046 b622 7030

**Prof. J. Strumpher** 041 504 2617 (work)

**Ms K. Longe** 041 504 2538 (REC-H)

Thank you for your time and consideration in this matter.

Yours sincerely,

Ms N. Sam
District Manager

Dear

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN PRIMARY HEALTH CARE CLINIC

My name is Ms Noluthando Sam, and I am a Masters student in NMMU and working at Fort England Hospital as a professional nurse. The research I wish to conduct for my Master's treatise is entitled: *Experiences of professional nurses related to caring for chronic mentally ill patients at rural primary health care clinics*. The project is being conducted clinics under the supervision of Professor J. Strumphler at the Department of Nursing Science at the NMMU. The study is about the increased rate of readmissions of chronic mentally ill patients living in a rural community despite the aim to deinstitutionalise these patients.

I will be interviewing health care professionals at your clinics. The objectives of the study are to explore and describe the experiences of professional nurses working in the primary health care services in the Eastern Cape in caring for chronic mentally ill patients living in a rural community, to make recommendations that can assist professional nurses working in primary health care services in taking care of chronic mentally ill patients who are attending a primary health care clinic.

The data will be collected by doing a semi-structured interview, observations and field notes with each participant. Each interview will last approximately 45 minutes. The questions that they will be asked are:

- Tell me about your experience taking care of chronic mentally ill patients, and also visits your clinic?
- What are some of the problems you encounter in caring for chronic mentally ill patients?
- How had you been prepared to care for these chronic mentally ill patients?
• What information do you think primary healthcare nurses need in order to help them take better care of these patients?

Participants should not feel coerced. They may withdraw at any time and information will be managed confidentially. Quotes from interviews may be used in the research report or in an academic article. However, the actual names of the participants will be replaced with pseudonyms. There are no direct benefits for the participants, but the improved skills and knowledge, improved patient care and job satisfaction

I am hereby seeking your consent to do research at your primary health care clinic. The Department of Health (DoH) has given me permission to conduct research at the Amathole District municipality is attached. I have included a copy of the consent form to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide your clinic with a letter explaining the research findings. If you require any further information, please do not hesitate to contact me:

Cell nr: 083 506 1934  
Tel. nr: 046 622 7003

Fax nr: 046 622 7030  
Prof J. Srumpher 041 504 2617

Ms K. Longe 041 504 2538 (REC-H)

Thank you for your time and consideration in this matter.

Yours sincerely,

Ms N. Sam
EXPERIENCES OF THE PROFESSIONAL NURSES RELATED TO CARING FOR
CHRONIC MENTALLY ILL PATIENTS AT RURAL PRIMARY HEALTH CARE
CLINICS

I give consent for you to approach the professional nurses working in primary health care and that they may participate in the above mentioned project.

I have read the accompanying letter explaining the purpose of the research project and understand that:

- The role of the institution is voluntary
- I may decide to withdraw the clinic's participation at any time without penalty.
- Only professional nurses who have signed will participate in the project
- All information obtained will be treated in strictest confidence
- The participants' names will not be identifiable and used in any written reports unless they have given authority as the study is not sensitive
- Participants may withdraw from the study at any time without penalty
- A report of the findings will be made available to the clinic.
- I may seek further information on the project from Ms N. Sam

Cell nr: 083 506 1934      Tel. nr: 046 622 7003
Fax nr: 046n 622 7030

_________________________________________
Hospital manager

_________________________________________
Signature

______________________________
Date

Please return to: Private Bag X 1002 Grahamstown 6140
ANNEXURE C

PROTOCOL FOR DATA ANALYSIS
ANNEXURE C

TESH' S METHOD OF DATA ANALYSIS

Tesh in Creswell (2003:192) identified the following steps that can be used in analysing data to identify themes and su-themes:

- Get a sense of the storyline by reading throughout all the transcriptions, carefully, highlighting some words and jotting down ideas come to mind.
- Select one interview, the most interesting one, and focus on the underlying meaning, jotting down thoughts in the margin.
- The step above is completed for several transcripts; and s list is then made of all the topics written in the margin.
- Similar topics shall be clustered together into major topics, unique topics and leftovers.
- Abbreviate topics as codes, new categories and codes can emerge.
- Find most descriptive wording for topics made into categories, and groups can be made to reduce the total list of categories.
- Abbreviate each category and put them into alphabetical order.
- Do a preliminary analysis of each category and
- Do a final look through the data, as existing data might need to be recorded
ANNEXURE D

PERMISSION TO CONDUCT RESEARCH FROM THE DEPARTMENT OF HEALTH
Dear Ms N. Sam

Re: Experiences of professional nurses working in Primary Health Care services when caring for chronically ill patients living in a rural community

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You will observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants. You will not impose or force individuals or possible research participants to participate in your study. Research participants have a right to withdraw anytime they want to.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

Deputy Director: Epidemiological Research & Surveillance Management
ANNEXURE E

PERMISSION TO
CONDUCT RESEARCH
FROM BUFALLO CITY
SUB-DISTRICT
Amathole District

9 Vincent Road, Vincent, East London, 5200, Eastern Cape
Private Bag x 9015, Main Post Office, East London, 5200, Eastern Cape
Tel No. +27 (0)43 711 1100  Fax No. +27 (0)43 721 1972
Website www.ecdoh.gov.za

To: CHC Managers; Clinic Supervisor
   Operational Managers: Buffalo City Sub District facilities
From: Buffalo City Sub-District Manager
Subject: Permission to conduct a research study in Buffalo City Sub District
Date: 08/08/2013

This communique serves to inform the operational managers of Buffalo City Sub District that Miss. Noluthando Sam has been given permission to conduct research in the facilities of Buffalo City Sub District.

The sub district office requests that she be assisted with the information they need without compromising confidentiality of both the consumers of the service and the image of the department.

Your co-operation is always appreciated.

N.V. Nelani

Chariperson: Research Forum
TO WHOM IT MAY CONCERN

I, Helen Holleman, was responsible for the language editing, the copy editing and the proofreading of the following thesis by Noluthando Sam:

EXPERIENCES OF PROFESSIONAL NURSES RELATED TO CARING FOR CHRONIC MENTALLY ILL PATIENTS AT RURAL PRIMARY HEALTH CARE CLINICS

I am an experienced and qualified editor on the NMMU list of recognised editors. My qualifications are as follows:

- Editing and Proofreading for Academic Purposes, McGillivray Linnegar Associates (July 2012)
- CELTA (January 2002), Shane English Language School, Cape Town, South Africa.
- BA degree (English and Philosophy), University of Natal, South Africa (1966).

My editing experience covers the following fields:

- Natural sciences: Entomology, Zoology, Ichthyology, Water Research, Hydrology
- Humanities: Fine Art, History
- Medicine
- Journalism

I can be contacted at: helenholleman807@gmail.com

I wish Ms Sam all the best for her academic and professional career.

Helen Holleman
17 November 2014
ANNEXURE G

TRANSCRIPTION OF INTERVIEWS
INTERVIEW NO 4

Researcher: Good afternoon sister

Professional nurse: Good afternoon

Researcher: Can you please tell me about your experience related to caring for chronics mentally ill patients who visit your clinic?

Professional nurse: Because when they come sometimes they don’t know what is happening to them at first and then I explain further about causes of mental illness. Then if they are aggressive sometimes, you just read guidelines because you cannot just treat but you have to go to your guidelines because you cannot keep all the information in your head all the time and then when they are okay they will come and will chat with you because they know you’ve helped them, they come for their follow up after they have relapsed, that’s all.

Researcher: Do the patients come regularly to the clinic even those who have not relapsed?

Professional nurse: Yes they do come regularly, some of them they do come, some they do not come (silence)

Researcher: What do you do about those who do not come to the clinic?

Professional nurse: Those who do not come to the clinic we just trace them, we have community healthcare workers in the clinic that we can use to trace them, sometimes we phone family members, because we cannot reach them, so the relatives can bring them.

Researcher: So you don’t have any problems about the family involvement with these patients as you are saying you phone the family?

Professional nurse: No we don’t have any problems, they accepted them and they take of them.

Researcher: Is there anything else that you want to tell me about the experiences that you gained from working with these patients?
Professional nurse: Yes there are some experiences because they come and ask sometimes "sister I want to know my date" sometimes they forgot the dates and we just tell them the dates, sometimes they tell you about the relatives that "my mother do this and that to me" and you have to contact the mother, ask what is happening, sometimes they will talk about their money, that "my mother is using my money, I don't have toothpaste, I don't have anything because my mother is using my money", sometimes they tell lies because they want to buy some cigarettes or what

Researcher: when you mean their "money", where do they get money?

Professional nurse: Some of them they got their disability grant, every month are getting their disability grant because after 6 months they have to go for a review to the doctor. We use to send them to CMH (Cecilia Makiwane Hospital) but now we don't send them to CMH we send them to Fort England, and then Fort England does not take all of them, there are certain patients that they take according to their treatment

Researcher: And others where do they go?

Professional nurse: They are seen by the doctors in the clinic and then if there is a problem they are just send to Fort England, they report to psychiatric doctor so this year i don't think that psychiatric doctor come here.

Researcher: so is there any other doctor who comes to the clinic?

Professional nurse: there is a GP from the hospital from who comes to our clinic every month. He asks us to collect some few patients not more than a certain number so that he can review them, if there is a problem we just send them to psychiatrist.

Researcher: what are some of the problems that you encounter in caring for these chronic mentally ill patients?

Professional nurse: sometimes when they relapse, they don't want to come to the clinic, you have to ask the relatives to bring them. In the community some of them are aggressive and they don't want people to handcuff them so that they can come to the clinic, and then parents will ask the family to bring them with scotch, donkey scotch, tie them and bring them, that is the problem we encounter, because if you
leave them in the community, they are aggressive in the community, they want to beat their family, they want to committee suicide sometimes, it's better off that we ask the relatives to bring them

Researcher: so when they are in the clinic what intervention do you do?

P/N: we just assess them; you assess them and ask some questions to them at then if you see that some of the questions like "what is your name? What is the date today? "You can see that he is up to date, he knows the date, the time, and whatever they know, and you just go to the file and give treatment

Researcher: is there anything else that you want to add on these problems?

Professional nurse: since now we do not have a psychiatric doctor, that is the main problem because if the psychiatric doctor would at least come once a month, so you collect them and you select those that are problematic and who become aggressive and send them to the psychiatric doctor because they will give us a date that psychiatric doctor would come on such and such a date. You will assess them in the clinic and you will tell them that there is a doctor who will be coming, so we will send them to a psychiatric doctor. I accompany them yo the psychiatric doctor because they could not just go alone, but now the psychiatric doctors don't come again

Researcher: so when they did come, where did they meet the patients?

Professional nurse: they met with the patients at Nompumelelo hospital

Researcher: you said now they don't come at all?

Professional nurse: no we don't have psychiatric doctor, we just send those who need treatment, some of the medication we don't have it in the clinic, we send them straight to Fort England Hospital

Researcher: how have you been prepared to care for these chronic mentally ill patients?

Professional nurse: i undergo a course, and it was very interesting, in fact 4 months when i attended the course i wanted to leave the course because it was difficult but my colleagues said, no, we are going to go through it, so i wish some of my
colleagues who are nurses can also do this course- psychiatry because it's very very interesting but i know some of the nurses hey say they don’t like psychiatry

Researcher: how long was the course?

Professional nurse: it was 15 months- 1 year 3 months at Frere Hospital East London

Researcher: what information do you think professional nurses at primary health care need in order to help the take care of these patients?

Professional nurse: first of all they must undergo a course so that they know how to treat them. They must love them, talk to them nicely, and they must involve the families because you cannot just take care of the patients alone the family must know because some of the treatment we don't give it to the patients, those who are taking oral treatment we just give it to the relatives so that they can keep them because if you give to them maybe they can take all the medication at once

Researcher: when the community health care workers go for home visits, do bthey give information to the family or they come back to report to you about the problems

Professional nurse: no they don’t give information because they are not trained on that, they come back to us

Researcher: okay then, is there anything else?

Professional nurse:: like what?

Researcher: anything regarding my questions

Professional nurse: no

Researcher: goodbye

Professional nurse: goodbye