STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR SEVERELY AND PERSISTENTLY MENTALLY ILL PERSONS

NONTEMBEKO GRYCELDA SHASHA

Submitted in fulfilment of the requirements for the degree of

DOCTOR PHILOSOPHIAE

in the

FACULTY OF HEALTH SCIENCES

at the

NELSON MANDELA METROPOLITAN UNIVERSITY

PROMOTER : PROF. J. STRUMPHER
CO-PROMOTER : PROF RM VAN ROOYEN

April 2015
DECLARATION

I Nontembeko Grycelda Shasha 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.

SIGNATURE: NONTEMBeko Grycelda Shasha

DATE: 4 April 2015
DEDICATION

This work is dedicated to all the people who are mentally ill and to their families as caregivers, living in the rural and remote areas of the Eastern Cape, who continue to strive to be the best they can be.

“The strength, resilience and innovation demonstrated by people living in rural and remote areas can be an inspiration to us all.” (The Rural Think Tank, 2005:23)
ACKNOWLEDGEMENTS

I would like to express my sincere thanks to the following people who have supported me through this journey:

- Primary acknowledgement goes to God for the abundance of His grace and mercy and for giving me the strength to complete this work. In Him everything is possible; I give Him praise and honour.

- My dearest husband (posthumous) for his love, tireless support, encouragement especially when the going is tough, and a wonderful sense of understanding throughout my study period.

- Special thanks go to Unathi, my daughter, who gave me all the technological and psychological support I needed.

- All my friends, especially Luleka Sincwala, Bulelwa Manuel, Kunjuzwa Macingwane and Ntombekaya Mjali who have fulfilled the old adage that a friend in need is a friend in deed.

- My colleagues at Queenstown Campus with their words of support and encouragement.

- My mother, brother and his wife who taught me perseverance and never to give up.

- All Shasha family members for their support and understanding and for keeping the fires burning at home when I am busy with my studies.

I would like to acknowledge and express my heartfelt gratitude to the following people who supported and guided me along the way:

- My promoters Prof. J Strumpher and Prof RM van Rooyen, without whose invaluable and expert accompaniment, guidance, support, patience and constructive criticism the work would not have been completed.
• Dr Jacobs for acting as an independent coder.

• Prof Gail Klopper for her language editing skills and her encouragement

• Redene Steenberg for technical layout of my study

• Madeleine Clare librarian, for all the literature searches

• Emalahleni LSA, Chris Hani District and Department of Health, Eastern Cape Province, for granting me permission to conduct the research study.

• The management of Lilitha College of Nursing for assisting me with funding and special leave to complete my study.

• Mr Aron Mtsha for helping me with data collection, without you I would not have completed the study.

• Last but not least, to my participants who were prepared to share their experiences with me, the PHC nurses, persons living with mental illness and their families at Emalahleni LSA - without you I would not have completed this research study.

Success is not measured by where you are, in life, but by the obstacles you have overcome.
ABSTRACT

The goal of mental health delivery system is to allow the individual with severe and persistent mental illness to live and function effectively in the community and to ensure that the consumers and their families have access to accurate information that promotes learning, self-monitoring and accountability (Stuart & Laraia, 2005:710). In community-based health care, the persons living with severe and persistent mental illness (SPMI) are in their natural environment in the context of the family and the community. The goals of care are focused around maximizing the person living with SPMI’s quality of life (Hunt, 2001:15-16). In South Africa, an integrated package of essential Primary Health Care (PHC) services has been made available to the entire population in order to provide the solid foundation of a single unified health care service (Department of Health, 2000:4).

The assessment of health care needs of persons living with SPMI is a dynamic ongoing process that is used to collect information, recognise changes, analyse needs and plan health care to provide baseline information to help evaluate the physiological and psychological normality and functional capacity of persons with SPMI (Hunt, 2001:100). There is insufficient information from the Department of Health to either satisfy the enquiry of whether the health care needs of persons living with SPMI are being met comprehensively or whether the practitioners rendering community-based health care are knowledgeable and comply with PHC norms and standards developed by this Department.

The researcher is interested in understanding how the persons living with SPMI and their families experience the community-based health care provided by PHC nurses. The purpose of this research study is to develop strategies that would assist the PHC nurses in the selected rural areas of the Eastern Cape to facilitate community-based health care and to render a health care service relevant to the health care needs of the persons living with SPMI and their families. To achieve the objective of the study, the research design was based on a qualitative, exploratory, descriptive, contextual research approach.

Phase one includes describing and selecting the research population and the sampling process prior to conducting the field work which comprises individual interviews with
persons living with SPMI and their families as well as PHC nurses. According to Dickoff, James and Weidenbach (1968:422) and Chinn and Kramer (1995:78), this strategy involves identifying concepts from fieldwork and creating conceptual meaning to provide a foundation for developing strategies to facilitate community-based care for persons living with mental illness.

Phase two of the research design will focus on development of conceptual framework in order to allow better understanding of the phenomenon of interest, as the major concepts will be simplified by connecting all related concepts together by means of statements. This was done by making use of the themes identified during data analysis and the literature sources used throughout this research process. The evaluation criteria of Chinn and Kramer (2008:237-248) were used to evaluate the strategies.

It is therefore concluded that the researcher succeeded in achieving the purpose of this study because strategies which were understandable, clear, applicable and relevant to the nursing practice have been developed for use by Department of Health and Primary Health Care to facilitate the multifaceted role of the PHC nurses.
KEY WORDS

Primary Health Care

Mental health

Mental illness

Community-based

Strategy

Deinstitutionalization

Health needs

Severe and persistent mental illness

Rehabilitation
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBHCS</td>
<td>Community-based Health Care Services</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSD</td>
<td>Department of Social Department</td>
</tr>
<tr>
<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
</tr>
<tr>
<td>NMMU</td>
<td>Nelson Mandela Metropolitan University</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Insurance</td>
</tr>
<tr>
<td>SAPS</td>
<td>South African Police Services</td>
</tr>
<tr>
<td>SPMI</td>
<td>Severely and Persistently Mentally Ill</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS

DECLARATION ................................................................................................................................................i
DEDICATION ..................................................................................................................................................ii
ACKNOWLEDGEMENTS ..........................................................................................................................iii
ABSTRACT ....................................................................................................................................................v
KEY WORDS ................................................................................................................................................vii
ABBREVIATIONS .......................................................................................................................................viii
LIST OF FIGURES ........................................................................................................................................xv
LIST OF TABLES ..........................................................................................................................................xvi

CHAPTER ONE

1.1 INTRODUCTION AND LITERATURE REVIEW ..................................................................................1
1.2 PROBLEM STATEMENT .......................................................................................................................7
1.3 THE PURPOSE OF THE STUDY .........................................................................................................9
1.4 RESEARCH OBJECTIVES ...................................................................................................................9
1.5 PARADIGMATIC PERSPECTIVE .........................................................................................................9
  1.5.1 METATHEORETICAL ASSUMPTIONS ..........................................................................................10
    1.5.1.1 PERSON ..................................................................................................................................10
    1.5.1.2 HEALTH .............................................................................................................................11
    1.5.1.3 ENVIRONMENT ...................................................................................................................11
    1.5.1.4 NURSING ...........................................................................................................................12
1.5.2 OREM’S SELF CARE CONCEPTS ..................................................................................................13
  1.5.2.1 Approaches to meet the persons living with SPMI’ self-care needs..............................................13
  1.5.2.2 Wholly Compensatory Phase ..................................................................................................14
  1.5.2.3 Partly Compensatory Phase ....................................................................................................14

ix
1.5.2.4 Supportive Educatve Phase .......................................................... 15
1.5.2.5 Reasons for choosing Orem’s Model and the application to support the persons living with SPMI and their families ...... 15

1.5.3 THEORETICAL STATEMENTS .......................................................... 15
1.5.4 CENTRAL THEORETICAL STATEMENT ........................................ 16

1.6 CLARIFICATION OF CONCEPTS ......................................................... 16

1.7 RESEARCH DESIGNS AND METHODS .............................................. 18
1.7.1 RESEARCH DESIGN ........................................................................ 18
1.7.2 RESEARCH METHODS .................................................................. 18
   1.7.2.1 PHASE ONE: SITUATIONAL ANALYSIS ....................................... 20
   1.7.2.2 PHASE TWO: DEVELOPMENT OF STRATEGIES ....................... 23

1.8 MEASURES TO ENSURE TRUSTWORTHINESS .................................. 23

1.9 CHAPTER DIVISION .......................................................................... 24

1.10 CHAPTER SUMMARY ......................................................................... 25

CHAPTER TWO
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION .................................................................................. 26
2.2 RATIONALE ........................................................................................ 26
2.3 THE PURPOSE OF THE STUDY ............................................................ 27
2.4 OBJECTIVES OF THE STUDY .............................................................. 27
2.5 RESEARCH DESIGN AND METHOD .................................................... 27
   2.5.1 RESEARCH DESIGN OF THE STUDY ........................................... 27
      2.5.1.1 QUALITATIVE RESEARCH ..................................................... 28
      2.5.1.2 EXPLORATORY RESEARCH .................................................. 28
      2.5.1.3 DESCRIPTIVE RESEARCH .................................................. 29
      2.5.1.4 CONTEXTUAL RESEARCH .................................................. 29

x
2.5.1.5 PHENOMENOLOGICAL RESEARCH ........................................ 30
2.6 REASONING STRATEGIES .......................................................... 30
  2.6.1 Inductive reasoning ............................................................. 30
  2.6.2 Deductive reasoning ............................................................ 31
2.7 RESEARCH METHOD ................................................................. 31
  2.7.1 PHASE ONE: SITUATIONAL ANALYSIS .................................. 31
    2.7.1.1 RESEARCH POPULATION AND SAMPLING ....................... 32
    2.7.1.2 SELECTING THE RESEARCH FIELD .................................. 33
    2.7.1.3 DATA COLLECTION ........................................................ 35
    2.7.1.4 DATA ANALYSIS ............................................................ 38
    2.7.1.5 PILOT STUDY ................................................................. 39
    2.7.1.6 LITERATURE CONTROL .................................................... 40
    2.7.1.7 MEASURES TO ENSURE TRUSTWORTHINESS ...................... 40
      2.7.1.7.1 Credibility ............................................................ 41
      2.7.1.7.2 Transferability ....................................................... 44
      2.7.1.7.3 Dependability ........................................................ 45
      2.7.1.7.4 Confirmability ....................................................... 46
    2.7.1.8 ETHICAL CONSIDERATIONS ............................................ 46
2.7.2 PHASE TWO – Development of strategies .................................. 49
  2.7.2.1 PHASE TWO: Step 1 Development of a conceptual
          framework ........................................................................... 50
  2.7.2.2 PHASE TWO: Step 2 Description of strategies ...................... 51
2.8 CHAPTER SUMMARY ..................................................................... 52

CHAPTER THREE
THE EXPERIENCES OF PERSONS LIVING WITH SPMI, THEIR FAMILIES AND
PRIMARY HEALTH CARE NURSES OF COMMUNITY-BASED CARE
3.1 INTRODUCTION ........................................................................... 53
3.2 OPERATIONALISATION OF DATA GATHERING AND DATA ANALYSIS... 53

3.3 DATA ANALYSIS....................................................................................................................... 55

3.3.1 DEMOGRAPHIC OF THE PARTICIPANTS............................................................................ 56

3.3.1.1 GROUP ONE: IDENTIFIED PERSONS LIVING WITH SPMI................................. 56

3.3.1.2 GROUP TWO: Family members of SPMI................................................................. 56

3.3.2 GROUP 3: PHC NURSES.................................................................................................. 56

3.4 DISCUSSION OF THEMES AND LITERATURE CONTROL ........................................ 59

3.4.1 SECTION ONE .................................................................................................................. 59

3.4.1.1 DISCUSSION OF THEME ONE AND RELATED SUB-THEMES OF GROUPS ONE AND TWO PARTICIPANTS ... 59

3.4.2 SECTION TWO ................................................................................................................ 89

3.4.2.1 DISCUSSION OF THEME TWO AND RELATED SUB-THEMES FOR GROUP THREE PARTICIPANTS........ 89

3.5 CHAPTER SUMMARY ....................................................................................................... 106

CHAPTER FOUR

A CONCEPTUAL FRAMEWORK FOR THE DEVELOPMENT OF STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR PERSONS LIVING WITH SPMI IN THE RURAL AREAS

4.1 INTRODUCTION .................................................................................................................... 107

4.2 FRAMEWORK DEVELOPMENT .......................................................................................... 107

4.3 CONCEPTUALISATION AND CLASSIFICATION OF CONCEPTS ............. 109

4.3.1 The agent .......................................................................................................................... 111

4.3.3.1 The sub-agent .............................................................................................................. 123

4.3.2 The recipient .................................................................................................................... 125

4.3.3 The context ....................................................................................................................... 127

4.3.4 Dynamics ......................................................................................................................... 134
CHAPTER FIVE
STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR PERSONS LIVING WITH SEVERE AND PERSISTENT MENTAL ILLNESS

5.1 INTRODUCTION ........................................................................................................................................... 144

5.2 IDENTIFICATION OF STRATEGIES TO BE USED TO FACILITATE THE MULTIFACETED ROLE OF PHC NURSES IN RURAL AREAS .......... 144

5.3 BACKGROUND TO STRATEGIES TO FACILITATE THE MULTIFACETED ROLE OF THE PHC NURSES IN RURAL AREAS................................. 147

5.4 DESCRIPTION OF THE STRATEGIES TO FACILITATE THE MULTIFACETED ROLE OF THE PHC NURSES IN RURAL AREAS ............... 149
  5.4.1 STRATEGY ONE: SUPPORTIVE-SUPERVISION .......................................................... 156
  5.4.2 STRATEGY TWO: COLLABORATION ........................................................................ 169
  5.4.3 STRATEGY THREE: MENTORING ............................................................................. 176
  5.1.4 STRATEGY FOUR: CAPACITY BUILDING STRATEGY .............................................. 182

5.5 EVALUATION OF THE DEVELOPED STRATEGIES ................................................................. 191
  5.5.1 Clarity of the strategies ........................................................................................................ 192
  5.5.2 Simplicity of the strategies ................................................................................................ 192
  5.5.3 Generality of the strategies ............................................................................................... 192
  5.5.4 Usefulness/utility of the strategy ...................................................................................... 192
  5.5.5 Significance of the strategy ............................................................................................... 193

5.6 CHAPTER SUMMARY ...................................................................................................................... 193
CHAPTER SIX
CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

6.1 INTRODUCTION .................................................................................. 194
6.2 CONCLUSIONS .................................................................................. 194
6.3 LIMITATIONS OF THE STUDY .......................................................... 199
6.4 RECOMMENDATIONS ....................................................................... 199
  6.4.1 Nursing practice ........................................................................... 199
  6.4.2 Nursing education ......................................................................... 200
  6.4.3 Nursing research ........................................................................... 200
6.5 CHAPTER SUMMARY .......................................................................... 201

BIBLIOGRAPHY ....................................................................................... 203

LIST OF ANNEXURES ............................................................................ 221
  ANNEXURE A: Approval from REC-H .................................................. 221
  ANNEXURE B: Request to conduct research ....................................... 225
  ANNEXURE C: Letter to participants .................................................. 227
  ANNEXURE D: Permission to conduct research ................................ 229
  ANNEXURE E: Informed Consent ......................................................... 230
  ANNEXURE F: Interviews .................................................................... 236
  ANNEXURE G: Letter to the independent coder ................................ 247
  ANNEXURE H: Letter from the editor ................................................ 248
  ANNEXURE I: Proposal of the research study ................................... 249

xiv
LIST OF FIGURES

Figure 1.1: Schematic presentations of meta-theoretical assumptions .................. 10

Figure 3.1: Mentally ill persons and their families’ experiences related to how their health care needs were met in the rural mental health care services. ........................................................................................................ 60

Figure 3.2: Reasons for non-adherence to treatment (Baumann, 2007:475-476) .... 77

Figure 3.3: Themes and sub-themes of the experiences of PHC nurses. ............... 91

Figure 3.4: A physiotherapist in the deep rural Eastern Cape goes the extra mile to deliver a much need wheelchair. .................................................................................................................. 103

Figure 4.1: A Schematic Presentation of The Roles of Phc Nurse (compare McEwen 2002).......................................................................................................................... 112

Figure 4.2: MAP Emalahleni LSA – Chris Hani District .................................... 127

Figure 4.3: Rural areas of Emalahleni LSA .......................................................... 133

Figure 4.3: Cogitation map for clarification of concept (Dickoff et. al, 1968)........ 142
LIST OF TABLES

Table 1.1: Summary of Research Methods ................................................................. 20

Table 2.1. The survey list (Dickoff, et.al., 1968:423) .............................................. 50

Table 3.1: Themes and sub-themes from the interviews from all groups of participants .......................................................................................................................................................................................................................................................... 58

Table 4.1: Six concepts and six questions of the survey list (Dickoff et al, 1968:423) .......................................................................................................................................................................................................................................................... 110

Table 4.2: The four identified strategies and four activities: ................................... 140

Table 5.1: Summary of strategies for facilitation of the multifaceted role of the PHC nurse using care approach .......................................................................................................................................................................................................................................................... 154
CHAPTER ONE

1.1 INTRODUCTION AND LITERATURE REVIEW

The goal of a mental health delivery system is to allow the severely and persistently mentally ill individual to live and function effectively in the community and to ensure that the consumers and their families have access to accurate information that promotes learning, self-monitoring and accountability (Stuart and Laraia, 2005:710). Community-based health care can be defined as care directed towards specific individuals and families within a community. Community-based health care is defined as the care that the consumer can access nearest to home, which encourages participation of people, responds to the needs of people, encourages traditional community life and creates responsibilities (van Dijk, 2008:100). It is designed to meet the needs of communities as they move between health care settings with an emphasis on a flowing model for care that does not necessarily occur in one setting. Community-based health care, as stated by Stuart et al. (2005:710) is based on the following concepts.

- The individual and the family have primary responsibility for health care decisions
- Health and social issues are acknowledged as interactive
- Treatment effectiveness rather than technology drives treatment decisions

Within community-based health care, the person living with severe and persistent mental illness (SPMI) is in his natural environment, in the context of the family and community. Illness is seen as merely an aspect of life and care goals are focused around maximizing the person’s living with SPMI quality of life. Nursing care in the community is an autonomous practice with nursing interventions decided on by the persons living with SPMI, their families and the community. The goal of community-based health care is to encourage self-care in the context of the family and the community with a focus on prevention and continuity of care. The first component of community-based health care is self-care. Self-care charges the individual person living with SPMI and his/her family with primary responsibility for health care decisions and actions (Hunt, 2001:1-16).
One of the services of community-based health care within the community targets primary prevention. Primary prevention aims to reduce the incidence of mental disorders within the population. Secondary prevention reduces the prevalence of psychiatric illness by shortening the course of acute illness through treatment. Tertiary prevention reduces the residual defects that are associated with severe and chronic mental illness. To ensure these preventions, a wide range of services, such as rehabilitation programmes, are made available as needed. The primary health care (PHC) nurses have to plan for the needs of the person who is severely and persistently mentally ill (Townsend, 2003:832).

In most developing countries mental health care services have been and remain underdeveloped. Mental health care is often confined largely to urban areas and restricted to hospital-based care for people with severe mental illness. Where community-based services are provided, these are directed to severe mental disorders and take the form of repeat prescriptions. Lack of sensitivity to mental health in allied systems such as police, justice or welfare departments has often exacerbated mental health care problems through a process of secondary victimization (Lazarus & Freeman, 2009:1). Decentralization of mental health services has been advocated in an effort to promote more equitable and accessible mental health care. There has been a particularly strong advocacy for the integration of mental health care into general health care especially at PHC level. Inadequate professional resources for mental health care in developing countries are a major reason for the large gap between the prevalence of mental illness and the provision of services (Lazarus & Freeman, 2009:1).

Before discussing good practice in primary mental health care in detail, it is worth recalling the definition of PHC in the Alma-Ata Declaration (WHO, 1978). PHC encompasses interventions that take place in community-based settings, involving families and communities, through outreach services such as those provided by community health workers and those offered at first level health care services such as listed facilities. All of the above function together with mechanisms to improve continuity of care at this level. However within the health care system, integration has not proven to be easy. Integration of mental health care services is aimed at creating a comprehensive service capable of meeting the health care needs of persons living
with SPMI (WHO, 2005). There has been a strong advocacy for the provision of mental health care at PHC level as mentioned previously. However, what is implied is the horizontal integration of mental health care within general PHC, through integration into activities of the general health workers who operate at that level. A central motivation for integration is to provide holistic and continuous patient care within and between levels of care (Goldberg, 2003:153-157).

In South Africa, an integrated package of essential PHC services has been made available to the entire population in order to provide the solid foundations of a single unified health care service (Department of Health, 2000:4). The package entails standardized comprehensive services to be delivered at primary health care level. These include non-personal health services, disease prevention and control, maternal, child and women’s health, Human Immunodeficiency Virus/Auto Immune Deficiency Syndrome care, Tuberculosis care, health monitoring and evaluation, mental health and substance abuse care and gender issues (van Rensburg, 2004:422). Secondly, the PHC package stipulates the common quality norms and standards that are required for each PHC service and are shared by those delivering the services. The core norms set by the Department of Health (Department of Health, 2001a) as listed by van Rensberg (2004:430) are:

- Through a one-stop approach the facility provides comprehensive integrated PHC services for a minimum of eight hours per day, five days per week.
- Access, as determined by the number of health care recipients living within five kilometres of the facility, is improved.
- The facility receives supervisory care at least once a month, to assist staff, identify and prioritize needs and shortcomings and monitor the quality of services.
- The staff component includes at least one service provider who has successfully completed a recognized PHC training course
- Medical officers and other specialists who undertake periodic visits and are accessible for supportive consultation and referral
- Facility managers who undergo training in facilitation skills and PHC management
Annual evaluation of the rendering of PHC services is undertaken to reduce the gap between service provision and actual needs.

Annual PHC strategy, based on the evaluation, is planned.

The facility has a method to monitor services and quality assurance.

The perception and views of the community are assessed at least biannually by means of patient interviews or anonymous patient questionnaires.

These core norms are applicable to all public PHC facilities and therefore community-based health services should take cognizance of these norms and standards because they fall within the realm of PHC services. The standards are practical, essential and comprehensive and describe the range of services that should be available to all South Africans (Department of Health, 2001a)

The trend in PHC is also shifting from that of inpatient care to a focus on community-based care. The goal of tertiary prevention is to limit the amount of disability and maladaptive functioning resulting from an illness. The concepts of tertiary prevention are particularly relevant to those with severe and persistent mental illness. Mostly, nurses care for these persons living with SPMI in community-based health care services and in the patients’ homes. Tertiary prevention can be achieved through activities such as rehabilitation, which is the process of helping the person return to the highest possible level of functioning. These identified activities include assertive community treatment, supported employment, illness management and recovery, integrated treatment for co-occurring mental illness, family psycho-education and medication management (Stuart and Laraia, 2005:239).

Nursing in tertiary prevention for persons living with SPMI focuses on helping patients learn or relearn socially approved behaviours so that they may achieve a satisfactory role within the community. This includes (Townsend, 2003:813):

- Consideration of rehabilitation processes at the time of initial diagnosis and treatment planning
- Teaching the client daily living skills and encouraging independence to his or her maximum ability
• Referring clients for various after care services. Examples include support groups, day treatment programmes and psycho-social rehabilitation
• Monitoring effectiveness of aftercare services through home visits or follow-up appointments within community-based health care services
• Making referrals for support services when required, for example, participation in social activities.

Mental health care and mental health care nursing are linked in an attempt to prevent mental health problems and to treat existing mental disorders more effectively. Much of that effort can be community-based as part of a continuum of care (Keltner, Bostrom and McGuinness, 2011:8). Community-based care has an opportunity to assert itself in mental health because many values traditionally emphasized by mental health care fit within the concept of the continuum of care. For instance Keltner et. al, highlight the following values:

• viewing the client as a whole
• working with families
• treating the clients in their own homes
• developing a relationship over time
• educating families about medication
• assessing the environment for safety, hygiene and support. Using a holistic approach, PHC nurses are able to deliver direct care to help integrate people with mental illness into community living as well as advocate and link individuals to needed services. The Mental Health Care Act (Act No. 17 of 2002) confirms and enforces the need for the promotion of mental health to those at risk of mental illness and the mentally ill. The Mental Health Care Act further, states that programmes should be aimed at promoting the mental status of the service user. This should be implemented with regard to the mental health capacity of the person concerned. It also stresses that a mentally ill person has rights: one of which is the right to care, treatment and rehabilitation (The Mental Health Care Act 17 of 2002).

Community-based health care is a critically important part of an effective mental health care delivery system. An ideal comprehensive health care system would provide
multiple points of entry for treatment, including direct access through self-referral and by a wide variety of providers (Stuart and Laraia, 2005:139). A PHC nurse can be helpful in identifying and addressing the health care needs of persons living with SPMI and their families. The PHC nurse and the individual with SPMI should develop specific problem oriented goals or outcome-based goals on both objective and subjective reports. A SPMI involves a permanent alteration in the patient's way of life and a need for reappraisal of life and what may be hoped for in terms of function and health.

An individual with a considerable lifestyle change may need a significant level of nursing intervention. The more the disease results in major changes in activities of daily living, the harder it may be for the Person living with SPMI and their families to continue with their lives and the greater the need for nursing intervention. The primary health care nurse's challenge in working with persons living with SPMI in the community is to determine what they view as appropriate functioning, maximizing their abilities and enabling them to live with their illness while functioning at maximum capacity.

Community-based health care reduces the functional impairments caused by mental illness in persons living with SPMI and in its broadest sense encompasses all forms of treatment of severe and permanent mental illness. Community-based health care addresses persons living with SPMI suffering from the most severely debilitating illnesses. These include schizophrenia which tends to strike in late adolescence and young adulthood. These individuals are removed from society during those years while their peers complete their education, establish careers, begin families and develop social support systems in the community. Even if the mental illness is completely cured without residual functional deficits, these persons living with SPMI will need extensive psychosocial rehabilitation (Uys and Middleton, 2010:53). Rehabilitation and treatment have the same ultimate aims of restoring persons living with SPMI to adaptive functioning with a good quality of life. Although treatment focuses on removing symptoms that are obstacles to a functional and satisfying life, rehabilitation focuses on building skills, teaching problem solving and resilience and crafting personal, social, educational and occupational supports that are instrumental to a functional and satisfying life (Saddock and Saddock, 2005:3884).
The person living with SPMI can have a wide range of psychological deficits that impair their ability to interact with others, handle the usual stresses of daily life and achieve their potential. Therefore, community-based health care involves a process in which the PHC nurses attempt to address the psychological, social and often medical needs of persons living with SPMI. The persons living with SPMI have continuing community-based health needs which can be broken down into several components. These categories are treatment, housing and social support. These components should be provided as part of integrated community-based health care plan (Uys and Middleton, 2010:53).

1.2 PROBLEM STATEMENT

According to Hunt (2001:100), any episode of illness may involve a lasting change in the person’s level of functioning. The person living with SPMI experiences stressors as distresses and life leaves the individual with a sense of pervasive helplessness. The more stressors the person living with SPMI experiences in day to day life, the more the person living with SPMI may develop this feeling of hopelessness and depression. The inability to handle life’s daily stress relating to illness and a treatment regimen can result in exacerbation of the disease or noncompliance with the treatment regimen (Hunt, 2001:100).

The first problem that faces the person living with SPMI is the need to maintain independence. The persons living with SPMI who are mentally ill are forced to face the reality of the outcomes of the disease daily, with many of these chronic diseases ending in loss of mental and physical functioning. Compliance can affect their feelings of independence and control. More often than not, when they do not follow their treatment plan the PHC nurses are tempted to label them as non-compliant.

Self-actualization is one of the needs of SPMI people. Even if they cannot work, they can find some sense of fulfilment, well-being and control over their lives. These areas can impact on each other and are part of how the person living with SPMI responds to the illness. This response can affect their motivation to maintain their well-being. Other challenges facing persons living with SPMI include lack of education or information about their diagnoses, the treatment regimen, available resources and how to access those resources. They are also expected to fulfil their roles, responsibilities and self-
care demands. The persons living with SPMI also need to be encouraged and guided to maintain social involvement to prevent isolation (Hunt, 2001:100).

The assessment of needs is an important and integral part of health care for the person living with SPMI. According to Stanhope and Lancaster (2008:500-501), identification and assessment of the needs of individuals suffering from mental illness is a neglected and often misunderstood aspect of SPMI needs. A needs assessment focuses on the characteristics of a specific population (persons living with SPMI), their health needs and the resources available to address those needs (Stanhope and Lancaster, 2008:501) and is a dynamic on-going process that is used to collect information, recognize changes, analyse needs and plan health care. In community-based settings, assessment of the mental status of the person living with SPMI provides baseline information to help evaluate physiological and psychological normality and functional capacity and to identify factors that may enhance or impair the individual's health status (Hunt, 2001:100).

The researcher became aware of the gradual increase in the number of persons living with SPMI whose conditions worsen when they are discharged into the community. It appears that the families and the primary health care nurses lack adequate information as to the health care needs of the person living with SPMI. There is not enough information on whether or not the health care needs of the person living with SPMI are being met comprehensively or whether the practitioners rendering community-based health care are knowledgeable and compliant with the PHC norms and standards developed by the Department of Health. These practitioners need to understand these needs in the wider context of the Person living with SPMI's family. The interprofessional team can also play an important role in coordinating the assessment and care plan. It has been found that nursing assessment is not valued and that nurses tend to focus on medical diagnoses and cures (Slater and McCormack, 2005: 603).

Although PHC supports the notion of health care seeking behaviour, it is also necessary for primary health care nurses to work towards improving and promoting the health care needs of persons living with SPMI. With reference to the above discussion, the following research questions could be asked:
• How do the persons living with SPMI, as health care consumers, and their families experience the health provided by the community-based health care services?
• What are the health care needs of the persons living with SPMI and their families?
• What can be done to facilitate community-based health care delivery relevant to the health needs of persons living with SPMI?

1.3 THE PURPOSE OF THE STUDY

The purpose of this research study was to explore and describe experiences of persons living with SPMI, their families and PHC nurses in community-based health care provided by the PHC services in order to develop nursing care strategies for PHC nurses in the rural areas relevant to the health needs of persons living with SPMI.

1.4 RESEARCH OBJECTIVES

• To explore and describe persons how the persons living with SPMI and their families experience community-based health care provided by primary health care nurses.
• To explore and describe what the perceived health needs of persons living with SPMI and their families are.
• To develop nursing strategies for PHC nurses in the rural areas relevant to the health needs of persons living with SPMI.

1.5 PARADIGMATIC PERSPECTIVE

According to Chinn and Kramer (2011:157) a paradigm implies a worldview or ideology, a medium within which knowledge and processes for knowing find meaning, coherence and expression. They further explain that a paradigm suggests standards and criteria for assigning value or worth to both the processes and products of a discipline, as well as for the methods of knowledge development within a discipline. All of the components of a paradigm are compatible with one another, but a wide variety can exist within its structure.
1.5.1 METATHEORETICAL ASSUMPTIONS

Meta-theoretical assumptions refer to the researcher’s beliefs about the person, environment, health and nursing as applicable to this research. These meta-theoretical assumptions were discussed and applied to this study in order to provide meaning to the experiences of persons living with SPMI regarding their support by their families and the primary health care nurses.

![Figure 1.1: Schematic presentations of meta-theoretical assumptions](image)

### 1.5.1.1 PERSON

A person is viewed as an integral whole or unit, functioning biologically, socially and symbolically (Fitzpatrick and Whall, 2005:180). Person, or human being, refers to both the recipient of care and the giver of care. Self-care deficit nursing theory includes the whole reality of human beings, singly and in social units as the material object of nursing. This includes individuals, dependent units, and multi-person units such as families and communities and their relationship to nursing as a profession and as a discipline. It includes persons who occupy the position or fill the role of nurse. Orem considers the individual person to be self-reliant and responsible for self-care. Orem emphasizes that all individuals have self-care needs and that they have the ability to meet these needs, except when their ability is compromised. The self-care agent is
the person who meets the self-care needs. It may be the person itself or it may be a family member or the nurse. In applying this concept to this study, the person living with SPMI as a person, should be considered for improving and promoting his health care needs. This will enable him to cope with family roles and emotions and be able to manage his own needs.

1.5.1.2 HEALTH

According to Orem’s description of health, it is a state of wholeness or personal integrity of the human being, his parts and his modes of functioning in terms of both function and structure. Wellbeing can be described in physical, social and psychological terms. The World Health Organization (1948) supports Orem’s definition of health as being a state of physical, mental and social wellbeing and not merely the absence of disease and infirmity (Taylor and Renppening, 2011:9). Orem defines health as a state that is characterized by soundness and wholeness of a developed human body as well as mental functioning. The SPMI patient is challenged to cope with his/her mental illness in order to develop into a responsible family member who functions optimally with or without the support and guidance of the family and the primary health care nurse.

1.5.1.3 ENVIRONMENT

The person and the environment are seen to be in constant communication. Orem calls it the person-environment interaction (Fitzpatrick & Whall, 2005:180-181). The person and the environment within which persons exist are inseparable but factors about the environment and the human relationship can be isolated and described. From the viewpoint of self-care deficit nursing theory, a significant meaning of environment is as a basic conditioning factor. Environment conditions the person’s need for self-care, the actions selected and the setting within which care is given, the opportunity to engage in those actions and the restricting influences which interfere with that engagement. There are physical, chemical, biological, social, and political features. Culture is an element of environment (Taylor & Renppening, 2011:8). Further references are made to the meaning of environment throughout the text.

The person and the environment are seen to be in constant communication. For example, a family environment that is supportive and free from stressors may be good
for the health of persons living with SPMI. In order to cope with his/her life and being long term mentally ill, the Person living with SPMI must be able to be responsible for all his/her physical, social and psychological needs and be able to maintain a relationship with the family in a supportive environment (Taylor & Renppening, 2011:8).

1.5.1.4 **NURSING**

Orem considered nursing to be a helping service. The special concern of nursing is “the individual's need for self-care and the provision and management of it on a continuous basis in order to sustain life and health, recover from the disease or injury and cope with their effects” (Taylor and Renppening, 2011:8). Nursing is an essential human service; the definitive characterising structure of nursing is made known through a general theory of nursing. Nursing is produced in a particular time and a particular place through discrete deliberate actions or sequences of actions. Nursing exists through the relationship of nurse and patient and what they choose to do. The self-care deficit nursing theory is a theory about the variables of concern when the service of nursing is required as nurses and patient interact, and about the variations in relationships among those variables (Taylor and Renppening, 2011:8).

The basic conceptual elements are a conceptual framework for nursing as described previously. At its most elemental, self-care deficit nursing theory is comprised of two patient variables – the self-care agency and the therapeutic self-care demand, one nurse variable, the nursing agency, and the relationship between the nurse and patient.

Nursing care refers to care, knowledge and practice skills learnt and used to provide supportive, facilitative acts to another individual or group in order to improve a human health condition, namely disability (Fitzpatrick and Whall, 2005:182). This distinction is most significant in the present study as the objective of the study is to describe the viewpoints of persons living with SPMI and families as well as of PHC nurses regarding mechanisms that can be instituted to develop strategies to facilitate a community-based health care of persons living with SPMI and their families.
1.5.2 OREM’S SELF CARE CONCEPTS

Orem’s self-care model for nursing (2001) was employed as the paradigm for this study in order to give the persons living with SPMI the skills to manage or cope with mental illness and its effects. This model considers the concept of “self-care” to be the phenomenon central to nursing (Burns and Grove, 2009:135). Orem proposed that individuals generally know how to take care of themselves (self-care). If they are dependent in some way family members may take on this responsibility (dependent care). If individuals are ill or have a health problem such as mental illness, they or their families may require special skills to provide that care (therapeutic self-care). An individual’s capacity to provide self-care is referred to as a self-care agency. A self-care deficit occurs when self-care demands exceed the self-care agency (Burns and Grove, 2009:138). This theory relates to the nurse-patient relationship where the persons living with SPMI and their families are completely dependent on the PHC nurses for care, treatment and rehabilitation and gradually becomes partly independent as the persons living with SPMI progress with treatment. The current notion of nursing intervention includes the persons living with SPMI and their families as part of the treatment team.

Persons living with SPMI and their families have to be supported as they move from a state of dependence to one of independence in a PHC setting in the rural areas. Orem describes the nurses’ role as assisting the person who has inabilities in the area of self-care. Nursing involves helping persons living with SPMI and their families to obtain optimal health and be self-sufficient in their own health care. The mental health care for persons living with SPMI includes doing the tasks, helping them to do tasks for themselves and to learn how to do these tasks. PHC nurses may also focus on mental health education to help persons living with SPMI and their families become as independent as possible and to take responsibility for their own health care.

1.5.2.1 Approaches to meet the persons living with SPMI’ self-care needs

Nursing systems describe the actions of both persons living with SPMI and their families and the PHC nurses when the persons living with SPMI have psychological and physical limitations. Therefore the PHC nurses’ role is to guide, support and teaches persons living with SPMI to enable them to become independent. The persons
living with SPMI also lack knowledge and skills and/or are not psychologically ready to perform self-care actions. The basic variations of the nursing system include a wholly compensatory nursing system, a partly compensatory nursing system and a supportive educative nursing system. The PHC nurses as agents and the families of persons living with SPMI as sub-agents will do the following to implement such nursing systems (Orem, 1995:308):

- acting or doing for the persons living with SPMI
- guiding the persons living with SPMI
- supporting the persons living with SPMI
- providing and teaching the persons living with SPMI

1.5.2.2 **Wholly Compensatory Phase**

In this phase the persons living with SPMI play no active role and depend entirely on PHC nurses. This could be because the persons living with SPMI have limitations imposed by their psychological and/or physical state of health. The persons living with SPMI and their families may also lack knowledge and may therefore require constant guidance and direct supervision from the PHC nurses. In this phase there is complete dependence on the PHC nurses. The persons living with SPMI have to be moved or assisted towards a state of independence. The wholly compensatory phase is applicable in this study when the persons living with SPMI are completely dependent on the PHC nurses and their families for their care, treatment and rehabilitation.

1.5.2.3 **Partly Compensatory Phase**

In this phase of the system both the persons living with SPMI and the PHC nurses have an active role to play in the performance of some tasks. This will depend on a number of factors such as the patient’s limitations, skills required to perform tasks and psychological readiness. Relevant to this study, PHC nurses and family members both have an active role to play in the treatment process. During this process, the aim is to move the persons living with SPMI from this partly compensatory level to one of independence for taking responsibility for their own mental health care.
1.5.2.4 **Supportive Educative Phase**

This is a nursing phase where persons living with SPMI should and can be rendering self-care but cannot do it without educational assistance. Relevant to this study, the PHC nurses provide the persons living with SPMI and their families with the skills of independent learning in order to progress from the state of dependence to the one of independence.

1.5.2.5 **Reasons for choosing Orem’s Model and the application to support the persons living with SPMI and their families**

Orem’s theory can be applied to the mental health care of persons living with SPMI and their families in the rural areas. The PHC nurses should strive to help the persons living with SPMI become independent persons who are capable of taking responsibility for their own health care needs. The nurse/patient relationship promotes self-directedness and active patient participation. Emanating from the paradigmatic perspective on which this study is based, the researcher espoused assumptions that guided this study.

1.5.3 **THEORETICAL STATEMENTS**

Theoretical statements drawn from the paradigm used in this study are as follows:

- PHC nurses as agents and family members as sub-agents caring for persons living with SPMI must be aware that they are persons who are being challenged to cope with the demands of mental illness physically, socially and psychologically
- The Person living with SPMI needs to interact with the family and the environment (community)
- The SPMI is a person who succeeds as a human being in regaining wholeness.

The assumption made is that although persons living with SPMI are mentally ill they have the right to quality care in the sense that they are still worthy human beings. Quality nursing care is a constitutional right of persons living with SPMI and their families which must be upheld. Integration of mental health care into PHC demands competent nurse practitioners to improve performance. An essential first step towards
improving performance is to understand factors that influence it. Rowe et al. (2008), as cited in Sibiya (2009:196), identify among other factors, health worker factors such as knowledge, skills, experience, professional values and comprehension of work experiences.

Competencies encompass the combination of knowledge, understanding, skills and attitudes that an individual develops or acquires through education, training and work experience and which can be used to describe particular occupational roles or functions against which individual performance may be assessed (WHO, 2008: 79). In order for effective integration of mental health care into PHC, PHC nurses need to possess appropriate knowledge, skills and behaviours. In other words they have to be multi-skilled to be able to provide comprehensive services, especially nurses who are using a one-stop shop approach. Reorientation programmes for nurses are therefore important in facilitating a comprehensive discourse of care. This requires an ongoing supportive supervision coupled with mentorship of staff following initial training to ensure competent and skilled nurses. Training of PHC nurses is therefore done in as close an approximation to the work situation as possible (WHO Regional Office for Africa, 2007:8).

1.5.4 CENTRAL THEORETICAL STATEMENT

Information gained from the exploration and description of the experiences of the persons living with SPMI as well as the experiences of their families related to the health care needs of the persons living with SPMI will assist with the development of the strategies to support the persons living with SPMI in their home environment and in the community. These strategies will be used to empower the primary health care nurses with the skills to facilitate the promotion of self-reliance and acceptance of responsibility of the persons living with SPMI. Gaining self-reliance will be promoted by encouraging provision of support by their families and the community as well as acceptance of support provided.

1.6 CLARIFICATION OF CONCEPTS

The theoretical definitions and explanations are given to the following concepts;
PRIMARY HEALTH CARE

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology. It is made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of development. It forms an integral part of the country’s health system and the overall social and the economic development of the community. It is the first level of contact for the individual, the family and the community within the national health system. Bringing health care as close as possible to where people live and work constitutes the first element of the continuing health care process (WHO, 1978, in Van Rensburg, 2004:28).

COMMUNITY-BASED HEALTH CARE

Community-based health care is defined as nursing directed towards specific individuals and families within a community to meet the needs of people as they move between and among health care settings (Stuart and Laraia, 2005:710).

PERSON LIVING WITH SEVERE AND PERSISTENT MENTAL ILLNESS

The person living with SPMI is an individual who has been suffering from a serious chronic mental illness over a period of time that resulted in loss of social skills and increased dependency. The individual does not possess adequate skills to live a productive life in the community. Severe and persistent mental illness involves a permanent alteration in the patient’s way of life and what may be hoped for in terms of function and health (Townsend, 2003:812).

STRATEGY

A strategy is defined as a plan designed to achieve a particular long-term aim (Soanes and Stevenson, 2008:1435). Ehlers and Lazenby (2010:176) refer to strategies as an important, high level plan. Long-term strategic goals are important because they set a specific direction. This study will develop strategies to facilitate community-based health care of persons living with SPMI and their families to meet their mental health care needs and to improve their standards of living.
MENTAL HEALTH

According to the Mental Health Care Act (Act No 17 of 2002), mental health refers to an individual being in a mentally healthy state. It means the level of wellbeing of an individual that is affected by physical, social and psychological factors. Mental health is a state of being in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stresses of everyday living. This does not mean that a mentally healthy person has no problems. She/he might at times experience distress but is able to cope with distress (Uys and Middleton, 2010:834).

1.7 RESEARCH DESIGNS AND METHODS

This research will use a theory generative design (Chinn and Kramer, 2011:185) that is qualitative, exploratory, descriptive, phenomenological and contextual in nature.

1.7.1 RESEARCH DESIGN

A research design is a blueprint for maximising control over factors that could interfere with a study’s desired outcome. The type of design directs the selection of a population, sampling procedure, methods of measurements and a plan of data collection and data (Burns and Grove, 2009:41). A qualitative, exploratory, descriptive, phenomenological and contextual research approach will be utilized by the researcher to achieve the objectives. These concepts will be discussed in more detail in chapter two.

1.7.2 RESEARCH METHODS

A qualitative study is used to identify patterns and themes in the life experiences of a particular group or community. These patterns and themes are used to create a better and deeper understanding of the particular circumstances of the group or community being studied. The research process will be carried out in two phases. The first phase includes the sampling procedure and selection of participants, the data collection process, data analysis and literature control. During Phase Two, a conceptual framework will be compiled for utilisation in the development of strategies to assist the PHC nurses facilitate the community-based health care of persons living with SPMI and their families in the rural areas. Themes identified during data analysis and the
literature review will underpin the compilation of the conceptual framework and the strategies. The research method implemented in this study was suggested by Chinn and Kramer (2011:188) and by Dickoff, James and Wiedenbach (1968: 423). These phases include:

PHASE ONE:  Situational analysis

PHASE TWO:  Development of strategies

Each of these phases will be dealt with and applied to this study.
### Table 1.1: Summary of Research Methods

<table>
<thead>
<tr>
<th>Method Research</th>
<th>Reasoning Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Collection</strong></td>
<td><strong>Data Analysis</strong></td>
</tr>
<tr>
<td><em>Population</em>: SPMI patients and their families who use the community-based health care services to access care for mental illness</td>
<td><em>Coding according to Tesch’s method</em></td>
</tr>
<tr>
<td><em>Sample method</em>: Purposive criterion based sampling</td>
<td><em>Independent coder</em></td>
</tr>
<tr>
<td><em>Methods of data collection</em>: Individual interviews</td>
<td><em>Themes, sub-themes and categories</em></td>
</tr>
<tr>
<td>Results from Step 1.1 concept identification from validated narratives, observation and literature</td>
<td><em>Literature control</em></td>
</tr>
<tr>
<td>Literature review</td>
<td><em>Dictionary and subject definitions of identified concepts</em></td>
</tr>
<tr>
<td></td>
<td><em>Identification of attributes and concepts</em></td>
</tr>
<tr>
<td></td>
<td><em>Conceptual definition of main concept</em></td>
</tr>
<tr>
<td></td>
<td><em>Structure and process description according to Chinn &amp; Kramer (2011:191)</em></td>
</tr>
<tr>
<td></td>
<td><em>Evaluation of the strategies by using the strategies of Chinn and Kramer (2011:198-204) and through consultation with relevant experts</em></td>
</tr>
</tbody>
</table>

The reasoning strategies to be implemented in this study are analysis, synthesis, deduction and induction. Reasoning strategies are used to enhance logical progression of the arguments directing the progress of the study. Information obtained from the themes and cases will be used to develop concepts.

#### 1.7.2.1 PHASE ONE: SITUATIONAL ANALYSIS

According to Dickoff, James and Wiedenbach (1968:422) and Chinn and Kramer (2011:188), identifying concepts from fieldwork and creating conceptual meaning provides a foundation for developing theory. Thus concept analysis will be conducted after the relevant data has been collected. The data collection process will result in concept identification and will include the following:
**Research population and sampling**

Burns and Grove (2009: 343) define population as the entire set of individuals or elements who meet the sampling criteria. The research population for this study will be persons living with SPMI and their families who use the community-based primary health services as well as the PHC nurses who are involved in providing services.

According to Polit and Beck (2012:742) sampling refers to the process of selecting a portion of the population to represent the entire population. A sample denotes the selected group of people or elements or a subset of the population that is selected for a study (Burns and Grove, 2009:721). A purposive and convenient sampling technique will be utilized to sample persons living with SPMI, their families and primary health care nurses from selected primary health care services. This means that three different research populations will be utilized in this study. The inclusion criteria for each of the three groups included in the study as well as how each group will be approached and sampled will be discussed in detail in chapter two.

**Data collection**

Data was collected by means of a semi-structured approach, which afforded the researcher flexibility. In a semi-structured approach, the researcher did not set specific questions to be asked in a certain order, but prepared a written topic guide which was a list of areas to be covered with each participant. The researcher started with a general question and allowed participants to talk freely and to narrate their concerns or stories. This approach allowed interaction and conversation. The researcher preferred this method because the participants could describe the experiences (Polit and Beck, 2012:537).

**Individual interviews**

Data will be collected by means of semi-structured interviews using an audiotape. Burns and Grove (2009: 705) define an interview as a structured or unstructured verbal communication between the researcher and the subject during which the information is obtained for a study. According to Polit and Beck (2012:731), an interview is a data collection method in which an interviewer asks questions of a respondent either face to face or by telephone.
In this study, the researcher will use individual, semi-structured interviews using a phenomenological approach, to try to understand the experiences of the persons living with SPMI, their families and the primary health care nurses involved in the PHC services utilized by the patients. The phenomenological approach describes a phenomenon as seen through the eyes of the people who experienced it at first hand. It attempts to understand people’s perceptions, perspectives and understanding of a particular situation (Holloway, 2008a:134).

Interviews for members of groups 1 and 2 will take place at their homes, a place perceived as convenient, and in a language preferred by participants. An audiotape recorder will be used to capture data during sessions. Each interview may take 40-60 minutes. The audio-taped interviews will be transcribed within 24 hours of the interview while the information is still fresh in the researcher’s mind. The researcher will translate the interviews into English to enable the promoters of the study and the independent coder, to understand the content of the interviews. The transcribed interviews will form the database of the study.

**Data analysis**

Polit and Beck (2012:735) defines data analysis as a systematic organization and synthesis of research data. The authors further stated that the purpose of data analysis is to organize and provide structure to and elicit meaning from data (Polit and Beck, 2012:556). Data analysis is conducted to reduce, organize and give meaning to data (Burns and Grove 2009:695). Data collected from the interviews will be transcribed verbatim and analysed according to the steps suggested by Tesch, to identify themes and sub-themes relevant to the development of case studies (Creswell, 2007:150-155).

**Literature control**

Literature control is the discussion of findings in the light of literature. Justification of the results of the study will be done by means of literature control. Sources of data verification will be carefully selected as the purpose of data verification is to predict whether the study is believable and accurate (Struebert and Carpenter, 2011:158). Before embarking on the major research study, the researcher will test the aforementioned design and method suitability as a means of achieving the objectives.
of the study. Guidelines to help in the formulation of recommendations will be developed, with input from the literature.

**Pilot study**

A pilot study is frequently defined as a smaller version of a proposed study conducted to refine the methodology (Burns and Grove, 2009:44). The function of the pilot study is to obtain information for improving the project or for assessing its feasibility (Polit and Beck 2012:195). The pilot study will be executed in the same manner as the main study.

1.7.2.2 **PHASE TWO: DEVELOPMENT OF STRATEGIES**

During this phase, a conceptual framework will be developed. A conceptual framework is used to clarify the relationships of concepts and themes identified during the research process and to link the gathered data to previously established models or theories (Burns and Grove, 2009:39). The results of the data analysis will guide the development of the conceptual framework and also indicate strategies to be used to facilitate community-based health care of persons living with SPMI and their families.

Strategies will be developed by identifying the health care needs of the persons living with SPMI from the themes that arose during data analysis. A literature review to validate the findings and proposed outcomes will be identified. Implementation activities designed to achieve the proposed outcomes will be formulated. Construction of relationship concepts allows better understanding of the study because the defined major concepts will be simplified by connecting them by means of relationship statements. Relationship statements describe, explain or predict the nature of the interactions between the concepts of the theory (Chinn and Kramer, 2011:180-181).

1.8 **MEASURES TO ENSURE TRUSTWORTHINESS**

The researcher will use a model proposed by Guba to ensure trustworthiness of the study, without sacrificing its relevance. According to Krefting (1991:214) these measures are:
Credibility
Credibility refers to the confidence in the truth of the data (Polit and Beck, 2012:584-585). This will be done by utilizing multiple references to draw conclusions about the truth such as data gathering in the interviews, field notes and literature control. The researcher will triangulate the findings by the use of multiple data gathering methods, interview techniques, peer review, member checking and the authority of researcher as strategies to establish credibility (Krefting, 1991:7-12).

Transferability
This refers to the external validity of data, that is, to demonstrate the applicability of one set of findings to another context as the researcher cannot generalise. The researcher will therefore have to provide an adequate database to allow transferability judgments to be made by others (Polit and Beck, 2012:197). The researcher will use comparison of sampling data and dense description strategies.

Dependability
This refers to the stability of data over time and over conditions (Polit and Beck, 2012:585). The researcher should account for changing conditions in the phenomenon chosen for the study as well as for changes in the setting. The researcher will use triangulation and dense description of research method strategies to establish the reliability.

Confirmability
Confirmability refers to the objectivity of the data (Polit and Beck, 2012:599). The researcher should decide whether another could confirm the findings. The researcher will use reflexivity and triangulation to confirm findings.

These strategies of trustworthiness will be described in detail in Chapter Two.

1.9 CHAPTER DIVISION
The research study report will be presented as follows:
Chapter one: Introduction and literature control
Chapter two: Research design and methods
Chapter three: The experiences of persons living with SPMI, their families and PHC nurses in community-based care

Chapter four: A conceptual framework for the development of strategies to facilitate community-based health care of persons living with SPMI in the rural areas

Chapter five: Strategies to facilitate community-based health care of persons living with SPMI.

Chapter six: Conclusion, recommendations and limitations

1.10 CHAPTER SUMMARY

This chapter introduced the topic “strategies to facilitate the development of community-based health care of persons living with SPMI and their families”. The problem statement highlights the difficulties faced by the community. This study aims to explore and describe how the health care needs of persons living with SPMI in the community by community-based health care services are met.
CHAPTER TWO
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION
An overview of the study was given in Chapter One. The purpose and the objectives of the study were introduced. This chapter discusses the research design and methods. The research design and method were based on two phases namely, concept analysis and construction of relationship statements, and the development and description of the strategies to facilitate community-based health care of persons living with SPMI and their families and the operationalization of those strategies.

2.2 RATIONALE
This study focused on the health care needs of the persons living with SPMI and their families. The Mental Health Care Act (Act 17 of 2002) confirms and enforces the health care needs and obligations for the provision of care, treatment and rehabilitation for those who are severely and persistently mentally ill. It further stated that programmes may be aimed at meeting the health care needs of persons living with SPMI and their families. This study will address the programmes for the SPMI patients whose mental health had been negatively impacted upon by mental illness. It also stressed that any persons living with SPMI has rights; one of which is the right to care, treatment and rehabilitation.

It appeared that the persons living with SPMI and their families as well as the primary health care nurses lacked adequate information as to what the health care needs of persons living with SPMI and their families are. There was not enough information as to whether or not the health needs of persons living with SPMI are being met comprehensively or whether the mental health care practitioners rendering community-based care were knowledgeable and compliant with PHC norms and standards. Strategies to facilitate the multifaceted role of the PHC nurses in the rural areas provided information that is both useful and relevant to deal with the health care needs of the persons living with SPMI and their families, thereby averting the negative impact of SPMI on mental health.
2.3 THE PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the health care needs of the persons living with SPMI and their families and to establish how they and the primary health care nurses experience the mental health care provided in community-based health care services in rural areas. This information was used to develop nursing care strategies to facilitate the community-based health care of persons living with SPMI and their families. This may assist primary health care nurses employed in the community-based health care services in rendering a health service relevant to the health care needs of the persons living with SPMI and their families.

2.4 OBJECTIVES OF THE STUDY

The following objectives were proposed in order to achieve the overall purpose of this study:

- To explore and describe how the persons living with SPMI and their families experience mental health care provided by community-based health care services.
- To explore and describe the health care needs of persons living with SPMI and their families.
- To develop strategies for community-based health care to address the needs of the persons living with SPMI.

The research design and method to achieve the objectives as well as the purpose of the study are discussed below.

2.5 RESEARCH DESIGN AND METHOD

The progress of this research study was guided by the research design and method suitable for the purpose of the study and will now be discussed.

2.5.1 RESEARCH DESIGN OF THE STUDY

A research design is a blueprint or a plan defining how the research will be conducted (Babbie and Mouton, 2008:72). A qualitative, exploratory, descriptive, contextual design with a phenomenological approach was implemented to gain understanding of
the phenomenon being studied, namely a community-based health care service that meets the health care needs of persons living with SPMI and their families. The above-mentioned concepts are discussed below.

2.5.1.1 QUALITATIVE RESEARCH

Qualitative research is a systematic, subjective approach used to describe live experiences and to give them significance. It is a way to gain insights that are obtained through improving our comprehension of the whole and through discovering meanings (Burns and Grove, 2009:51). Thus qualitative research refers to a process of interpretation carried out for the purpose of discovering concepts and relationships in raw data. According to Creswell, (2007:36) the qualitative approach was used to explore behaviour, perspectives, feelings and experiences of people and what lies at the core of their lives.

This approach was deemed suitable to holistically describe the experiences of the persons living with SPMI and their families as role players. This design was, therefore appropriate for this study because the researcher intended to explore and describe the health care needs of the persons living with SPMI and their families and also how they experienced the mental health care provided by PHC nurses. The researcher also intended to explore and describe how the PHC nurses experience the rendering of primary health care to mentally ill persons. Individual interviews were implemented to obtain the data.

2.5.1.2 EXPLORATORY RESEARCH

Exploratory research begins with some phenomenon of interest, but rather than just observing and recording the incidence of the phenomenon, this research will explore the manner in which it is manifested and the other factors to which it is related. Exploratory research aims at exploring the dimensions of the phenomenon, the manner in which it is manifested and the other factors to which it is related (Polit and Beck, 2012:18). The researcher therefore intended to explore and describe what are the experiences and the mental health care needs of persons living with SPMI and their families are and also how the PHC nurses experience rendering mental health care to persons living with SPMI and their families in the rural areas. The study may be regarded as explorative (Burns and Grove, 2005:736) as the researcher explored
the views of persons living with SPMI and their families as well as those of PHC nurses in the mental health care sector in order to have a better understanding of these phenomena.

2.5.1.3 DESCRIPTIVE RESEARCH

The purpose of descriptive research is to explore and describe phenomena in real life situations. This approach was used to generate new knowledge about concepts or topics about which limited or no research has been conducted (Burns and Grove, 2009:45). The description of the participants’ experiences were transcribed and analysed. The information from this analysis formed a database for concept identification, definition and clarification. Different participants narrated their experiences from different perspectives due to the uniqueness of the participants that was included in the description. In this study the intention was to gain a complete account of the characteristics of the health care needs of the persons living with SPMI and their families. This design was appropriate for this research study because very little information is available on the community-based health care of persons living with SPMI and their families and not much formal research has been conducted in this field in the rural Eastern Cape.

A full accurate description of the experiences of persons living with SPMI and their families was acquired by means of listening, observing, describing and documenting the experiences naturally as they occurred (Polit and Beck, 2012:226). A description was given of the experiences of persons living with SPMI and their perceived health needs, as well as those of their families. The experiences of the participants were described as well as the methodology that was followed. The strategies were also described.

2.5.1.4 CONTEXTUAL RESEARCH

The contextual research approach is suitable when the problem under investigation has to be understood within its entire context (Creswell, 2007:36). The authors further explained that the context includes the environment and the conditions in which the study takes place as well as the culture of the participants and the location (Creswell, 2007:36). Contextualization of the study was an important factor in recognizing the analysis of the experiences of the role players in this study. In this study the immediate
context was the homes of the persons living with SPMI and their families, the community as well as the primary health service where the patients received care. This research design was therefore suitable as it sought to explore and describe whether the health care needs of persons living with SPMI and their families are met in the context of PHC and the community-based services within the rural area of Emalahleni LSA, Chris Hani District in the Eastern Cape.

2.5.1.5 PHENOMENOLOGICAL RESEARCH

A phenomenological research approach seeks to describe the meaning of lived experiences of study participants (Burns and Grove, 2009:54). The purpose of this study was to explore and describe the perceived health care needs of persons living with SPMI and their families and how they experience the health care provided by the primary health care nurses in the rural areas. Therefore a dense description of these experiences was crucial. The principle adhered to was bracketing and the participants were allowed to provide a precise description of their experiences related to the health care services (Polit and Beck, 2012:495). Bracketing is the process of identifying and holding in abeyance any preconceived beliefs and opinions about the phenomenon under study (Polit and Beck, 2012:721).

2.6 REASONING STRATEGIES

Reasoning is the processing and organising of ideas in order to reach conclusions. Through reasoning, people are able to make sense of their thoughts and experiences (Burns and Grove, 2009:6). Some reasoning strategies were applicable and used at specific levels while other reasoning strategies were used simultaneously and repetitively until the desired level of sophistication was reached. The reasoning strategies were used to formulate logical arguments aimed at exploring and describing the experiences and views of the persons living with SPMI and their families about mental health care. The logical reasoning strategies that were used in this study were inductive and deductive reasoning.

2.6.1 Inductive reasoning

Inductive logic is reasoning that moves from the particular to the general. With inductive logic, particular instances are observed to be consistently part of a larger
whole or set (Chinn and Kramer, 2011:181). Supportive statements were gathered by means of analysing the explorative and descriptive interview results in this study as well as by utilizing available and relevant literature on the topic being discussed. Conclusions made were based on the context of this study.

2.6.2 Deductive reasoning

According to Polit and Beck (2012:11) deductive reasoning is the process of developing specific predictions from general principles. It moves from the general to the specific. It moves from a pattern that might be theoretically expected to observations that test whether the expected pattern actually occurs. Deduction is a form of reasoning where two premises are relevant. Subsequently, the deductive conclusion was drawn logically, appearing almost self-evident. In this study, individual interviews assisted deductive reasoning by attempting to collect accurate data that acted as the initial point for prediction.

2.7 RESEARCH METHOD

According to Polit and Beck (2012:41) research methods are techniques used to structure a study and to gather and analyse information in a systematic fashion. The research process consisted of two phases which cover collecting the data, analysis of the data and the creation of the conceptual framework and strategies that assisted with the facilitation of the multifaceted role of the PHC nurses. The research methods were discussed in two phases:

- PHASE ONE : Situational analysis
- PHASE TWO : Development of strategies

Each of these phases were discussed and applied to the study.

2.7.1 PHASE ONE: SITUATIONAL ANALYSIS

The data collected must be relevant and focused on the purpose of the study. The data collection process should be recorded in detail to provide an historical record and as a form of quality assurance. In this study, data were collected and analysed from three research populations. The first research population consisted of persons living
with SPMI and the second research population consisted of family members of mentally ill persons while the third group were the PHC nurses working in the PHC services at Emalahleni LSA, Chris Hani District. The data collection method used was individual interviews. The data collection process that resulted in concept analysis included the following:

### 2.7.1.1 RESEARCH POPULATION AND SAMPLING

A research population is the entire aggregation of cases that meet a designated set of criteria (Polit and Beck, 2012:738). The research population in this study comprised three groups, namely; the persons living with SPMI, their families who use the PHC facility as well as the primary health care nurses employed in the primary health services. According to Polit and Beck (2012:742), sampling refers to the process of selecting a portion of the population to represent the entire population. A purposive and convenient sampling technique was utilized to sample persons living with SPMI, their families and primary health care nurses from selected community-based health care services. This means that three different research populations were utilized in this study. The inclusion criteria for each of the three groups included in the study was discussed as well as how each group was approached and sampled. The size of the sample was determined by the saturation of the data. Data saturation means the collection of quality data to the point where a sense of closure is attained because new data yield redundant information (Polit and Beck, 2012:742). The three research populations were discussed.

**Group 1: persons living with SPMI**

The researcher requested a meeting with the primary health care nurses working in the primary health services to discuss the purpose and objectives of the research and requested them to prepare a list of names and contact details of all health care consumers with severe and persistent mental illness. The researcher requested the persons living with SPMI to willingly participate in the research study. The criteria for inclusion of this group of participants included the following:

- DSM IV TR diagnosis of mental illness
- Be a person with a history of severe and persistent mental illness for at least 2 years
• Be either a female or a male
• Between 30- 45 years
• Unemployed and receiving a disability grant
• Living with a partner or relative in one home

**Group 2: Family member of persons living with SPMI**
This group of participants was selected in the same manner as the first group of participants. The criteria for inclusion for this group of participants:

• Must be related to the identified client from group 1 and may be a spouse, blood family member or in-laws living with the identified patient in one home.
• Be able to communicate and express him/herself in Xhosa and or English.
• Have been exposed to an Person living with SPMI for at least six months while living in the same home

**Group 3: Primary Health Care Nurses**
These participants are employed in the primary health care services. They must:

• Be employed in the primary health care services (PHC)
• Be employed in the primary health care services for at least one year.
• Have experience in dealing with persons living with SPMI and their families

Primary health care nurses had to have expertise in working with the persons living with SPMI with health or social care needs. They had to understand these needs in the wider context of the Person living with SPMI's family. This team can also play an important role in coordinating assessment and care plans (Slater and McCormack, 2005:603).

**2.7.1.2 SELECTING THE RESEARCH FIELD**

The choice of the problem was directly linked to the particular field in which the inquiry was to be undertaken. Prior knowledge of the setting was valuable in order to be able to foresee possible problems that might crop up during the investigation. In order to avoid subjectivity the researcher investigated various fields as part of the pilot study. In selecting the research field, the characteristics of the setting were studied carefully in order to ascertain the best field for the study. The ideal research field was one that
was easily accessible, where cooperation with participants could easily be achieved, where the researcher could move about freely and where the required information could easily be obtained.

Relevant health authorities, that is, the local Director of Provincial Hospitals, Superintendents and the Directors of Nursing in all local state hospitals were approached for permission to access the persons living with SPMI as well as for obtaining their addresses. Permission to enter the clinics and access the records was obtained from staff members who were also asked to assist where necessary with regard to talking to the potential participants (Annexure D).

Successful field work depends on the accessibility of the field and the ability of the researcher to build and maintain relationships with the gatekeepers (Polit and Beck, 2010:76). A gatekeeper is someone who is able to grant access to the field (Silverman, 2010:434). The researcher negotiated with gatekeepers, who were the people who have the power to grant or to withhold access to the setting. They provided the researcher with the information giving insight on how to identify problems that could have affected fulfilment of the research objectives (Polit and Beck, 2010:107).

The PHC nurses acted as gatekeepers to help the researcher with the selection of participants and also protected them from harm. They achieved this by the following activities:

- They contacted persons living with SPMI and their families
- They explained the study to the persons living with SPMI and their families
- They obtained provisional consent
- They gave the researcher the patients’ contact details

Families were asked for informed consent for the researcher to conduct interviews with both the Person living with SPMI and a family member in their homes. Permission to conduct the research study was obtained in writing from the relevant Department of Health, the families and the persons living with SPMI. All ethical research requirements were observed when identifying and gaining access to the site of research. As soon as the site and permission for entry to the site had been established, data collection commenced.
**2.7.1.3  DATA COLLECTION**

Burns and Grove (2009:43) explain that data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives of the study. In this study, the researcher chose the semi-structured interviews to obtain the relevant research data. The researcher met each participant at the appointed time at a venue where minimal distraction was present in order to collect data.

**a. Individual interviews**

Data was collected from all three groups by means of semi-structured individual interviews using an audiotape. Denzin and Lincoln (2005:712) state that an interview is a conversation, the art of asking questions and listening. Interviews for persons living with SPMI and their families took place at the PHC facilities at a place perceived as convenient and comfortable and in a language, either English or Xhosa, preferred by participants. Earlier on the researcher had planned that interviews will take place at the homes of the participants but this was not possible because of inaccessibility of their homes due to bad roads and in other rural areas no roads for vehicles at all. An audiotape recorder was used to capture data during sessions. Each interview took 40-60 minutes. The audio-taped interviews were transcribed within 24 hours of the interview while the information was still fresh in the researcher’s mind. The researcher translated the interviews into English to enable the promoters of the study and the independent coder to understand the content of the interviews. The transcribed interviews formed the database of the study. The same question was asked to all participants but rephrased according to the group to which they belong, namely:

**To person living with SPMI:**

“Tell me about your experiences of health care provided to you at the clinic?”

(Ndichazele ngamava akho ngenkonzo yempilo oyifumanayo eclinic)

**To the family member:**

“Tell me about your experiences relating to health care provided to your relative?”
To the PHC nurse:

“Tell me about your experiences in rendering health care to mentally ill persons in your clinic?”

b. The communication skills utilised by the researcher to facilitate participants’ verbalisation of experiences

The researcher employed the following verbal and non-verbal communication skills briefly discussed below:

Clarification

Clarification aims to resolve ambiguity and confusion about meaning. It involves the ability to ask the participant to clarify when responses are not clear or are vague (Uys & Middleton 2010:180). The following question was asked by the researcher for clarity - "Let me just make sure you are saying the problem with this clinic there is usually no medication for you in this clinic?"

Paraphrasing

Paraphrasing is confirming the main points made by the participant, either the content or the feelings by restating them (Elder, Evans and Nizette, 2009:411). This refers to the repetition by the researcher in her own words. The participants expressed feelings and opinions to ensure that she understands correctly (Uys & Middleton 2010:179). The rephrasing of an answer may be an interpretation to some degree, to ensure clarification of data obtained; an example would be - "You are sometimes confused by other patients’ behaviour towards you at the clinic because you are mentally ill".

Probing

It becomes necessary for the researcher to prompt and /or probe in order to understand the patient state that the purpose of probing is to elicit more useful information from the participant than was volunteered during the first reply. Probing
may also be used when the researcher realizes that the participant does not understand the question (Uys & Middleton 2010:179).

Active listening

Active listening requires attention, genuineness and an ability to hear what the participant has to say and validate the meaning of the participant’s perceptions. The researcher uses minimal verbal response such as; mhm, yes, or nodding and so on to demonstrate his/her presence (Elder, Evans and Nizette, 2009:410).

Using silence

The researcher used silence to often motivate the participant and share the thoughts or feelings (Uys and Middleton 2010:179). It is often useful for the researcher to break a silence, for example by saying; “You have been quiet for a while now, I wonder what you are thinking about?

Summarizing

Summarizing means putting together the main issues and ensuring that you have understood them from the participant’s perspective (Elder, Evans and Nizette, 2009:410). The researcher used summarizing in order to see whether participant’s ideas, thoughts and feelings verbalized were really understood. For example; “So what you are saying is….?” This technique stimulates the participant to give more information.

c. Observations and field notes

Observation is another data collection method that was used in this study, where the researcher reports on what he or she sees, hears, smells, touches and/or tastes in the environment. Information collected from the process of observation is objective in that it is factual and usually supports that which was collected in the interview. In this study, the researcher noted everything she observed, especially during the interviewing process. Observations are added to the field notes and this translates into data.
In addition to recording the interviews, data were generated through the use of field notes. The researcher made field notes during and after the interviews. Field notes are a written account of the things the researcher hears, sees or experiences and thinks about during the course of interviewing. They are notes or notations made by the researcher which may describe observations, assumptions about what is being heard or observed or a personal narrative about what is felt by the researcher during a particular encounter. This exercise is regarded as an interpretive attempt at attaching meaning (Creswell 2009: 183). Taking field notes immediately after each interview allowed the researcher to conceptualize the data. This complemented the data obtained in the interviews and helped to validate the recorded information. The field notes became valuable to the researcher during the subsequent transcription of the audiotapes. Field notes are detailed reproductions of what occurred. The researcher observed the nonverbal communication of the participant when answering questions. Field notes contained a chronological description of what happens to the setting and participants.

Observations and field notes were suitable for use as an additional data collection method as it enhanced the richness of data analysis results. The researcher observed both human activities and the physical setting in which activities took place.

2.7.1.4 DATA ANALYSIS

Polit and Beck (2012:556) state that the purpose of data analysis is to organise and provide structure to, and elicit meaning from data. Data analysis is conducted to reduce, organise and give meaning to data (Burns and Grove, 2009:695). Data collected from the interviews was transcribed verbatim and analysed according to the steps suggested by Tesch, to identify themes and sub-themes (Creswell, 2007:150). These steps are as follows:

- Get a sense of the whole. Read all the transcriptions carefully and make short notes.
- Pick one document at a time, go through it and make meaning of its contents then write notes in the margin
When this action has been completed for several documents, make a list of all the topics. Cluster similar ones together and form them into columns that can be arranged as major topics, unique topics and leftovers.

Take the list and go back to the data. Abbreviate topics as codes and write the codes next to the appropriate segments of the text to see whether new categories and codes emerge.

Find the most descriptive wording for the topics and turn them into categories. Reduce the total list of categories by grouping topics that relate to one another. Lines could be drawn between categories to show interrelationships.

Make a final decision on the abbreviation for each category and arrange these categories alphabetically.

Assemble the data material belonging to each category in one place and perform a preliminary analysis.

Re-code existing data, if necessary.

Transcripts from the audio-taped interviews were made and were sent to an independent coder who has completed her PhD together with a data analysis guide (see Annexure H). The independent coder was instructed to use the data analysis guide provided to analyse data from the transcribed interviews to assist in excluding biases of the researcher. The data was analysed by the researcher as well as by the independent coder. Using the services of an independent coder assisted in ensuring the trustworthiness of the research findings. The process of coding was undertaken using Tesch’s method of identifying themes in the data which allowed a structured organization of data to take place (Creswell, 2007:150). Data was verified through a literature control to place findings within the context of existing literature. Concepts were identified from the data and fieldwork conducted in the first phase of the study. In this study, the emerging themes were re-contextualised within existing literature to find support, or not, for aspects revealed during the analysis.

2.7.1.5 PILOT STUDY

A pilot study is frequently defined as a smaller version of a proposed study conducted to refine the methodology (Burns and Grove, 2009:44). According to Polit and Beck (2012:737), a pilot study is a small scale version or trial run done in preparation for a
major study and is sometimes called a feasibility study. A pilot study was undertaken to assess the research question and the interview technique. The researcher interviewed one participant who met the criteria for inclusion in this study from each group of participants and analysed the data using the Tesch’s method of data analysis (Creswell, 2007:150). All the ethical prescriptions were observed and applied. Measures of trustworthiness were applied as stated by Guba’s model (Krefting, 1991:214).

2.7.1.6 LITERATURE CONTROL

A literature control is the discussion of findings in the light of literature. Justification of the results of the study will be done by means of literature control. One of the reasons why one would conduct a qualitative study is to allow it to be exploratory, since not much has been written about the research phenomenon. As a result the researcher needed to listen to participants, establish facts, gather new data and construct a bigger picture based on their experiences with the purpose of comparing it to existing knowledge in literature about the phenomenon (Mouton, 2006:103).

The place of a literature review in qualitative research studies was subject to debate in the literature. Streubert and Carpenter (2011:49) assert that a literature review in qualitative studies should be done after data analysis in order to place the findings in context. The researcher reviewed studies and other literature to support or refute the findings. Holloway and Wheeler (2010:37) advise that previous authors should be treated as ‘experts’ or authorities in the field. This continued engagement with the literature enhanced the credibility of the study.

2.7.1.7 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness means methodological soundness and adequacy in qualitative research (Holloway and Wheeler, 2005:254). In essence, trustworthiness could be thought of as the ways in which qualitative researchers ensure that transferability, credibility, dependability and confirmability are evident in their research. The application of these strategies is reflected below.

The researcher used a model proposed by Guba (in Krefting, 1991:214) to ensure the trustworthiness of the study, without sacrificing its relevance. Trustworthiness in
qualitative research means methodological soundness and adequacy. Authenticity was thus achieved by the researcher’s fairness to all participants and gaining their acceptance throughout the study. According to Krefting (1991:214) the following four aspects of trustworthiness form the basis of Guba’s model:

- Truth value – strategy: credibility
- Applicability – strategy: transferability
- Consistency – strategy: dependability
- Neutrality – strategy: confirmability

These activities to ensure trustworthiness are discussed below. The researcher enabled judgment of trustworthiness through ensuring that these activities were applied throughout the study:

2.7.1.7.1 Credibility

Credibility refers to the confidence in the truth of the data (Polit and Hungler, 2008:539). Credibility is also known as truth value. This can be done by utilizing multiple references to draw conclusions about the truth including data gathering during the interviews, field notes and literature control (Polit and Hungler, 2012:175). It establishes how confident the researcher is with the truth of the findings based on the research design, the participants and the context (Krefting, 1991:215). According to Guba and Lincoln (as cited in Krefting, 1991:215), truth value asks whether the researcher has confidence in the truth findings for the participants or informants, and also in the context in which the study was undertaken. The goal of credibility is to demonstrate that the enquiry was conducted in such a manner as to ensure that the subject was accurately identified and described. Credibility was also enhanced during the interviewing process as the researcher reframed questions and repeated or expanded questions on various occasions during the interviewing process.

The researcher triangulated the findings by the use of multiple data gathering methods, interview techniques, peer review, member checking and the authority of researcher as strategies to establish credibility (Krefting, 1991:7-12). The researcher ensured a varied field experience by spending time establishing a rapport with the
participants before commencing the interviews. In this study the researcher made use of the following activities to ensure trustworthiness.

- **Prolonged and varied field experience** is essential for building trust and rapport with participants. Prolonged engagement is proposed as a strategy to prevent distortions of the findings related to the researcher and field workers’ presence at the research site or their involvement with the participants (Guba and Lincoln, 1989:105). This refers to the investment of sufficient time in data collection activities to have an in-depth understanding of culture, language or views of the individual under study, and to test for any misinformation (Polit and Beck, 2006:322). It additionally assists participants to become familiar to the researcher (Krefting, 1991:218). In this study, the researcher ensured prolonged and varied field experience by spending time with participants before commencing the interview to establish rapport.

- **Triangulation** refers to the process by which a phenomenon or topic under study is examined from different perspectives. Denzin (1989), as cited in Holloway and Wheeler (2010:303), differentiates between four types of triangulation, which are as follows:
  - Data triangulation, which means that the researcher used multiple data sources;
  - Investigator triangulation requires more than one expert researcher to be involved in the study;
  - Theoretical triangulation refers to the researcher having employed several possible theoretical interpretations in the study. Competing explanations or interpretations are developed and tested against each other. One explanation was looked at to explain the phenomenon;
  - Methodological triangulation refers to when the researcher has used two or more methods to answer a similar question. This was done by means of observations, interviews and documents. In this study the researcher used colleagues, an independent coder and the promoters of the study.
- **Peer examination** involves a session being held with objective peers to review and explore various aspects of the inquiry. Peer debriefing exposes the researchers to the searching questions of others, who were considered to be experienced in either qualitative research or in the phenomenon being studied, or in both (Polit and Beck, 2006: 333). In this study, peer examination took place through discussing the research process and findings with the independent coder who has completed her PhD, the two promoters who had a wealth of experience with qualitative research methodologies.

- **Interview technique.** According to Brink et al. (2006:152), a semi-structured interview is conducted like a normal conversation, but with the specific purpose of gathering data (See Annexure H)

- **Establishing the authority of the researcher refers to the researcher being viewed as a measurement tool** (Krefting, 1991:220). Miles and Huberman (in Krefting, 1991:220) identified four characteristics that are necessary in assessing the trustworthiness of the human instrument:

- A strong interest in conceptual knowledge, and the ability to conceptualize large amounts of qualitative data.

- The ability to take a multi-disciplinary approach that is to look at the subjects under investigation from a number of different theoretical perspectives.

- Investigation skills are developed through the literature review, course work and experience in qualitative research methods. One way of assessing these investigative skills or technical competence, is to examine the researcher’s background for special training, and whether s/he has received training that is relevant to the project: for example experience in interviewing or observational techniques (Krefting, 1991:220).

- **Structural coherence:** Structural coherence entails the integration of the masses of loosely connected data in the thesis to create a logical holistic picture (Krefting, 1991:220). Evidence is structurally coherent when different parts of evidence verify each other, the parts fit and the facts are consistent (Guba and Lincoln, 1989:106). According to Guba (1981, as cited in Krefting, 1991:11), structural coherence ensured that there were no unexplained
inconsistencies between the data and their interpretations. Structural coherence in this study included evidence of concept analysis.

2.7.1.7.2 Transferability

Transferability refers to the external validity of data, that is, to demonstrate applicability of one set of findings to another context as the researcher cannot generalise. Transferability ensures that the findings of the research have meaning and quality to fit to others in similar situations. This therefore implies that transferability refers to the extent to which the findings of a particular enquiry have applicability in other contexts or with other participants (Lincoln and Guba, 1985:290). Transferability is the ability to generalise from the findings to larger populations (Krefting, 1991:216). Lincoln and Guba (as cited in Krefting, 1991:216) noted that transferability is more the responsibility of the person wanting to transfer the findings to another situation or population than that of the researcher of the original study.

The researcher provided an adequate database to allow transferability judgments to be made by others (Polit and Hungler, 2012:197). The researcher utilised a nominated sample and dense description strategies. A dense description of the background information about the participants and the research context and setting was provided in order to allow others to assess how transferable the findings are. A complete description of the results, including verbatim quotes from the individual interviews, was described. The following activities were utilized.

- **Dense background information**: The researcher provided dense background information about the participants and the research context and setting to allow others to assess how transferable the findings are (Krefting, 1991:12). A dense description was given of the findings together with direct quotations from the participants. The entire research process was described comprehensively. The researcher also provided direct verbatim quotes made by research participants during field work. This would allow transferability judgements to be made by others (Krefting, 1991:220). In this study, transferability was achieved by purpose sampling of participants in the rural areas (Babbie and Mouton, 2008: 277) and through dense description of research findings supported by quotations from the participants (Polit and Beck, 2012: 585).
A nominated sample refers to the selection of research participants who are representative of the particular study population (Krefting, 1991:220). In this study, purposive sampling was the sampling method of choice for the research process and also selection criteria guided the choice of participants. In this study transferability was achieved by purposive sampling of persons living with SPMI, their families and PHC nurses in the rural areas.

2.7.1.7.3 Dependability

Dependability refers to the stability of data over time and over conditions (Polit and Beck, 2006:335). They argued that as the original researcher presents sufficient descriptive data to allow comparison, she/he has addressed the problem of applicability. Dependability is a strategy for consistency and, according to Lincoln and Guba (1985:324). Consistency refers to the ability to repeat the findings of an inquiry with the same participants in the same context. In this study triangulation and dense description of the research method and peer examination were used by the researcher. A dense description of the research methodology was done. A step-wise replication of data collection method was described. Code-recode procedure of data analysis was carried out.

In this study, consistency was ensured by applying the strategy of dependability. Dependability is only achieved if the findings of a study are credible. Dependability is concerned with the stability of the data over a specified time and over conditions. Researchers can depend on research findings once there is truth-value in the results. In this study, a dependability audit was ensured through the involvement of experts. To meet the code-recode criterion, the researcher reached consensus with the independent coder on the collection and analysis of the data from the participants.

Consensus on identified categories was reached between the researcher and independent coder to increase dependability. The researcher should account for changing conditions in the phenomenon chosen for the study as well as for changes in the setting. This study was also subjected to review by a colleague who is an expert in qualitative research methods. Audit trails of all the audiotapes, transcriptions and field notes were done. According to Streubert, and Carpenter (2011:49), one cannot achieve credibility without dependability. As stated above, this criterion was thus met.
2.7.1.7.4 **Confirmability**

Confirmability refers to the objectivity of the data (Polit and Beck, 2012:599). It refers to the degree to which the findings are a function solely of the participants and the conditions of the research, and not of other biases, motivations and perspectives (Guba in Krefting, 1991:216). This means the readers can trace the data to the source. They must be able to follow the path of the researcher and the way she arrived at the findings. The findings and conclusions adhere to the findings and achieve the aim of the study and not the researcher’s assumptions and pre-conceptions (Holloway & Wheeler, 2010:303). In this study, the researcher ensured neutrality by applying the strategy of confirmability. The researcher left an audit trail. This is a record of activities that can be followed by another researcher. This works in the same way as an audit that is done in health services to identify a clear picture of what was done, and the reason why it was done. In this study another strategy used was that of peer review. In an attempt to implement peer review of the collected data, the researcher used an independent coder who was a specialist in qualitative research methods to evaluate the process.

The researcher used reflectivity and triangulation to confirm findings and the examiners will also look at the research project. In this study, objectivity was maintained throughout the research process. The actual evidence in this study includes the transcribed interviews, field notes of observations and participation with the informants and document analysis. Details on data analysis will be provided in Chapter 4.

- **Audit trail**: as described previously
- **Peer review**: as described previously
- **Triangulation**: as discussed previously
- **Reflexivity**: as discussed previously

### 2.7.1.8 ETHICAL CONSIDERATIONS

The researcher understood that the research population was vulnerable persons living with SPMI who should not be stressed. The researcher observed and adhered to the basic principles of ethical conduct in research. The following ethical aspects relate specifically to this study.
The right to privacy, confidentiality and anonymity

The right to privacy is the individual’s right to decide when, to whom and to what extent to reveal her attitude, beliefs and behaviour (Burns and Grove, 2009a:195). Babbie (2007:65) states that the researcher guarantees confidentiality when the researcher can identify a given person’s responses but essentially promises not to do so publicly. Confidentiality refers to agreements between persons that limit the access of others to private information (Soanes and Stevenson, 2004:55). Anonymity means that the researcher cannot link the participants with the information reported. Anonymity is guaranteed in a research study when neither the researchers nor the readers of the findings can identify a given response with a given participant (Burns and Grove, 2007:196).

This study ensured that these rights were protected by using pseudonyms rather than the names of the participants during the interviews. Cassettes and transcriptions will be destroyed once the study is completed. Findings will be communicated in such a way that data cannot be linked to a specific person. Each participant was interviewed alone and no family members were present to ensure privacy.

The informed consent indicated that the findings of the study would be made available in a report in the form of a thesis, as well as a publication in a research journal, so the participants waived the right to absolute confidentiality. However, no one would be linked by name or any other identity to the report. In giving the assurance regarding confidentiality and anonymity to the participants as indicated above, the researcher was cognisant of the legislative framework that underpins such an undertaking.

Informed consent

Informed consent is a norm in which participants base their voluntary participation in a research study on a full understanding of the possible risks involved (Babbie, 2007:64). Informed consent entails informing the participants about the purpose of the study and the main features of the design as well as possible risks and benefits from participation in the research study. It further involves obtaining voluntary participation of the participants, while allowing the participants the right to withdraw from the research at any time. Voluntary consent means that the participant has decided to take
part in the research study of his own volition without coercion or any undue influence (Burns and Grove, 2009:727). Autonomous participants, who are capable of understanding the benefits and risks of a proposed study, are competent to give consent (Burns and Grove, 2009:190). In this study participants were informed of the purpose of the research methods and procedures, recording of data, nature of participation and possible advantages and benefits. They were informed that they may withdraw from the study should they feel uncomfortable (see Annexure E). The researcher requested the participants’ permission to audiotape the interviews. The audiotapes were locked in a cupboard in the researcher’s office. Only the researcher and the supervisors had access to the audiotapes. The audiotapes will be destroyed two years after publication of this research.

**Deception of participants**

Deception of participants is the deliberate misinterpretation of facts in order to make another person believe what is not true and violates the respect to which a person is entitled. It involves withholding the information or offering incorrect information in order to ensure participation of the participants when they would otherwise possibly have refused it. However participants had the right to withdraw at any stage of the study (Burns and Grove, 2009a:188).

**Action and competence of the researcher**

Researchers are ethically obliged to ensure that they are competent and equitably skilled to undertake the proposed investigation. The researcher worked according to the research protocol under the guidance and mentorship of an experienced supervisor.

**Publication of findings**

The findings of the study were published in written form so that the public had access to the information. The report was as clear as possible and contained all the information necessary for readers to understand what the researcher has written and carried quotes from the interviews. Participants would be informed about the findings in an objective manner without violating confidentiality.
Right to protection from discomfort and harm

Participants are more likely to suffer emotional harm during this study although physical harm cannot be ruled out completely. The researcher asked participants to recall negative behaviour of the past that was the beginning of the renewed personal harassment or embarrassment. Should the participant experience emotional discomfort, a counsellor was available to provide professional intervention as necessary. However if the participant wished to withdraw from the research study, due to any emotional discomfort, his/her wish would be granted. The principle of self-determination will be adhered to throughout this study. The right to self-determination is based on the principle of respect for persons (Burns and Grove, 2009a:189). In this study, this means participants have a right to decide voluntarily whether to participate in the study without the risk of prejudicial treatment.

Debriefing

The researcher invited the participants for a debriefing session after the study. This provided the participants with an opportunity to work through the experience and its aftermath, to minimize possible harm that may have arisen in spite of all precautions taken against such harm. The researcher rectified any misperceptions that arose in the minds of the participants after completion of the research. Termination was handled with sensitivity.

Permission to conduct the study

Permission was granted by the Research Ethics Committee-Human (REC-H) at the NMMU to conduct the study (See Annexure A). It is important to seek approval in order to gain entry into a research setting (Creswell, 2003:184; Silverman 2006:81). The researcher approached the Department of Health of the Eastern Cape and Managers of PHC services for permission to conduct the study (see Annexure D).

2.7.2 PHASE TWO – Development of strategies

During Phase Two of the study, a conceptual framework was developed. A conceptual framework is used to clarify the relationships between concepts and themes identified during the research process and to link the gathered data to previously established
models or theories (Burns and Grove, 2009:39). Two steps were followed in Phase Two of the research study. In step one, the researcher compiled a conceptual framework and the second step was to formulate a strategy to facilitate the community-based health care of persons living with SPMI and their families in the rural areas. The strategy related to the emerging themes (Phase One), as agreed upon by the researcher and independent coder while the process of compiling a conceptual framework evolved subsequently. A conceptual framework helps to depict the relationship between the research methodology, the research setting and the participants. Schneider et al. (2004:133) contend that a conceptual framework is used to link the data gathered to previous models or theories. The conceptual framework of Dickoff, James and Wiedenbach (1968) was used to provide a link between the different concepts in the research study. This is discussed below.

2.7.2.1 PHASE TWO: Step 1 Development of a conceptual framework

The identified concepts were classified and conceptualized using the six elements of the survey list of Dickoff, James and Weidenbach (1968:422-434). The survey list included the agent, recipient, context, dynamics, procedure and terminus. The following six questions correlated with the six concepts in the survey list (Dickoff, et.al., 1968:423).

Table 2.1. The survey list (Dickoff, et.al., 1968:423)

<table>
<thead>
<tr>
<th>Agent</th>
<th>Who or what performs the activity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient</td>
<td>Who or what is the receipt of the activity?</td>
</tr>
<tr>
<td>Context</td>
<td>In what context is the activity performed?</td>
</tr>
<tr>
<td>Dynamics</td>
<td>What is the energy source or the activity?</td>
</tr>
<tr>
<td>Procedure</td>
<td>What is the guiding procedure, technique or protocol of the activity?</td>
</tr>
<tr>
<td>Terminus</td>
<td>What is the end-point of the activity?</td>
</tr>
</tbody>
</table>

- The **agent**: The agent is a person whose activity leads to the realization of the goal (Dickoff et al., 1968:426). In this study, the agents were the PHC nurses
when they assumed responsibility for the persons living with SPMI and their families.

- The **recipient**: The recipients are those persons who receive an action from the agents and who benefit from the same activity (Dickoff et al., 1968:427). In this study, the recipients were the persons living with SPMI and their families who utilized the PHC service.

- The **context** involves seeing an activity in relation to other factors, and their interrelatedness constitutes the whole unity or the total context of the activity (Dickoff et al., 1968:430). In this study, the context was the PHC clinics which are widely dispersed in rural areas of Emalahleni LSA where the study was conducted.

- The **procedure** suggests the steps to be taken towards some accomplishment and it may even suggest the equipment or situation for carrying out the activity. The procedure should provide sufficient detail to enable the activity to be performed (Dickoff et al., 1968:430). In the study the procedure was the process to meet the health care needs of the persons living with SPMI and their families.

- The **terminus** means viewing an activity from the perspective of an end point or an accomplishment of an activity (Dickoff et al., 1968:428). In the study the terminus was the development of strategies to facilitate the multifaceted role of the PHC nurses who in turn would render high quality standards of mental health care to persons living with SPMI and their families.

Each of aspects of these activities is discussed individually in chapter four.

### 2.7.2.2 PHASE TWO: Step 2 Description of strategies

In Chapter 1, the third objective of the study was to develop strategies to facilitate the community-based health care for persons living with SPMI and their families. In this Phase, the collected data was analysed and interpreted, resulting in the development of the conceptual framework. The identified themes that emerged from the analysed data formed the basis of the development of strategies to facilitate the multifaceted role of the PHC nurses in the rural areas.

On completion of Phases One and Two of the research process, the collected data were analysed and interpreted, resulting in the compilation of a conceptual framework.
Strategies were then compiled to assist in the facilitation of the multifaceted role of the PHC nurses in the rural areas in order to meet the mental health care needs of the persons living with SPMI and their families. The identified strategies were based on data obtained during the interviews conducted with the participants of the study. A literature control validated the findings and proposed outcomes were identified. Implementation activities specifically designed to achieve the proposed outcomes were formulated. The resulting strategies are presented at functional levels. Functional strategies are those strategies that are utilized at grassroots level.

2.8 CHAPTER SUMMARY

The aforementioned discussion provided an in-depth description of the research design and methods used to conduct this research. The purpose and research objectives were stated within the context of research and ethical principles were outlined and discussed. A description of the proposed process for the development of a nursing model for the community-based health services was outlined in this chapter. The method chosen for conducting the study was deemed suitable to achieve the objectives of this study. A research design, using a qualitative, explorative, descriptive and contextual was utilized. Measures of trustworthiness as stated in Guba’s model of trustworthiness for qualitative research were applied (Krefting, 1991:221).
CHAPTER THREE

THE EXPERIENCES OF PERSONS LIVING WITH SPMI, THEIR FAMILIES AND PRIMARY HEALTH CARE NURSES OF COMMUNITY-BASED CARE

3.1 INTRODUCTION

In chapter two, described the research methodology in detail. The purpose of this chapter is the analysis, interpretation and discussion of the data collected during the data collection phase. The themes identified were discussed and supported through extracts from the transcribed interviews. The field notes made by the researcher soon after completion of the interviews were added to the data. The results were discussed in conjunction with literature that allowed for the verification of the relevant research findings. The researcher adapted the descriptive data analysis approach to assist her in creating information for the development of the desired strategies.

3.2 OPERATIONALISATION OF DATA GATHERING AND DATA ANALYSIS

Relevant health authorities, that is, the local Director of Primary Health Care Services, the District Manager of the Chris Hani District, the Sub-district Manager and Clinic Supervisors of Emalahleni Local Service Area (LSA), were approached for permission to access the participants (Annexure D). Permission to enter the clinics and access the records was obtained from staff members who were also asked to assist where necessary with regard to talking to the potential participants (Annexure D). Families were asked for informed consent (Annexure E) to conduct interviews both with the patient and a family member in their homes. All ethical research requirements (Annexure C) were observed when identifying and gaining access to the site of research (Annexure D).

Data collection commenced as soon as the site and permission for entry to the site was established. The researcher interviewed three groups of participants who met the criteria for inclusion in the study in order to explore their experiences related to the health care that they received from the community based health care services.

Successful field work depends on the accessibility of the field and the ability of the researcher to build and maintain relationships with the gatekeepers (Polit and Beck,
2010:78). The researcher negotiated with gatekeepers, who were the people who had the power to grant or withhold access to the setting. They provided the researcher with information that provided insight concerning how to identify problems that could have affected fulfilment of the research (Polit and Beck, 2010:107). The PHC nurses acted as gatekeepers to help the researcher with the selection of participants by doing the following:

- They contacted participants
- They explained the study to the participants
- They obtained provisional consent
- They gave the researcher the participants’ contact details

The researcher chose to conduct semi-structured individual interviews to obtain the relevant research data. The researcher met each participant at the appointed time at a venue where minimal distraction was present in order to collect data. Data was collected from three groups of participants using an audiotape. Interviews for members of groups 1 and 2 (persons living with SPMI and their families) took place at PHC clinics a place perceived as convenient and in a language preferred by participants, which was either English or Xhosa.

Interviews for data collection from the third group of participants, the PHC nurses, was arranged with them at a convenient time, in their clinics where they work. An audiotape recorder was used to capture data during sessions. Each interview took 40-60 minutes. The audio-taped interviews were transcribed within 24 hours of the interview while the information was still fresh in the researcher’s mind. The researcher translated the Xhosa interviews into English to enable the promoters of the study as well as the independent coder to understand the content of the interviews. The transcribed interviews and field notes formed the database of the study. The same question was asked of all participants but rephrased according to the group to which they belong. These multiple data sources will help to confirm important findings and access information that the individual may not be in a position to supply. It will also be useful in generating a holistic picture of health care needs for persons living with SPMI.
3.3 **DATA ANALYSIS**

Polit and Beck (2008:507)) state that the purpose of data analysis is to impose some order on a large body of information so that some general conclusions can be reached and communicated in the research report. The research data needed to be processed and analysed in a systematic fashion so that trends and patterns of relationship can be detected (Polit and Beck, 2008:511). Data collected from the interviews were analysed according to the steps suggested by Tesch, to identify themes and sub-themes (Creswell, 2007:150). These steps were described in detail in Chapter Two. Transcripts from the audio-taped interviews were sent to an independent coder with a data analysis guide (See Annexure F). The researcher briefly described the participants of each group. The themes identified for each group were presented in tabular form. The themes of each group were discussed separately with the data presented as direct quotations to illustrate the identified themes. The discussion of each theme included the results of literature control that was conducted by the researcher. The results were presented in two different sections. The sections were discussed as follows:

**Section One**

Section one presents the discussion of results that were obtained from the semi-structured interviews with persons living with SPMI and their families during the data collection process. Their experiences of how their health care needs and how they were met by community-based health care (PHC) services in the rural areas were discussed together with their health care needs.

**Section Two**

Section two presented the discussion of results that were obtained from semi-structured interviews with the PHC nurses during the data collection process. Their experiences of rendering mental health services to persons living with SPMI and their families were discussed.

As there are three distinct research populations, each one will be discussed separately.
3.3.1 DEMOGRAPHIC OF THE PARTICIPANTS

3.3.1.1 GROUP ONE: IDENTIFIED PERSONS LIVING WITH SPMI

Eighteen severely and persistently mentally ill patients were recruited for interviews. The participants ranged in age from 30 to 44 years of age. All participants were using the rural PHC services. Eight females and ten males were interviewed in this group. During interviews the following participants were eliminated for these reasons:

- One participant did not meet the inclusion criteria of age (58 years)
- One participant withdrew from the study, because he/she was tired of the questions that were asked.

The researcher explained the purpose of the study and what was expected from the participants. The researcher explained their rights to anonymity, confidentiality and privacy as well as the fact that participation was voluntary and that they could withdraw at any stage if they so wished (Annexure C). All participants in this group were willing to take part but, while being interviewed, some participants were not able to answer the questions with relevance at times because of their mental status. Some participants were not very forthcoming with the information and it appeared that it was due to the effects of medication. Through the interviews the researcher learned that the participants felt rejected and discriminated against by both the community and health professionals.

3.3.1.2 GROUP TWO: Family members of SPMI

Eleven participants were interviewed in this group. They were all females. They all met the criteria for inclusion in the study. This group of participants were selected and contacted in the same manner as the first group of participants. This group of participants was also asked to make use of a reflective journal to provide further information. However, the participants were not interested in writing in the journals.

3.3.2 GROUP 3: PHC NURSES

The researcher requested an opportunity to be included in the agenda of their scheduled meeting which is usually on the first Thursday of the month to discuss the purpose and objectives of the research and the opportunity was granted. The
researcher also requested PHC nurses to participate in the research study. The sample comprised of twelve (12) professional nurses who volunteered to participate in the study and be interviewed on their experiences of rendering PHC to mentally ill persons. Data saturation, as defined in Chapter Two, occurred in the seventh interview but the researcher continued with interviews of this group. Participants gave informed consent to participate in the study (Annexure E). Interviews took place in their workplace, namely various PHC clinics. Members of all three groups met the criteria as described in Chapter Two.

The discussion of the results will be presented in two sections coordinating with two themes emerged from data analysis process. The discussion will be presented into the following two themes and related sub-themes with direct quotes from the participants. A visual presentation of the themes and sub-themes of the experiences of mentally ill persons and their families relating to their health care needs plus those of the PHC nurses is presented below. The themes and sub-themes identified are presented in tabular form in table 3.1 below.
Table 3.1: Themes and sub-themes from the interviews from all groups of participants

<table>
<thead>
<tr>
<th>THEMES AND SUB-THEMES FROM THE INTERVIEWS - GROUPS 1 AND 2 (PERSONS LIVING WITH SPMI &amp; THEIR FAMILIES)</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>THEME 1</td>
<td>1.1 When mentally ill patients experience a crisis, there is no 24-hour service to help the patient or family.</td>
</tr>
<tr>
<td>Persons living with SPMI and their families experience challenges regarding community-based health care</td>
<td>1.2 The ambulances and police service are not helpful, when patients need access to mental health care service.</td>
</tr>
<tr>
<td></td>
<td>1.3 The mental health information given to mentally ill persons and their families is inadequate.</td>
</tr>
<tr>
<td></td>
<td>1.4 When a person living with SPMI needs to be referred to a multi-professional team member, the service can only be accessed in large metropolitan areas.</td>
</tr>
<tr>
<td></td>
<td>1.5 Family members are not included in the treatment plan of their mentally ill relatives.</td>
</tr>
<tr>
<td></td>
<td>1.6 The specific pharmaceuticals that are prescribed for the mentally ill patient may not be available during regular clinic visits leading to non-adherence and relapse.</td>
</tr>
<tr>
<td></td>
<td>1.7 When visiting a PHC service, the mentally ill patient may feel stigmatized by both the community as well as the nurses.</td>
</tr>
<tr>
<td></td>
<td>1.8 Participants are dissatisfied with long queues and waiting periods.</td>
</tr>
<tr>
<td></td>
<td>1.9 Rural clinics do not initiate support groups or any specific projects focusing on the needs of mentally ill patients and their families.</td>
</tr>
</tbody>
</table>
THEMES AND SUB-THEMES FROM PHC NURSES

<table>
<thead>
<tr>
<th>THEME 2</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PHC nurses experience the integration of mental health care services into primary health care as challenging</td>
<td>2.1 In spite of a policy of a comprehensive approach, PHC nurses tend to focus on curative care.</td>
</tr>
<tr>
<td></td>
<td>2.2 Lack of managerial support to assist nurses hinders the functioning of rural PHC services.</td>
</tr>
<tr>
<td></td>
<td>2.3 Time constraints due to a high workload cause the PHC nurses to spend inadequate time with the patients.</td>
</tr>
<tr>
<td></td>
<td>2.4 Mentally ill patients who default on treatment or those who are home bound, are not visited at home due to staff shortages and transport constraints.</td>
</tr>
</tbody>
</table>

3.4 DISCUSSION OF THEMES AND LITERATURE CONTROL

The themes and sub-themes were discussed comprehensively and direct quotations from the raw data obtained from the participants were used to support the identified themes and sub-themes. According to Burns and Grove (2009a:91), the purpose of literature control is to share with the reader the results of other studies that are closely related to the study being reported. It relates a current study to a larger ongoing dialogue in the literature about a topic.

3.4.1 SECTION ONE

3.4.1.1 DISCUSSION OF THEME ONE AND RELATED SUB-THEMES OF GROUPS ONE AND TWO PARTICIPANTS

THEME 1: Persons living with SPMI and their families experience challenges regarding community-based health care

Both groups of participants (persons living with SPMI and their families) highlighted that their health care needs are not met in the rural area. The following issues came out:
Theme 1
Persons living with SPMI and their families experience challenges regarding community-based health care

Sub-themes
1.1 When mentally ill patients experience a crisis, there is no 24 hour service to help the patient or family.

1.2 The ambulances and police service are not helpful when patients need access to mental health care service.

1.3 The mental health information given to mentally ill persons and their families is inadequate.

1.4 When a person living with SPMI needs to be referred to a multi-professional team member, the service can only be accessed in large metropolitan areas.

1.5 Family members are not included in the treatment plan of their mentally ill relatives.

1.6 The specific pharmaceuticals that are prescribed for a mentally ill patient may not be available during regular clinic visits leading to non-adherence and relapse.

1.7 When visiting a PHC service, the mentally ill patient may feel stigmatized by both the community as well as the nurses.

1.8 Participants are dissatisfied with long queues and waiting periods.

1.9 Rural clinics do not initiate support groups or any specific projects focusing on the needs of mentally ill patients and their families

Figure 3.1: Mentally ill persons and their families' experiences related to how their health care needs were met in the rural mental health care services.

Mentally ill patients were admitted to either a secondary or tertiary health institution to be stabilized. Once they were stabilised; they were discharged to primary health care services in their communities where they were expected to get their medication and
continued care. According to Lund, Petersen, Kleintjies and Bhana (2012:403) several studies have reported that primary health care facilities and staff in the rural areas are not well equipped to address these needs. From the information gathered from the mentally ill participants and their families, it became evident that the rural PHC services still face significant challenges with respect to the provision of mental health care. All these concerns hindered quality service delivery to the communities in the rural areas.

**Sub-theme 1.1: When mentally ill persons experience a crisis there is no 24-hour service available to help the patients or family**

The participants stated that the clinics in the rural areas close at 16:00 on weekdays and do not open during weekends. This means that mentally ill persons can present problematic behaviour after 16.00 and during the night it becomes a serious problem as rural people are dependent on the clinics that refer the patients to the hospital. According to Uys and Middleton (2010:69), the community health service would be delivered from a community health centre or a community clinic serving a designated community. A community clinic renders a 40-hour per week service while a community health centre renders a full time service, that is, 24 hours a day, seven days a week. All clinics in rural areas function 40 hours of the week that is, they are opened from 08:00- 16:00 during the day (Uys and Middleton, 2010:69). Although mental illness usually takes time to develop, a crisis can be experienced at any time of the day or night and over weekends. The participants expressed a need for a 24-hour hour emergency service. The following quotes illustrate the problem:

“The clinic is closed during the night so we do not have a health service. I think it would be better if there is a 24 hour service for us for a situation that occurs overnight. At night there are no nurses in the clinic so we have to get transport to take us to the hospital which becomes very expensive” (Participant group1).

“As a mentally ill person and a member of the community, I think we need to have the clinic opened even at night and during weekends. You know, if somebody gets sick over the weekend and at night that is a problem because the clinic is closed” (participant group1).
Participants expressed a need for 24 hour service to cater for their emergency needs. In view of the above-mentioned experiences, a great need for health care services available on a 24 hour basis was expressed by the participants. Johnson and Thornicroft (1995) in Sallah and Clark (2005:305) conducted a survey on Crisis and Emergency service needs and stated that out of 87 services that were identified as providing an emergency service only 22 could be identified as offering a 24-hour service. However it is clear that even services that are established to provide a 24-hour service tend to operate at a much reduced level overnight and during weekends.

Sub-theme 1.2: The ambulance and police service were not helpful when patients needed access to mental health care services

The participants expressed that after 16:00 there are no emergency health care services in the rural areas to help them when help is needed. The participants expressed a need for emergency transport that is, access to ambulance services in case of crisis situations. Participants experience the public transport in the rural areas is inappropriate for mentally ill patients who may be psychotic and/or aggressive on the way to hospital. The participants shared the following experiences:

“When you call an ambulance from hospital many a time it does come immediately. I wish emergency help can be available to these people (mentally ill patients). We call an ambulance and it takes a long time to arrive or does not come at all. Sometimes I wish there could be an ambulance in the clinic nearby so that when one needs an ambulance we only call it from the clinic” (participant group 2).

“Ambulances do not want to come to our villages. They claim that our roads are bad. It becomes a problem really. I wish things could get right for us. The government must build this road for us” (Participant group1)

The participants stated that ambulances and police are not helpful especially in the event of an emergency. With no ambulance service, families are faced with the challenging task of bringing disturbed and agitated mentally ill persons for treatment using public transport which is for most an affordable means (Read, Adiibokah and Nyame, 2009:8). In view of the above-mentioned experiences it appears that the participants experienced a need for reliable transport in cases of emergency. They
indicated that ambulances are reluctant to go to their homes because of bad roads. One participant expressed a need that the government should supply clinics with ambulances so that they (participants) can access them from the clinic.

In terms of the Constitution of the Republic of South Africa (Act No 108 of 1996) access to emergency medical services is a right. The aim of Health Care 2010 for emergency medical services (DOH-Western Cape Government: 2011) was to determine the requirement for emergency medical service which include the following components: ambulance services, rescue services, aero-medical service, planned patient transport and a specialized communication service. When a call for emergency medical service is registered with the communication centre the appropriate service must be dispatched. The intention was that all communities must have access to emergency medical services within the response time target. The ambulance services were distributed across the province but the response times in the rural districts were not good. The services were under pressure to meet the demands in the Metro (DOH-Western Cape Government: 2011). One participant shared this experience:

“My son had a bad experience being taken off in a police van as a criminal meanwhile he is sick. The police officer actually handcuffed his feet together as well as his hands while he is in the police van” (participant group 2).

“Ambulance or police take time to come when they are called and they always complain of bad rural roads which make them not to be keen to come to the villages. Sometimes when you call the police they do not come at all and you are told that they do not have a vehicle in the police station” (Participant group 2).

“When you call the police, they take about five hours to arrive and sometimes you are told that they do not have a vehicle. One is to hire a vehicle from a community member which is quite expensive. They say it is a special trip” (Participant group 1).

The family members of mentally ill patients stated they were often dependent on PHC nurses regarding how they deal with crisis. If assistance was unavailable, they resorted to help from the police when their mentally ill relative’s behaviour started becoming disruptive or aggressive. Although it hurt them to see their relative being taken away in a police van not having committed any crime, participants felt that resorting to police
help saved their mentally ill relatives. The study conducted by Kolwapi (2009:69) revealed that police did not have generic knowledge about mental illness and the handling of mentally ill patients. There seemed to be a need among police for education and training to prepare them for working with mentally ill people and to understand mental illness. A lack of knowledge and skills may result in police not understanding the behaviours of mentally ill patients when they were called to help during crisis situations at the homes of mentally ill persons. Kolwapi further stated that all participants believed that lack of knowledge made it difficult for them to manage mentally ill persons. In the study it was further explained that police unanimously linked their incompetence in handling mentally ill persons to lack of knowledge and skills. The findings further indicated that the police officers were partially aware of the Mental Health Care Act (Act No 17 of 2002) and Section 40 of the Act which involves them directly in the management of mentally ill persons. However their awareness did not make them better equipped for handling mentally ill persons as they did not have the knowledge and skills needed (Kolwapi, 2009:69).

Section 40 of the Mental Health Care Act (2002), deals with the role of members of South African Police Service (SAPS) with regard to mentally ill people. It explains that if a member of the SAPS has reason from personal observation or from the information obtained from a mental health care practitioner that a person, due to his or her mental illness, is likely to inflict serious harm on himself or herself, the SAPS member must apprehend the person and take the person to an appropriate health establishment for assessment of the mental status of the person and hand the person over into the custody of the head of the health establishment (Mental Health Care Act No 17 of 2002). In the literature studied, other researchers studying the involvement of police in the care of the mentally ill person reported similar findings (Moore, 2006 and Sanchez and Fay, 2005, as cited in Kolwapi, 2009: 25).

The government’s failure to ensure accountability for security forces’ (SAPS) violation of human rights remains a very serious problem with regard to the handling of mentally ill persons. In terms of the Constitution of the Republic of South Africa Amendment Act 1996 (Act No 108 of 1996) and the South African Police Strategic Plan (South African Police Service Strategic Plan 2004 B, 2007), one of the objectives of the SAPS is to maintain public order yet lack of personnel, professional misconduct and discipline
problems in the police is rampant as evidenced by the use of excessive force against mentally ill persons by police officers.

Sub-theme1.3: Mental health information given to mentally ill persons and their families was inadequate.

Health education is an active process that is, education directed at changing people’s attitude and influencing their behaviour in health related matters (de Haan, 2010:32). Mental health education is cited as a priority activity for nurses to reduce stigma and improve the lives of the mentally ill. However a shortage of staff prevents mental health education from happening. According to de Haan (2011:32), the process of good health education programmes is to communicate with people and give them information they specifically need to be able to attain good health. The role of the nurse in health education is to motivate the community to participate in improving its health status (Vlok, 2010:225). The participants expressed that inadequate health education was provided to mentally ill patients and their families about mental illness. Information about mental illness was highlighted as important by several participants in this study. They described difficulties in getting information about what it means to have a mental illness. The participants indicated that there was inadequate health education given to them regarding their treatment, mental health problems and what to do when a patient relapsed. The participants shared their experiences as follows:

“I would have liked the information about her mental illness and some guidance on what the family should do when she becomes ill. The nurses do not give us enough information about mental illness. Education and communication from nurses to us as family members is important. It does not only lessen the family problems but also makes us better. No information was given to me by nurses and doctors except the interviews that they normally conduct when somebody reports illness. I do not know whether I can say nurses do not care because they do not give us the needed information about our family members who are mentally ill” (Participant group 2).

Participants stressed how important it was to them to receive information about mental illness. They felt they lacked information about what it is really like to have mental illness and asked for more information about their illness. Participants described experiencing a lack of information about the support activities available.
“As family members we need to have information at hand so that we know how to handle a mentally ill relative appropriately, should a need arise. We were not given instruction. For the first few months I did not know how to interact with her anymore. I did not know about mentally illness because I had never seen anybody in the family suffering from mentally illness. The family members become trapped with little or no information to help to handle the situation. I would have loved to know the causes of her illness and how to handle her at home. Right now I am not sure about the causes of her mental illness; I am just in the dark. I do not go through a day without questioning what is happening” (Participant group 2)

Participants who were mentally ill also spoke about the positive experiences of having been given health education with other groups of patients that are not mentally ill. Therefore, they were informed about other health issues that also affect them as mentally ill persons. Some of the participants (family members) were very specific regarding the information that is required in order for them to care for their family members who are mentally ill. One participant shared the following positive experience in this regard:

“Nurses educate us about treatment. They explain to us, about whatever we do not understand and educate us on other things like HIV/AIDS, rape and so on” (Participant group 1).

According to the study conducted in the Roma Valley in Lesotho by Obioha and Molale (2011:79) there are problems in relation to the aspects of health education linked to the fact that many people, when invited for awareness campaigns, do not attend in large numbers to get health education. They (nurses) decided that regular mental health education must also be conducted in the community events and gatherings to educate the families at large about the nature of mental illness and the need for sustained treatment (Sariah, 2012:32). According to Shankar and Muthuswamy (2007:305), their study revealed that there is a need for mentally ill patients and their families, in fact for the entire rural community, to be educated about mental illness, the symptoms and medication. Hatonen, Kuosmanen, Malkavaara and Valimaki (2008), in Gummo and Bergman (2011:4-7) have studied patients’ perceptions of the information provided in patient education programmes and concluded that patients frequently asked for
information about their mental illness, especially about treatment plans and various alternative treatments. They found that health professionals failed to provide information to the patients because they took it for granted that the patients already had knowledge about their mental illness, while patients for their part, felt they lacked sufficient knowledge about their illness in order to ask the right questions leading to the desired information (Gummo and Bergman, 2011:4-7).

**Sub-theme1.4: When the mentally ill patients needed to be referred from rural areas to inter-professional team member, the service could only be accessed in large metropolitan areas.**

Referral means that you transfer responsibility for the patient’s care to another institution or person (Uys and Middleton, 2004:70). The purpose of a referral to another organization or provider is to ensure that appropriate and timely information is communicated so that the patient’s needs are met and that care is coordinated effectively. Although it may occur within a primary care team it usually involves referral to a specialist at PHC level of care. An example of referral within the PHC level would be to a psychologist for psychotherapy or to an in-patient unit at a district level. Referral may also be made to services in other sectors, for example social or employment services, for assistance necessary to support recovery. In each example responsibility for some aspect of care may be retained by the referring PHC nurse for monitoring adherence and response to psychotropic medication. Referral is an essential component of care that requires resources at PHC level such as knowledge of resources to which referral can be made and their referral procedures (Lazarus and Freeman, 2009:18).

The PHC nurses referred persons with mental illness to the nearest district hospital. The participants revealed that there were no doctors in the rural clinics to take care of their health needs. These mentally ill persons would remain at home until relapses occur due to non-adherence. The participants revealed that the mentally ill persons were referred to a doctor or psychiatrist who is based either at Komani or Glen Grey hospitals and again to other clinics to access health care. The participants indicated that they experience referral to hospital or any other services as costly. The above information from the participants was confirmed by the following quotes:
“There is no doctor in this clinic; we are being referred to Komani Hospital if we have to see a doctor for maybe reassessment” (Participant group 1).

“A strong support team is necessary and I am not referring to the nurses only. I am referring to the social workers and doctors too. They are all supposed to be helping individuals in the process of mental illness. I feel they do not support us as the family. I think I need help” (Participant group 2).

“There is no doctor and no social workers in this clinic. We need to have them visiting at least once a month so that we do not go to hospital as travelling to hospital is expensive and you have to wake up early and stay the whole day in hospital and come back late” (Participant group 1).

One participant suggested that he/she will not mind paying a small fee. The following quote illustrate this:

“I think we need the doctor. If there can be a doctor visiting the clinic on monthly basis, even if we pay a small fee like in the hospital because in the hospital, services are not free as in the clinic. I can be happy so that we are not always referred to the hospital. Going to hospital is very expensive for us and it is not easy” (Participant group 1).

The findings from the data collected revealed that mentally ill persons are referred to the hospital for further mental status assessment or reviews and treatment. It transpired that all the rural clinics in Emalahleni LSA are not visited by doctors or any other member of the multi professional team. Referral back to PHC services is also facilitated as mentally ill persons become stabilised and their routine care can be delegated back to PHC services closer to home. This formalised referral system will contribute in ensuring medication compliance and treatment (Reddhi, 2008:119).

Sub-theme 1.5: Family members were not included in the treatment plan of their mentally ill relatives.

Promoting family inclusive practices recognizes the need to support and work in partnership with families. Family inclusion focuses on meeting the needs of the mentally ill persons within the context of their ability and opportunities to change (Mental Health Commission, Wellington 2009:9). Families are often unprepared for the
demands of taking care of a person who has a mental illness. They often feel scared, disempowered and isolated. At the same time, most families want to help the mentally ill family member but lack the resources and may need help. A family inclusive practice recognizes that family members may need practical and emotional support. (Mental Health Commission, Wellington, 2009:9). One participant had this to say:

“The service that we are getting is inadequate because there is no programme to provide to families to be involved in the treatment plan of their mentally ill family members. There is a long way to go before the nurses and doctors start including the family. This becomes painful to us, here at home” (Participant group 2)

The families indicated that they lack understanding regarding the mentally ill person’s unacceptable behaviour. They therefore needed information regarding mental illness. This study showed that mentally ill persons remain a responsibility for their families who have to support them and monitor their treatment adherence. Sometimes families offer support to their mentally ill relatives without being exposed to any teaching about the provision of proper support. Families expressed the wish to be empowered with knowledge and skills to provide care and support for their mentally ill relatives.

Family inclusion means that families are involved in planning, developing and delivering mental health services to mentally ill patients and their families rather than simply receiving them (Fitzgerald and Gayler, 2007:11). In their study they further reported that the implementation of family inclusion strategy improves family information while support services increase family involvement in the assessment and treatment process and raise staff awareness and skill in working with families.

The presence of mental illness in the family may result in the family experiencing an enormous, overwhelming burden. The findings show that families were dissatisfied with their level of involvement in their mentally ill relatives’ treatment and felt left out of the treatment process. Similarly Murray Swank et al. (2007, in Molefi, 2009:44) say that there have been consistent reports from family members whose relatives have severe mental illness that their need for information and support are rarely met in order for them to help their mentally ill relatives. The authors further stated that family members
often feel frustrated about not knowing where to find help in coping with mental illness of a relative (Molefi, 2009:44). This is illustrated by the following quote:

“It is a heavy responsibility because as a mother you feel that it is your role to look after your child. I felt drained physically and mentally. The stress that this causes to me is too much. It is very hard” (Participant group 2)

The family also mentioned that they developed an understanding and acceptance of the person’s mental illness as they gained experience through caring for this person over a long period of time. They gained understanding through acceptance of mental illness and by being empathetic towards the mentally ill person. Family adaptation and functioning are important concepts that help in understanding the family’s effort to manage the situations created by severe mental illness. Family adaptation consists of a positive change and a successful balance among persons with mental illness, family members and a community level of functioning. Severe mental illnesses affect all aspects of family functioning and all family relationships and roles are altered, sometimes permanently. These alterations include finances, employment, social life, physical health and family relationships (Saunders, 2003:178-189).

“I think the only thing I need to do is to accept the situation by being close to my husband. He has changed now from being our breadwinner and giving us all the support to now being on the edge of mental illness” (Participant group 2).

To accept the mentally ill person is seen as part of emotional support to the person. This means listening to the mentally ill person without being judgmental. Participants identified several benefits for family inclusion in mental health services including creating a better understanding of mental illness that in turn leads to improved treatment adherence and improved overall well-being. The patients are only given instruction on how to take the medication. The following quotations illustrate the need for family inclusion in mental health care services:

“There is little recognition given to family. They (nurses) always say they are busy. As a family member I feel that nurses are not willing to work with us in the treatment of our daughter. I sometimes accompany her to the clinic or hospital and I am still not recognized as a resource person when they are planning her treatment. I would like
that nurses should have worked with me from the beginning. I would have liked the information about illness and some guidance on what the family need to do when she becomes ill."

“We were not given information. For the first few months I did not know how to interact with her anymore. It was just like a foreigner has come to my house and we could not communicate with her as we used to anymore.”

“I had not been informed of my brothers progress while in hospital or be informed by nurses if there is something that we can do as a family to help my brother to get better. How can I help him? I do not know what is going on” (Participant group 2).

Participants said that PHC nurses often did not listen to what they have to say, rarely asked for their opinion and did not involve them in decisions about on-going treatment and care of their mentally ill relative. Family members felt very anxious when PHC nurses did not tell them what was going on with the mentally ill person. Participants indicated a need to be taught how to handle mentally ill patients when they become difficult and not to react in a manner that will agitate the mentally ill patient further. They should also be educated on how to handle the mentally ill patient in the event that they begin to display aggressive behaviour. It is also important for the family to have an understanding of mental illness.

Another important issue is to include families in the pre-discharge programme of their relatives who are mentally ill (Reddhi, 2008:119). The pre-discharge programme prepares the persons living with SPMI admitted to the hospital for discharge back to the community. The family indicated that the effects of being caregivers to mentally ill persons, though sometimes positive, are generally negative with a high rate of burden of psychological effects to the carer because of strain. Other factors include social isolation and financial hardships which are due to consultation, transport costs and personal care of the mentally ill persons.

Families offer support to their mentally ill relatives without being exposed to any information about the provision of proper support to them. In their study, Modiba, Schneider, Porteus and Gunnarson (2002:189) reported that there was considerable evidence of limited understanding of mental illness with service users and caregivers.
Almost all families of mentally ill persons attended the mental health service but when they were asked to explain further, most displayed little knowledge of mental illness. Family members were keen to know about the diagnosis and what the future holds but such specific information was not available.

Family inclusion means that families are involved in planning, developing and delivering of mental health services to mentally ill patients and their families rather than simply receiving them (Fitzgerald and Gayler, 2007:11). Some of the families of mentally ill persons left their employment to take care of their mentally ill relatives. Glynn, Cohen, Dixon and Niv (2006), as cited by Fitzgerald and Gayler, (2007:11), suggested that while family inclusion can be helpful in reducing family stress and burden, there are a number of common features which are positive. These features include showing empathy for all the family members, enhancing the knowledge level of caregivers and teaching communication skills to family members. They also believe that many of the underlying principles of family inclusion in the treatment plan of mentally ill persons are consistent with community based teaching, emphasizing personal health, goals, instilling hope and enhancing social support.

The positive effect that motivates the family members as care-givers are a sense of love, spiritual fulfilment, a sense of duty, guilt, social pressures or greed where a family member would want to use the social grant of a mentally ill person (Brodaty and Donkin, 2009:217-228). The family also indicated that they are faced with many obstacles such as balancing care-giving of the mentally ill person with other demands including child rearing, careers and relationships.

They further explain that the effects of care-giving to a mentally ill person are diverse and complex and there are many other factors that may exacerbate how they feel and react as a result of their role. Brodaty and Donkin (2009:217-228) reported that caring for a mentally ill person is more stressful than caring for a person with a physical disability. Since family members often lack social contact and support, sometimes they tend to sacrifice their leisure and hobbies. This is expressed in the following quotes:

“My hands are full and I have never been able to socialize with friends. I really think I have done the best I can do and I am getting old and cannot do much. I worry about
the future of my other children. I have never taken any holiday because I see my role as an extended one” (Participant group 2).

It was evident from the findings that mentally ill persons were a burden of care to their families as most participants still lived with their families. The mentally ill persons were dependent on their families for financial assistance, support, medication, compliance to medication and daily activities of living. They stated that family inclusion in the treatment plan of the mentally ill persons could help to alleviate the perceived burden. The study indicated that lack of education and skills was a barrier to quality caregiving of mentally ill persons at community level. The findings in this study suggest the need for family members of mentally ill person to be given information about mental illness which emphasises that they also need to be equipped with skills aimed at the interaction with mentally ill persons who display bizarre behaviour at times.

Participants expressed that they lack knowledge about mental illness and often do not understand the behaviour of mentally ill family members. Participants asserted that lack of knowledge prevents them from managing these patients at home. They also explained that they were not able to cope with mental illness. Participants also felt that they do not receive the necessary support from the nurses. Pitshel- Waltz, Leucht, Bauml, Kissing and Engel (2004), as cited in Fitzgerald and Gayler (2007:11) found that relapses could be reduced by up to twenty percent if family members are included in the treatment plan of the mentally ill patients.

Eventually most family members begin the process of coming to terms with mentally ill person. It involves accepting the mentally ill person’s mental illness and the need to be there, to be accessible to them. This at times entails mourning the loss of the previous relationship between the family member and the mentally ill person. This is supported by the following quote:

“It is hard to accept yourself as being mentally ill when that is the kind of picture that people draw of you. They (mentally ill patients) are looking for a little bit of acceptance and when they are mentally ill they get just the opposite” (Participant group 2).

In view of the above discussion, this problem of the relationship necessitates family members accepting their situation and coming to terms with the role change from a
parent, spouse or partner to that of a caregiver. McCann, Lubman and Clark (2011:381-388) reported that implicit in this role change is the acceptance that the mental illness is not a temporary phenomenon but necessitates long term role change, for example from being a mother to becoming a caregiver. The findings indicated that families living with a severely mentally ill person face numerous issues associated with their family members. These issues include exhibiting behavioural mental illness which influences a family’s ability to function.

In summary the literature on families experiencing severe mental illness provided evidence that mental illness creates a burden and distress for families. Family stress can involve a change in family functioning. Mental health professionals need to work hand in hand with families of mentally ill persons in the care of a family member who is mentally ill. (Saunders, 2003:186-187).

**Sub-theme 1.6: The specific pharmaceuticals that had been prescribed for mentally ill patients may not be available during regular clinic visit leading to non-adherence and relapse**

Access to psychotropic medication is a major challenge for integrating mental health into PHC. Problems sometimes occur in supplying and distributing these medications directly to PHC facilities due to restrictions in who is able to prescribe and dispense these medicines. Psychotropic medicines were previously delivered to the psychiatric hospital responsible for treating the people with mental illness. Integrating mental health into PHC required redirecting the supply of psychotropic medicines to PHC facilities.

In some countries nurses and even general physicians are not permitted to prescribe psychotropic medication. In Brazil and Saudi Arabia, PHC physicians are required to prescribe psychotropic medication (WHO and Wonca, 2008:164-165. In Uganda, PHC nurses are permitted to prescribe psychotropic medication on the recommendation of a mental health professional (WHO and Wonca, 2008:164-165). In South Africa a new law has been passed that will allow PHC nurses who complete training to prescribe psychotropic medication (WHO and Wonca, 2008:164-165).
The participants stated that there is a problem of unavailability of medication. Participants gave the example that while they are in the queue; medication would be finished, meaning that those who came first or early may get prescribed medications. The non-availability of medication for mental illness is a factor that discourages access to health care services. Without a regular supply of medication to the patient, mental illness is cannot be stabilized because their medication is the most important resource for stabilization of mental illness.

Medication is reported as not being available at times and some participants attributed this to free services. Non-availability of medicines forces people to go to other clinics or to the local hospital where they can get their prescribed treatment. Non-adherence to medication regimens was indicated by all the participants who revealed that they have difficulty taking their medication regularly. The reason for non-adherence is attributed to non-availability of medication supplies from rural clinics and some participants had a history of having relapsed and being admitted due to the non-availability of their treatment. Noncompliance with a treatment regimen was one of the reasons for these relapses. It appears that non-adherence issues in the mentally ill person may be associated with the unavailability of prescribed anti-psychotic drugs from the clinics.

**Treatment resistance in schizophrenia**

The main goal of treatment in patients with mental illness is usually to restore a state of psychological wellness and high functioning. Although many mentally ill persons do improve with adequate psychotropic treatment, a significant proportion fails to reach acceptable levels of functioning and well-being. The most simplistic dysfunction of treatment resistance is the failure to achieve and sustain adequate treatment effect (Mahamba, 2010:25-26). The term *resistance to treatment* is used to define patients failing to respond to a standard form of treatment.

In mental health theory the term “treatment resistance” should apply to mental illness that is not resolved after anti-psychotic treatment in adequate doses and for a time sufficient to allow for a response. The answer to what constitutes an adequate treatment trial however depends on what specific expectations for treatment outcome are appropriate (Fava and Davidson 1996, in Mahamba, 2010:25).
In the study conducted by Mahamba (2010:25) it is stated that there are factors with poorer outcomes in people with schizophrenia that may be relevant when considering treatment resistance. These include an increased number of episodes of psychosis, poor treatment adherence, side-effects of medication and substance abuse. According to Jones and Castle (2006:18, in Mahamba, 2010:25) Clozapine is the best anti-psychotic medication for treating schizophrenia. Second generation anti-psychotic drugs namely Clozapine and Risperidone have fewer side-effects. Other potential benefits of Clozapine include the reduction in aggressive and suicidal behaviours.

Adherence or compliance to the treatment regime is an important part of the successful treatment of chronic disease and prevention of complications. Mental illness medication must be taken by persons living with SPMI as prescribed every day for the remainder of the patient’s life. Failure to keep to the determined regime will usually result in relapse. Non-adherence, when an Person living with SPMI does not take their prescribed medication, is often the cause of relapse and readmission to hospital. Adherence to the anti-psychotic medication regimen has been claimed as the most important factor in preventing re-admission. Causes of non-adherence are related to issues such as drug side-effects, where the anti-psychotic medication may have an adverse impact on the person’s quality of life and may even cause more distress than the symptoms of illness.

Sometimes people stop taking their medication and because they do not relapse immediately thus they fail to see the connection between the medications and their health (Elder et.al, 2009:47-468). The non-adherence to medication regimes instituted in people with mental illness is common. The reasons for non-adherence to psychotropic drugs and other chronic agents are complex and multiple. They include the following:
In this study, non-adherence was due to non-availability of medication from PHC services. Psycho-pharmaceuticals largely used to treat mental illness cause many adverse reactions, adding the problem of disability to be faced by the individuals and resulting in non-adherence by mentally ill patients. Against such a backdrop, many mentally ill persons choose not to adhere to their treatment programme. Some health professionals treat mentally ill persons in an authoritarian and paternalistic way so cooperation between the patient and the clinicians is not maintained (Elder et.al, 2009:261).

Li and Arthur (2005:343, in Mahamba, 2010:25) compared the relapse and adherence after discharge amongst patients who did adhere to treatment regimen and those who did not adhere. Nine months after discharge the relapse rate among the patients who did not adhere to the prescribed treatment was higher than among those who did adhere. This indicated that lack of adherence to psychotropic drugs may be a profound problem that hinders recovery. Participants (PHC nurses) indicated that the shortage of psycho-pharmaceutical supplies compromises the quality of mental patient care. Participants stated that there are insufficient anti-psychotic drugs available in rural PHC health centres. This is supported by previous researchers, namely Kazadi, Moosa and Jeenah (2008), in Saria (2012:43), who also identified that non-adherence to
medication, appears to be one of the factors most likely to increase the risk of relapse. In the study by Liu-Seifeit et al., (2010), in Sariah (2012:43) the majority of patients admitted to the mental hospital have been linked to non-compliance. The participants expressed their experiences:

“That is why I say government should try by all means that medication is available at all times at the clinic. Also nurses to order medication regularly and in time. I have to fight with nurses that they do not have enough medication for my son. I wish he can get his treatment because it takes a long time for the treatment to be available. Sometimes we go to the clinic and we are told that his treatment is not available or we get only one type of tablets and we are told that other tablets are out of stock” (Participant group 2).

“The problem of the clinic is that there is usually no medication and we do not get them regularly and that is why we use the other clinic that is on the other side of the village. I feel this clinic has been neglected by the government because really there is always no medication in this clinic not only for us (mentally ill patients) but for everybody who is getting medication here” (Participant group 1).

While nurses understand that basic psychotropic drugs must be available at primary and secondary care levels in an integrated health care system, it was noted that second generation psychotropic drugs are seldom available at the health facilities in the district. This illustrates the need for the district health management to ensure that sufficient funds are allocated to purchase the basic essential psychotropic medicines and also to make sure that they are always available in the primary rural care setting in accordance with the adopted policy (Nguyeni and Manzana, 2004:14). These authors further stated that even if all the clients suffering from a mental disorder were willing to come in for assessment and treatment, the health care system would not be able to provide for all their needs. Even patients on Modecate injections which need only be taken once a month have trouble getting their treatment on a regular basis. The most shocking cause of defaulting on treatment is the unavailability of the drugs from the PHC services, Fluphenazine and Chlorpromazine have been out of stock for the most of the year. Patients who came seeking treatment had to be turned away without their medication (Nguyeni and Manzana 2004:115).
The WHO (2001) recommended that basic psychotropic drugs must be available at PHC and secondary levels. The treatment gap is high for most mental disorders in Europe. Governments need to ensure that money is allocated for the purchase of the basic essential psychotropic medicines and to make sure they are available in PHC settings. Psycho-pharmaceuticals may be purchased under generic names from non-profit organizations, allowing the access to drugs of good quality at low prices (WHO: 2001). This is further supported by Reddhi (2008:80) who emphasised that there is much focus in the literature on the patient as the one to blame for non-compliance in one way or another but that there has been little focus on the health system as a possible cause of non-adherence. The findings from the interviews suggest that the clinics run out of stock of pharmaceuticals quite a number of times. In view of the above, inadequate medication supplies at these clinics are seen as a problem that is embedded in the governance system. This problem is beyond the scope of control of nurses and as such the nurses are also seen as frustrated.

**Sub-theme 1.7: When visiting a PHC service, the mentally ill patients may feel stigmatised by both the community as well as the nurses**

Stigmatisation is a process of labelling or branding or a process that appears to justify being labelled or branded or singled out (Kristie and Leech, 2006:68). The stigmatisation of mental illness makes it difficult for persons living with SPMI to cope and accept the condition resulting in the persons living with SPMI isolating them. Mnisi (2011:26) identified three theoretical frameworks that attempt to explain the prominence of the stigma namely:

- The sociocultural perspective which holds that stigmatising attitudes may lead to discrimination against people with mental illness. For example, the Person living with SPMI is less likely to be leased an apartment due to their mental instability.
- Some people may think that being admitted to a mental hospital is a sign of personal failure in the sense that the patient can longer cope on his/her own.
- Social-cognitive theories which regard stigma as the product of the human knowledge structure.
From a social-cognitive perspective, a person with mental illness signals to the public that he/she is mentally ill. These signals are related to stereotypes about the person with mental illness as crazy or dangerous. Stereotyping then leads to discrimination (Mnisi, 2010:26). Regardless of the diagnosis of the patient any kind of mental illness has profound social implications for both the mentally ill persons and their families. As such it is important for the family to be supportive of those who are affected and not discriminate against or reject them (Mnisi, 2010:27).

**Stigma and mental health**

The stigma of mental illness pervades all aspects of the community including health care system. Severe mental illness often robs people of the characteristics that otherwise we find most endearing. One issue in the reduced access to PHC for persons leaving with SPMI is the way that some health care providers regard persons living with SPMI as being difficult or disruptive, attributing abnormal behaviours as individual characteristics rather than one of the symptoms of mental illness (Lawrence and Kisley, 2010:64). The impact of stigma on persons living with SPMI and their families has come to mean any attribute, trait or disorder that marks an individual as being unacceptably different from normal people with whom he/she interacts (Thornicroft, 2006:170). According to Thornicroft (2006:170), there are three different types of stigma that can be identified: stereotypes, prejudice and discrimination (Thornicroft, 2006:170):

- **Stereotypes** can be described as a process of generalising from overt physical characteristics and non-observable characteristics. For example, an HIV/AIDS infected person is perceived as having a set of assumed traits, for instance being irresponsible or reckless. Stereotypes deal with beliefs we may hold about people.

- **Prejudice** can be described as the unwarranted negative attitudes of people based on their own beliefs and preoccupations. Prejudice deals with attitudes on these beliefs.

- **Discrimination** may be a consequence of prejudice which is basically a cognitive and affective response, which often results in unfair treatment. Discrimination is a set of behaviours which may follow from stereotypes and prejudice. In this study the persons living with SPMI and their families are exposed to stigma
based on all types of stigmatisation as confirmed by their quotes and supported by literature from other researchers.

At a community level, stigma may affect how an organization, including social development services, employers, health care providers and schools, responds to people with mental illness and their families. At an individual level, stigma creates changes in identity and changes the way in which they are perceived by others (Molefi, 2008:37).

**Stigma to the family**

Stigma also affects the families of people with mental illness because of their association with the persons with mental illness. Scheffer (2003:4, in Molefi, 2008:38) asserts that it is common for families of mentally ill persons to feel stigma by association resulting in discriminatory and prejudicial behaviours towards them. Hendrickson, Schmal and Eklebery in Molefi (2008:38) reiterated that when the family feels rejected by friends and extended family members or isolated and inadequate, they experience hopelessness as a result of being stigmatised. The family distress may lead to powerlessness.

**Stigma and employment**

People with mental illness are less likely to be employed because of the stigma associated with mental illness. For example, members of the public are less likely to employ people who are labelled mentally ill. Scheffer (2003 in Molefi, 2008:41) mentioned a survey carried out regarding employment and mental illness. The survey “Consumer Experience with Stigma” focused on the experience of individual information about discrimination in the workplace that impedes the stigmatised individuals from reaping their full professional and personal potential. In this survey, Scheffer (2003) explained that seven out of ten said that they encountered negative reception when their mental illness was revealed. People treated them with as incompetent regardless of the skills set that they possessed.

It is evident from the findings of this study that some of the mentally ill persons were reluctant to attend social gatherings due to stigma and discrimination from the
community. People with mental illness still face discrimination in their daily lives, both from outside and within the health system. Mentally ill persons encounter discrimination in the form of reduced work and social opportunities. This means that people with mental illness experience a fundamental violation of their basic right to care as instituted by the state. This calls for a human rights approach to bridge the mental health gap in South Africa (Burns, 2011:107).

Stigma towards adults with mental illness is longstanding and is a widespread phenomenon. Stigma is the cause of discrimination and exclusion. The Mental Health Care Act of 2002 (Act No 17 of 2002) forbids unfair discrimination against a mental health care user on the grounds of his or her mental health status. Involving mentally ill patients in planning the delivery of services and increasing contact between mentally ill patients and community members is effective in reducing stigma (Lund, Petersen, Kleintjies and Bhana, 2012:404).

The participants in the study had problems socialising with people living in their social environment. Stigma affects people’s self-esteem, helps to disrupt their family relationships and limits their ability to socialise. Inability to sustain relationships was one of the problems experienced by mentally ill persons. It is evident from this study that the inability to sustain relationships had an impact on family life as some mentally ill persons felt their relationships were strained. It contributes to disrupted family relationships and affects their ability to become employed.

The importance of relationships cannot be underestimated even for mentally healthy persons. Problems with family relationships are nothing new because of expectations and a lack of understanding. Patients and their families revealed a considerable experience of stigma from the community, often resulting in feelings of sadness. This was attributed to the stigma attached to mental illness. The findings reflected that in the community, mentally ill persons are deprived of opportunities to socialise with community members. Awareness campaigns must be conducted on a wide scale to eradicate the stigma that is associated with mental illness.

“As mentally ill patients, we are not given a chance to talk in the meetings. I think because we are mentally ill, people think we cannot make sense. Even in the clinic the
service is good for those who are not mentally ill because the nurses and patients say mentally ill patients are full of nonsense and think that we will beat them up” (Participant group 1).

“You know what worries me most is that some people are still judgmental and that does not help. That is not supportive. He had wonderful friends and family members but they cannot deal with mental illness alone. It is very hard to help me, I mean to come and visit for a friendly talk with him” (Participant group 2).

“I wish nurses treat them (mentally ill persons) like everybody else or treat them first because people become uncomfortable around them” (Participant group 2).

In view of the above it is evident that stigma is a major problem experienced by mentally ill persons. They further assert that the issue of stigma often affects both the mentally ill person and their family members. This is supported by Lund and Flisher (2012:404) who stated that stigma and discrimination against people living with mental illness is widespread. Even when family members of mentally ill patients have the knowledge to deal with mental illness, the family is often reluctant to discuss their family members with others because of the associated stigma. The result of the stigma attached to mental illness is that the family and the mentally ill patients become withdrawn and isolated (Mental Illness Info Pack: July 2011:2). According to Mkhize and Kometsi (2008:106-107) family and community members are not well informed about mental illness and stigmatisation continues.

Unfortunately stigma towards people with mental illness originates not only from the community but also from the PHC nurses (Smith, 2011:1). Kapungwe, Cooper, Mayeya, Mwanza, Mwape, Sikwese and Lund (2011:290-297) indicated that there is widespread stigmatising and discriminatory attitudes from nurses in Zambia. They further stated that there are a high proportion of general nurses who expressed discomfort when dealing with people with mental illness. This has negative implications for efforts aimed at integrating mental health with PHC, given the fact that this group constitutes the front line of staff in the delivery of mental health care in PHC services.
They also cited that stigma and discrimination towards mentally ill people has negative implications for the prevention and treatment of mental disorders as well as for the quality of life of those suffering from mental illness. Even though there has been an integration of mental care services into PHC, stigmatisation of these patients is very much alive and health care workers themselves promote this (Reddhi, 2008:119). According to the WHO report (2005) the widespread stigma attached to mental health problems jeopardizes implementation of mental health services. The participants confirmed this by the following quotes:

“I also wish that nurses give him love and care because sometimes he becomes reluctant to go to the clinic stating that nurses are silly, they are shouting at him. That is a problem to us as a family.” (Participant group 2)

Nurses at times also shout at them to say they are dirty. It is not easy for us to wash these people. They are very stubborn. Sometimes they are not keen to wash and it becomes a fight when you say they must wash. Another thing here in the clinic nurses do not quite care for them (mentally ill patients) sometimes they do not listen to them because they think that they do not make sense. My daughter does not like that, she always complain that people do not listen to them as if what they say does not make sense. This is painful.” (Participant group 2)

There is evidence that stigma and discrimination can have adverse effects on a mentally ill patient's willingness to access appropriate care and adhere to treatment (Kapungwe et.al, 2011:290-297). Makhele and Mulundzi (2012:104-112) reported that in their study participants revealed that because of the stigma attached to mental illness people believed that patients should be kept at home and be nursed secretly. They further stated that according to the Ubuntu philosophy, people are best taken care of at home. This philosophy was applicable to people with all types of diseases including mental illness.

The South African Federation for Mental Health has noted that stigma and discrimination towards persons with mental illness is still the greatest obstacle to the improvement of the lives of people with mental illness and their families. Mental illness is the least understood health problem in society and because of this many mentally
ill persons face stigma, prejudice and discrimination in their daily lives. Challenges associated with stigma also affect the family. Providing care for the mentally ill person may be a burdensome experience to many family members and stigma may make the experience even more difficult.

Stigma affects the family of people with mental illness purely because of their association with mental illness (Molefi 2009:39). Stigma and discrimination in any form is not acceptable. Stigma and discrimination is belittling and dangerous. Persons with mental illness become marginalised and this causes pain and distress to the mentally ill persons. A person with a mental illness experiences many forms of stigma and discrimination. They may be denied access to education, employment, accommodation, relationships, social dignity and adequate services (Mental Illness Info Pack, 2011:1).

Although mental health problems occur in almost every family at some point, people exposed to stigma and discrimination still experience fear and prejudice from others and are made to feel ashamed and excluded (WHO, 2005:41). The stigma and discrimination associated with having a mental illness are often so devastating that they prevent people from seeking help for fear of being labelled. Reducing stigma and discrimination requires a concerted effort by mentally ill persons, the family members, mental health professionals and the community at large (WHO, 2005:41).

**Sub-theme1.8: Participants are dissatisfied with long queues and waiting periods**

Participants expressed dissatisfaction with particular dimensions of time spent in long queues waiting to be examined. The problem is attributed to the shortage of staff. On the other hand some health facilities serve a very large population. Participants expressed their experiences with the following quotes:

“But this clinic serves all this big area even other villages come to this clinic for help so it is always full. So a person has to wake up early to go to the clinic because you have to be in a queue with other patients that are sick with other diseases like diabetes and hypertension and others, some have come for wound dressing and so on. This take a long time before a person gets help” (Participant group 1)
“There are times when you come to the clinic you get only one nurse and you are told that the other nurse is on holiday and the other one has attended a meeting that delays us in the sense that you have to be in the queue for a long time because this nurse is to help everybody in the queue not mentally ill patients only” (Participant group 1).

“When both sisters are here each patient takes about three hours waiting before you get help but if it is only one sister available you can take the whole day before you get help. You have to sit in a long queue with so many patients and the sisters will take a long time to help you. I think having more nurses will make things quick” (Participant group 1).

According to Ige and Nwachukwu (2010:22) in a survey done in Nigeria, it was reported that the participants expressed dissatisfaction with having to wait a long time for service. Furthermore waiting time has repeatedly been raised as the one element with which mental health care patients in the rural areas were dissatisfied. The survey showed that mentally ill patients who were dissatisfied were less likely to utilize the health facilities. Long queues hinder utilisation of the health service (Ige and Nwachukwu, 2010:22). Long queues were perceived as ineffective care and anticipated disrespectful treatment accounted for delayed care. These long queues were due to the belief that the mental illness was not serious enough to warrant immediate care and to be treated as urgent (Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersish, 2011:35). Petersen in his study revealed that it became obvious that having to wait in long queues contributed to defaulting (Petersen, 2011:38).

**Waiting time**

In the study done by Mashego and Peltzer (2005:19) it was reported that there was too much waiting time during which nurses took long breaks and lunchtimes. The PHC services are overwhelmed with long waiting times and long delays. Participants who experienced long waiting times had negative perceptions. Participants struggle with the length of time spent waiting in the clinic as cited below:

“Although sometimes you find that there is only one sister on duty in the clinic which makes us to wait for a long time before you are helped. I think government has to
employ more nurses for this clinic. Sometimes when you go to the clinic you have to stay the whole day” (Participant group 1)

As far as waiting time is concerned most patients in rural areas cannot give an accurate estimate of how much time they spent waiting at a facility, so waiting time was estimated directly by observing a sample of patients. The field researcher selected patients from the moment they took their seats in the waiting room up to the point when they got their medication at the dispensary or were referred home or to another facility. A stopwatch was used to estimate how long it took to receive service at a facility. This is found to be consistent with the waiting time reported recently of 54 minutes for rural health centres (MoH, 2007). A survey (as reported in the Equinet Discussion Paper, series 57) was conducted from September to December 2004 and reported an average waiting time of 55 minutes (Masiye, Chita, Chanda and Simeo, 2008:10).

Sub-theme 1.9: Rural clinics are not initiating support groups or any specific projects focusing on the needs of the mentally ill patients and their families.

Participants expressed the feeling of being bored, lonely and isolated. Almost all the participants reported that they do not attend support groups because there are no support groups in the rural areas or at the clinic. Such groups should be mobilized to offer assistance and care to the mentally ill persons (Mnisi, 2011:61). The mentally ill person needs to belong to a group of people for interaction. This can be achieved by encouraging them to be involved in group activities such as support groups, community projects and any other community activities. All of the participants were unemployed and most were not meaningfully occupied at home. The findings showed that due to lack of community resources, mentally ill persons were not occupied constructively so they became bored. Participants expressed this through the following quotes.

“I just stay at home with my mother doing nothing. I sometimes go to the events that are taking place in the community. On Sunday I attend my Zion church. I like the sound of the drums and I like to sing” (Participant group 1)
Support groups can play an important role in supporting both the mentally ill and the family member, as it enables them to cope with the burden of mental illness as identified above. Mentally ill patients as well as their families must be involved in support groups once their families have been diagnosed with mental illness. The support groups will be therapeutic and will assist in alleviating stress care-givers experience in caring for their relatives. The support groups will also facilitate the sharing of ideas and advice as well as coping mechanisms (Reddhi, 2008:118).

According to Uys (2010:54), a support group can play an important role in the community as there are few PHC nurses available to meet the needs of caregivers. Families must participate in support groups and mental health professionals must find alternative methods to ensure that families receive the necessary mental care services. Another participant had this to say:

“At home I just stay or look after my neighbour’s livestock just to keep busy and prevent boredom”. (Participant group 1)

In keeping with this, participants in this study could not benefit from community resources because these resources do not exist in their communities. In view of the above, there appears to be a need for community programmes that will also benefit the mentally ill. It is evident from this study that the mentally ill have to be provided with adequate community resources to meet their needs. The participants shared similar views about the need for projects whereby the mentally ill patients could engage in various activities such as gardening, handwork, involvement in support groups and other activities. Some of the participants reported that the information they would receive from the support group would help them manage their behaviours of the mental illness. The participants indicated that they experienced the following:

“The nurses did not tell us about support groups or any other resources such as programmes that can be available for my daughter. My daughter spends the whole day in bed doing nothing and has put on a lot of weight” (Participants group 2).

“I am just sitting at home, maybe watch TV or listen to the radio nothing else. So I am thinking about my health. I would like mentally ill people to be given a chance to do something to improve their lives and that of their families” (Participant group 1)
The participants reported that the support group is important as they received information. They indicated that if such activities were available, they would take part. This is supported by Mphelane (2006:29-30) who stated that the mentally ill and their families need to belong to a group for social interaction and to boost their level of self-esteem and self-worth. This can be achieved by encouraging them to be involved in group activities. It was further reported that the families of mentally ill persons also suffer social isolation.

According to Modiba, Schneider, Porteus and Gunnarson (2002:193) the participants in their study shared similar views about a need for a central place where people with mental illness could engage in various activities such as vegetable gardening, knitting, sport, sewing and handwork. Support groups have been shown to provide an effective means of reducing social isolation and enhancing social support by meeting the behavioural, cognitive, emotional and social needs of families providing care to a family member with severe and persistent mental illness (Saunders, 2003:185). Saunders, in her literature, provides strong evidence of the value of support groups as a key component of social support for families providing care for a family member who is mentally ill. This author further stated that a reduction in family burden as well as improved emotional well-being has been reported among families who belong to a support group when dealing with severe and persistent mental illness (Saunders, 2003:185-186).

3.4.2 SECTION TWO

3.4.2.1 DISCUSSION OF THEME TWO AND RELATED SUB-THEMES FOR GROUP THREE PARTICIPANTS

According to Dreyer, Hattingh and Lock (2005:6) the PHC nurses should be oriented to study and to understand the philosophical baseline of nursing as well as philosophy of health and health care. Without a philosophy it is impossible to provide quality community-based nursing care. The PHC nurse is involved in complex long-term personal interactions, direct practice and professional practice as well as political issues that directly affect the community. It is therefore important that the PHC nurse should have a sound philosophy of her own. This will enable her to support and help
families in their own environment and to resolve problems (Dreyer, Hattingh and Lock, 2005:8):

- The WHO (1948, in Pennill and Vasathevan, 2011) define health “as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity”. This is generally accepted as the core philosophical view of health. Most literature emphasises the fact that health encompasses the well-being of body, mind and spirit and the integration of a person with himself, society and the environment (Dreyer, Hattingh and Lock, 2005:8). This implies that the PHC nurse should provide holistic care for the persons living with SPMI and their families and the health care delivery should meet the health care needs of the persons living with SPMI as a whole. PHC practitioners believe that the attainment of optimal mental health care for persons living with SPMI is of great importance and that the following aspects are inherent in any philosophy for community-based health care delivery

- Health care delivery must be comprehensive to provide for the health care of persons living with SPMI and their families
- All members of the family must understand that their state of health is their responsibility
- PHC practitioners should assist persons living with SPMI and their families to take responsibility for their health
- The community as a whole must participate in disease prevention Themes and sub-themes of the experiences of PHC nurses relating to how they experience the rendering of mental health care services is presented below:
GROUP 3: PHC NURSES

THEME 2: The PHC nurses experience the integration of mental health care services into PHC as challenging

Sub-themes

2.1 In spite of a policy of a comprehensive approach, PHC nurses tend to focus on curative care.

2.2 Lack of managerial support to assist nurses hinders the functioning of rural PHC services.

2.3 Time constraints due to a high workload cause the PHC nurses to spend inadequate time with the patients.

2.4 Mentally ill patients who default on treatment or those who are home bound, are not visited at home due to staff shortage and transport constraints.

Figure 3.3: Themes and sub-themes of the experiences of PHC nurses.
THEME 2: THE PHC NURSES EXPERIENCE THE INTEGRATION OF MENTAL HEALTH CARE SERVICES INTO PHC AS CHALLENGING

According to de Haan (2011:23), a comprehensive approach is an integrated and coordinated approach of health care having promotive, preventive, curative and rehabilitative components. Mental health services should include all facilities and programmes that are required to meet the essential care needs of the mentally ill persons, including psychosocial rehabilitation. The services should work in an integrated manner and attempt to meet the social, psychological and medical health care needs of mentally ill persons (de Ameilda and Killaspy, 2011:4). In this study it became evident that the PHC nurses are faced with challenges in their comprehensive approach to health care delivery. The challenges that the participants are faced with are presented below. The participants expressed both positive and negative experiences towards a comprehensive approach to health care delivery. The positive experiences expressed are cited in the following quotes:

“We are combining the services comprehensively in which we are able to meet the patients’ needs and not only needs for mental illness but also other needs too whether socially or physical. I think they (community) are happy now that the clinic is comprehensive and offers a supermarket style of service” (Participant group 3).

The resources required to deliver mental health services including human resource and service facilities have been consistently shown to be inadequate in the rural clinics. The negative experiences expressed by participants are:

“The problem is that the clinics are short staffed it takes a lot of time for PHC nurses to handle all programmes comprehensively” (Participant group 3).

“…the clinic building is not suitable for running a comprehensive health service” (Participant group 3).

It is evident that the participants had ambivalent feelings. Ambivalence is described as having mixed feelings or contradictory ideas about something or someone. Ambivalence is the co-existence of two opposing impulses towards the same thing in the same person at the same time (Saddock & Saddock, 2007: 273). According to Uys
and Middleton (2010:829), ambivalence is a simultaneous conflicting feeling, attitudes or thoughts in a person towards another person, object or event.

It is envisaged that health care in the PHC system will take place at the district level. Mental health care users should be able to access all their health care needs in an integrated health care system at the level closest to them. In line with this understanding, South Africa’s White Paper on the Transformation of Health Systems (Notice of 1459 of 1997:15-17) endorsed the PHC within an integrated health care system at the district level. It further states that all citizens should have equal access to the service to which they are entitled. It is envisaged that the integration of mental health care into the PHC system would enable patients to receive physical and mental health care simultaneously in one visit. Further it was considered that this integration would also help to reduce the stigma of mental illness WHO (2001).

Effective community based mental health care as part of the PHC is important for the integration of mental health services into the community. The Mental Health Care Act (Act No 17 of 2002) in South Africa makes provision for the integration of mental health care into state services at PHC levels. The integration of mental health services has made the care of mentally ill patients part of general patient load in clinics. The mentally ill patients and the PHC nurses have been dissatisfied with problems inherent in the integration of health care services (van Deventer et.al, 2008:136). According to the PHC system, health care will take place at the district level and the mentally ill patients should be able to access all their health care needs in an integrated health care system at the clinic level closest to them as previously mentioned (Mkhize and Kometsi, 2009:104).

The Integration of Service Policy (1996) was enacted in South Africa with the aim of increasing health care utilization by increasing the accessibility of all services at the primary health care level. Integrated PHC consists of the following three categories that encompass an integrated PHC structure:

**Comprehensive health care**
A comprehensive health care service may be described as one that provides all people with maximum health benefits at a reasonable cost. It is a system of health care that
sees the individual as belonging to a family and a community and operating within a specific social and physical environment from which he/she is inseparable and which has a profound influence on his/her health. In such a system use is made of all community resources and the participation of community members in planning, organization and evaluation of the services is encouraged (Dennil & Vasutheran in de Haan, 2011:23).

**Supermarket approach**

The supermarket approach is an approach where patients who require more than one service were seen by different nurses allocated to different consulting rooms. These patients had to join different queues in order to access different services (Sibiya, 2009:132). According to Shah, Bruin and Darling (2002, in Sibiya 2009:132) similar situations existed in the food products retail industry where one had to go from shop to shop to buy different items. These authors state that consumers did not have knowledge of the quality of products and prices could be unreasonable.

The supermarket revolution in the food products sector was the model whereby consumers were guaranteed quality products at a reasonable price and the availability and choice was greater. Like any sector, supermarkets were faced with challenges such as labour shortages. The supermarket approach remained the most preferred solution to increased revenue and client satisfaction with respect to the availability of a range of products under one roof. This mode of delivery continues to be based on the principles of convenience and time saving, affordability and quality products (Sibiya, 2009:133).

In the health sector, the supermarket approach was initiated in Tanzania and has been successfully adopted in several East African countries. The emphasis of this approach is client-orientated and aims for the provision of all services to the PHC service (WHO, 1996). In this study, there was a strong feeling among PHC nurses that generally the supermarket approach is not appropriate for mental health care however a mandate is in the Mental Health Care Act (Act No 17 of 2002).

**One-stop shop**
One-stop shop is the provision of PHC services to the patient by one nurse, which means the patients receive a comprehensive package of PHC services in one location in one visit. Toomey (2000:14, in Sibiya, 2009:135) implies that services will be rendered by the same PHC nurse in the same consultation room in one visit.

During data collection the researcher observed that PHC nurses are not uniform in what they were doing when rendering services to mentally ill patients. Some clinics in the rural areas have adopted the one-stop shop approach, some have adopted the supermarket approach and some continue with vertical programmes. One of the distinct aims of the National Department of Health is to ensure accessible, equitable, adequate and appropriate mental health services for its citizens. In 1995 there was more emphasis to shift primary health care services from hospital to community-based service provision by integrating mental health services into the PHC. However, limitation of funds hampered this process. Integration of mental health care services into the PHC has been progressing very slowly and has been impeded by the massive clinical loads of PHC workers with their inadequate training in mental health. There is a severe lack of services in rural areas. In 2001, the National Department of Health introduced a comprehensive PHC package which represented services that should be rendered for the PHC to be regarded as fully comprehensive (Department of Health, 2001a). Integration of health services means that a PHC nurse is expected to render all clinical services on a daily basis.

While South Africa has made progress at the level of policy and legislation, thus bringing the country in line with other countries, there have been a number of challenges at the level of implementation. Participants found that there are barriers to adequate access to rural health care facilities including a lack of specific medical service for mentally ill patients, shortage of nurses, difficulty in reaching the PHC facilities and the lack of affordable transport for consumers. Access to health care varies according to the geographical terrain within the rural areas. Some of the participants also felt that the integration of mental health care in the PHC contributed to some problems, as expressed in the following sub-themes:

“I am aware that it is important to integrate mental health care services into PHC but we are short staffed. We cannot implement mental health services as expected. I think
the concept of integration of mental health is a problem because we cannot really meet the needs of mentally ill patients as expected. I mean most of the time we end up compromising the mental health programmes.” (Participant group 3).

“The supermarket strategy that is used today where patients just flow in large numbers every day and every time does not give a nurse a chance to flow smoothly with the work because the nurses do not concentrate on one type of patient. We see supermarket method making us to work haphazardly; meanwhile this is not because supermarket method is not right but it is because of shortage of staff” (Participant group 3).

There is a strong feeling among staff members that the supermarket approach is not suitable for mental health services. This is perhaps due to the fact that compared to other areas, mental health service remain low on the priorities of most of governments in low and middle income countries including South Africa (Mkhize & Kometsi 2009:104-105). The participants reported negatively about infrastructure at the rural areas. They reported that some clinics are too small and old and do not accommodate all the services. This is supported by McLeod et al., (2004:1), in Mashego and Peltzer (2005:19) who stated that the rural clinics are coping with limited resources. They also reported that few PHC facilities have adequate waiting areas before entering the consultation rooms. Inadequate resources emerged as one of the problems that the participants regarded as a constraint against successful service delivery.

Sub-theme 2.1: In spite of a policy of a comprehensive approach PHC nurses tend to focus on curative care

The findings in this study suggest that PHC nurses tend to still use a curative approach. Curative services referred to treatment and therapies provided to a patient with an intention to improve symptoms and to cure the patient’s health problems. Curative service means that the PHC nurse should devote her time to the diagnosis and treatment of patients, taking a full history, doing a full physical examination, making a diagnosis, giving treatment and managing the care according to signs and symptoms using prescribed protocols (Vlok, 2010:38). Protocols are standardised prescriptions compiled by doctors to be used by PHC nurses as prescriptions for mentally ill patients and that are available to all the clinics. It was evident from
observations by the researcher that at the clinics the primary focus when caring for the persons living with SPMI was on medication compliance which is a traditional curative approach.

According to Lund et al. (2012:403), primary health care nurses are comfortable with the maintenance of severe mental disorders. Psychotropic medication is not always available at PHC clinics. Without medication mentally ill persons are at risk of defaulting on their treatment and are more likely to relapse and be admitted again. Lund et al. (2012:403) reported that mentally ill persons indicated a lack of continuity of care from rural health care and would prefer a dedicated mental health service over an integrated service at PHC level. The authors further explained that there is a large treatment gap and treatment is irregular and inconsistent. It is evident from the findings that care for mentally ill persons by PHC nurses is limited to dispensing of already prescribed medication by the doctor. The following quotations were taken from the research data to illustrate the above statement:

“The job that we are doing is more curative. Our role as PHC providers is to concentrate a lot on promotive and preventive. We do not do that because people come in being sick and we have to treat them” (Participant group 3).

“Curative service is taking up much of our time; we are unable to spend more time on promotive and preventive care” (Participant group 3).

The participants expressed that when they noticed that there is a long queue they ended up taking short cuts, for example, dispensing medication without listening to the patients’ problems or doing observations for side-effects because of a high workload. From the data collected it is clear that nurses assumed that mentally ill patients and their families needed a curative approach.

**Sub-theme 2.2: Lack of managerial support to assist nurses, hinders the functioning of rural PHC services.**

Supervision of one’s clinical work is one of the most important events for PHC nurses; however it is the most poorly carried out. All too often it does not happen at all, usually because other issues are somehow seen to be more important or at least more urgent. The relationship between the supervisor and the supervised is important to facilitate
quality service (Salter & Turner, 2008:186). Lack of managerial support lead to problematic health care service delivery. This is supported by a quote from the raw data from the interviews:

“We have never been visited by anybody (supervisor) to familiarize her/himself with this integration of psychiatric services to PHC” (Participant group 3).

One participant expressed that there were limitations to the care of mentally ill persons that nurses could provide at the clinic despite the policies. These included inadequate knowledge and skills as it is noted in the observational notes. The limited skills and knowledge are related to the practice of the nurse. These were seen as being deficient in several areas necessary for effective mental health care provision. In this current study, a participant in this research indicated that the supervisor lacked the knowledge and skills in order to perform his/her job effectively. The following quote confirms that:

“I remember when I was trying to share a problem with my supervisor, she used to say, I (supervisor) know nothing about psychiatry. So I ended up consulting Komani Hospital whenever I have a problem” (Participant group 3).

Borders (2001 in Scott 2009:67) stated that supervisors should be experienced in supervision, should be up-to-date with knowledge and skills as well as know their roles and responsibilities and should receive input from others about their work as supervisors. The author further indicated that supervisors assist the PHC nurses to become more effective in their work through enrichment of skills and knowledge. He asserts that it is the supervisor who needs to be able to think about what the supervisee needs in the next supervisory session. He suggested that often the supervisor who is just promoted without any skills and knowledge for the job struggles to do what is expected of him/her, becoming confused, uncertain and feeling inadequate (Scott, 2009:67-68). This quote below revealed this information:

“I remember when I was trying to share a problem with my supervisor, she used to say, I (supervisor) know nothing about psychiatry. So I ended up consulting Komani Hospital whenever I have a problem” (Participant group 3).
“Our supervisor comes once a month to deliver stationery, gas and so on, being in too much of a hurry to listen to our problems” (Participant group 3).

The WHO (2005) reported that a skilled workforce is essential if the country is to respond adequately to the burden of mental disorders. According to the WHO (2005), most countries face a significant need to develop a skilled workforce to ensure the delivery of effective and efficient mental health service. Saunders (2003:185) cited that PHC nurses expressed their frustration, especially when they provided a service that is not appreciated by their supervisors, because the supervisors are not trained in psychiatry. The PHC nurses also expressed a further feeling that they are alone in some instances when they know that there is somebody who is supposed to support them and they have to get support somewhere else. The nurses also mentioned that until their managers listen to their problems and help them to address them they will remain with a lot of problems. They expressed a need for a support system for their problems at the workplace.

“The supervisor comes once a month or sometimes they will call and report that they are not coming because of transport problems. If it happens that they come; it is just for a short time” (Participant group 3).

“Our supervisors take even two to three months without visiting us. The clinic nurses are on their own. You only see a supervisor when there is a problem that affects the community members” (Participant group 3)

The PHC nurses reported receiving no support supervision from their supervisor in the Local Service Area of Emalahleni. Supervision visits are habitually irregular not because of conflicting responsibilities and demands on the time of the supervisor but also due to lack of transport. Scheduled visits are often cancelled at the last moment because of competing requests for vehicles. Adequate supervision of PHC staff is a key issue which needs to be addressed if integration is to succeed. Mental health care supervision of PHC staff should be regular to give advice as well as guidance on management and the treatment of people with mental disorders (WHO, 2001). The PHC nurses do not receive the necessary support and supervision to enable them to confidently undertake their tasks. The WHO further noted that this is against the Alma
Ata Declaration which called for a PHC system complete with supervision and support amongst others (Saraceno et al., in Mkhize & Kometsi, 2009:104).

**Sub-theme 2.3: Time constraints due to a high workload cause the PHC nurses to spend inadequate time with the patients**

The family members of mentally ill persons argued that the time the mentally ill persons spend with the PHC nurses when they come for their medication and follow up in the health care service is very short. It does not allow the mental health care provider to talk and listen to the mentally ill persons and their needs. The high workload seemed to be hampering the adequate service delivery by PHC nurses at the clinics. Placing too high a workload on PHC nurses reduces their efficiency.

Krause (2004, in Mfuko, 2010:21) developed staffing norms for district personnel in South Africa. Kraus explained that “A workload variable of 25 patients per eight hour shift has been used in all clinics. What proved interesting about applying this ratio is not only the general agreement that the workload variable of 25 is quite reasonable (if not too generous) but remarkable variation in workload that PHC nurse is in fact handling in PHC facilities. It is uncommon to find services where nurses average 6 patient a day or 60 patients a day on a routine basis. Kraus further states that what desperately needs to be addressed is not how many minutes should the PHC nurses spend on a particular type of a patient rendering specific services but rather how many hours of production time a nurse can be expected to work in a day providing patient care as opposed to attending seminars, performing administrative tasks, drinking tea, cooking, doing home visits and shopping, being on vacation or taking compulsory sick leave”. Mfuko (2010:21) illustrated that PHC delivery in South Africa takes place within the complexity and diversity of health care delivery. Nursing practice and staff allocation are measured against the same yardstick, that is, number of patients seen at the clinic per day, regardless of whether the nurses are in urban and rural settings. For instance in the rural areas the nurse has to do administration work before doing her core nursing duty. This is supported by the following quotes:

“Opening of patient’s file consumes a lot of time but there is nothing that we can do we have to do it… We do not have clerical staff to help us with clerical work. We do
everything on our own and we are only two professional nurses in this clinic” (Participant group 3).

Consultation with an person living with SPMI is reported to be brief with no thorough examination except giving the mentally ill patient medication and a return date. Such a negative attitude is seen in a bad light and makes patients angry. PHC nurses indicated that the workload was too much for them. The following quotations from a family member confirmed that:

“We get into a consulting room and the nurse will ask the patient if the medication helps, then we will get an appointment date for the next visit. They are just so busy. Even the doctors do not get involved with their patients they do not spend enough time. We see the doctor for a short time. He renews the medication and says; see you in three months” (Participant group 2).

In addition to the shortage of nurses there is no doctor visiting the clinics. This is confirmed by the following quote:

“The nurses have only ten minutes sessions with the mentally ill patients. They do not treat them as they do to other patients with physical illness. There is no time for the nurse to check my brother and to find out if the treatment is still fine for him or maybe check for side-effects of medication” (Participant group 2).

Participants in this study stated that the shortage of staff increased individual workloads. In the study conducted by Sibaya and Muller (2000:10) shortage of staff, medication as well as equipment and supplies were found to be among the greatest problems of PHC nurses during transformation of PHC services. Discussion with the PHC nurses revealed that the introduction of the policy on free health care service is frustrating because they feel they are not providing adequate primary health care due to their increased workloads. Most of the nurses felt that the introduction of free health service had brought more work because of frequent visit by patients, shortage of staff, introduction of the supermarket approach and the lack of support personnel (Netshandama, Nemathaga and Shai-Mahoko, 2005:63).
Sub-theme 2.4: Mentally ill patients who default on treatment of those who are home-bound, are not visited at home due to staff shortage and transport constraints

A home visit is a component of comprehensive health care whereby health services are provided to mentally ill persons and their families in their place of residence for the purpose of promoting, maintaining and restoring health. The major role of a home visit is to care, reinforce education and encourage patients and families as caregivers about ongoing care needs. All nurses working in the community should be prepared to do home visits. A home visit will often reveal information not obtained in other ways (Hunt, 2001:336). This highlights the need expressed for extending care into patients’ home through home visits. The participants involved in the study also indicated that home visits are not done due to shortage of staff and transport constraints.

“We do not visit the families of people with mental illness especially that family can provide a vital feedback so that we can make informed decision about treatment plan of mentally ill patient” (Participant group 3).

“We are supposed to do other projects such as a home visit for defaulters especially for mentally ill patients. I mentioned that we are only two professional nurses therefore it is not possible to leave the other sister alone with a long queue. This task also needs transport as some villages that we serve are far away from the clinic and more so that our defaulters are mostly patients who live far away in the rural areas” (Participant group 3).

“…They are defaulters and some of them are staying away from the clinic and we cannot follow them due to transport problems that make it difficult for us to reach out to the patients to assess and help them with their needs” (Participant group 3).

Another contributing factor to non-adherence may relate to the lack of home visits and follow-ups from PHC nurses. Lack of education of patients and community members about mental illness indicated that home visits should be carried out at least once a month. The family members need to be empowered with skills as to how to handle their mentally ill relatives if they are engaging in disruptive behaviour. The families as caregivers also need counselling. During home visits the nurse has an opportunity to
experience the mentally ill person’s situation and factors that could affect the clients’ health. The findings revealed that the unavailability of transport for nurses to conduct home visits affected the provision of PHC. Home visits for mental health care patients as well as the tracing of defaulters are often simply not done. Due to rough and bad roads, vehicle breakdowns were a constant threat impacting on the ability to deliver outreach services.

Figure 3.4: A physiotherapist in the deep rural Eastern Cape goes the extra mile to deliver a much need wheelchair.

Lack of transport hinders PHC nurses from observing the factors in the home environment that could negatively affect the health of mentally ill persons. Home visits by PHC nurses from rural clinics to mentally ill patients and their families must be carried out in order to assess the relationship at home (Reddh0020i, 2008:119). Shortage of staff contributed to dissatisfaction and resulted in increased waiting time. The participants experienced the shortage of staff as a hindrance in the execution of their daily tasks in managing health services to rural mentally ill patients and their
families, resulting in failure of PHC nurses to carry out home visits. The participants stated:

“I wish that we have more nurses in the clinic because we have only three nurses. There are times when you come to the clinic and you get only one nurse and you are told that the other one has attended a meeting or is on holiday that makes it difficult for a nurse to leave the clinic and do home visit” (Participant group 2).

“Again the government should employ more nurses for the clinic so that our needs are met because the clinic has two nurses for all the patients with different problems and different health needs and this delays other programmes like home visits. There are times when there is only one nurse in the clinic for all the patients. Sometimes it is not even a PHC nurse it is a staff nurse and you are told that (PHC nurses) have attended a meeting at Emalahleni Local Service Area” (Participant group 1).

Participants expressed that there is a shortage of nurses and non-availability of other health care professionals that form part of the inter-professional team such as the psychiatrist and social worker. The shortage of nurses often leads to long queues for patients including those with mental illness. In some instances the staff shortage was related to only a few nurses being allocated in the rural clinics and in some instances nurses had to be released to attend meetings or workshops or to go on leave or study leave. In Canada, McLeod (2004:3) indicated that PHC nurses are a key component of rural health services and rural communities are dependent on a sustained rural health care workforce (Thutse, 2006:34). Rural areas suffer from a shortage of staff. There is a relatively low availability of mental health providers in rural areas and an even lower availability of specialised mental health care providers such as mental health care nurses, psychiatrists, social workers, psychologists and occupational therapists (Gamm, Stone & Pittman, 2010:102). In view of the above discussion the scarcity of providers may be required to travel great distances for patients. Travel distance is a feature of rural settings and is associated with fewer mental health visits by mentally ill persons.
Transport constraint

Participants suggested that living in rural areas causes difficulties associated with access to PHC. Participants indicated that PHC services are available in the rural areas but transport constraint is still a problem. Participants from Groups 1 and 2 expressed that the additional burden of travelling costs to mental health services is expensive. Most PHC services serve a relatively large rural area posing challenges to travel. The WHO project Atlas (2008:18) stated that in rural areas of Kanokom, because of the size of the catchment area, the communities travel one to two hours to reach the services. The patients receiving care for Abuja and Tabaco WHO project Atlas (2008:18) indicate that the programmes are reaching only a fraction of those in need of care. Transport is a significant challenge. Travelling long distances and coping with weather is an everyday reality in the rural areas.

Mental health care services are inaccessible for mentally ill persons as some of them have to travel long distances to get health care. For many people in the rural areas the cost of travelling is a barrier to health care (Humphreys & Wakeman, 2008:5). According to the norms and standards that have been developed concerning the range of mental health services to be provided through the PHC, it is stated that primary health care should be available to everyone within five kilometres of their homes (WHO 2008), which is not the case at Emalahleni Local Service Area. In rural areas there are at times physical barriers to a clinic though it may be within 5 kilometres of the clinic. Geographic barriers include rivers, lakes, bad roads, valleys and mountains (See annexure I Map 1). This is also a barrier to access service in the rural areas which can make it difficult for mentally ill persons to go to the clinics resulting in non-adherence and relapse of mentally ill persons as mentioned previously.

In the study conducted by Kitty (2007:14) regarding transport, participants pointed out that everybody is spread out in the rural areas; lack of transport is a huge barrier to access health care services. At times it becomes very hard for mentally ill persons in rural areas to go to the hospital when referred because a person who does not behave in a social acceptable manner will not be allowed to board a bus. Sometimes the family members will transport their mentally ill person in a wheelbarrow or a donkey cart to the clinic. At times the parents are old and not physically strong enough to push the wheelbarrow, the distance is too far for them to walk and the hills are too steep for them.
to manage a wheelbarrow. In view of the above discussion, transport is a problem to both mentally ill persons and the mental health professionals. There is no transport in the rural clinic for nurses to do home visits.

Sometimes it takes the whole day by foot for patients to get to the clinic which is far away from where they stay. One of the participants explained that they have to take a four hour walk on the narrow gravel roads to the nearest health clinic. The roads are steep and at some places there are only paths to climb up and down (See annexure J Map 2). Sometimes, as the mentally ill patient needs to be accompanied by a family member, transport expects to be paid for an extra person. The person living with SPMI and the family cannot afford this, hence they default their treatment. In some areas mobile clinics used to be available, but because of bad roads they break down resulting in non-availability.

3.5 CHAPTER SUMMARY

This chapter mainly focused on a discussion of data analysis which emerged from the data collected from persons living with SPMI and their families as well as from PHC nurses working in Emalahleni LSA of Chris Hani District Municipality. Data was analysed and described. The themes that emerged clearly described the experiences of the participants. Literature control was done to validate the outcomes of the relevant themes and place them in context with the research study.
CHAPTER FOUR

A CONCEPTUAL FRAMEWORK FOR THE DEVELOPMENT OF STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR PERSONS LIVING WITH SPMI IN THE RURAL AREAS

4.1 INTRODUCTION

The previous chapter dealt with the analysis, discussion and interpretation of findings emerging from individual interviews that were conducted with three groups of participants, namely severely and persistently mentally ill persons, family members of mentally ill persons and PHC nurses from rural areas of Emalahleni Local Service Area (LSA). The discussion also included findings from a literature control and field notes. This information will now be used to identify the main concepts in order to create conceptual meaning that will provide a foundation for developing strategies to facilitate community-based health care of persons living with SPMI in the rural areas.

4.2 FRAMEWORK DEVELOPMENT

The conceptual framework is a guide to represent the interrelationship between six aspects of activities, namely the agent, recipient, context, dynamics, procedure and terminus. The conceptual framework of Dickoff et al. (1968) further examines the relationship between nursing theory, nursing practice and nursing research (Dickoff et al., 1968:415). In this study the relationship between research information acquired and the needs of persons living with SPMI and their families in the rural areas needs to change, therefore the development of strategies to facilitate community-based health care of persons living with SPMI and their families in the rural areas is significant to facilitate that change. The nurse’s role involves responsibility for meeting mental health care needs and the nursing needs of persons living with SPMI and their families (Karkaiken and Eriksson, 2004:233).

To secure order and a systematic approach in the development of strategies, the researcher has chosen the theory of Dickoff, James and Wiedenbach (1968). However, it is important as you create conceptual meaning to make choices that help to ensure the meaning that is created is useful to nurses as they manage human responses and help persons to move toward health (Chinn and Kramer, 2011:164).
this study, concepts were selected from the findings of the individual semi-structured interviews conducted on persons living with SPMI, their family members as well as the PHC nurses at Emalahleni LSA. All three participant groups revealed diverse experiences with regard to community-based mental health care. It was evident from the information obtained from the interviews that all groups of participants experienced certain shortfalls with regard to community-based mental health services that hindered access to quality service.

The shortfalls experienced by the mentally ill persons and their families were as follows:

- When mentally ill patients experience a crisis, there is no 24 hour service to help the patients or family.
- The ambulances and police service are not helpful, when patients need access to mental health services.
- The mental health information given to mentally ill persons and their families is inadequate.
- When a SPMI patient needs to be referred to a member of the multi-professional team, the service can only be accessed in large metropolitan areas.
- Family members are not included in the treatment plan of their mentally ill family members.
- The specific pharmaceuticals that were prescribed for mentally ill patients may not be available during regular clinic visits leading to non-adherence and relapse.
- When visiting a PHC service, the mentally ill person may feel stigmatised by both the community as well as nurses.
- Participants are dissatisfied with long queues and long waiting periods.
- Rural clinics have not initiated support groups or any specific projects focusing on the needs of mentally ill person and their families.

Group Three: PHC nurses. The sub-themes were identified as follows:
• In spite of a policy of a comprehensive approach, PHC nurses tend to focus on curative care.
• Lack of managerial support to assist nurses hinders the functioning of rural PHC services.
• Time constraints due to a high workload cause the PHC nurses to spend inadequate time with the patients.
• Mentally ill persons who default on treatment or those who are home bound, are not visited at home due to staff shortages and transport constraints.

During the analysis of data, the concepts that were utilized in the development of the conceptual framework were identified to assist in the creation of strategies to facilitate community-based mental health care of persons living with SPMI in the rural areas. The community programmes should include multiple interventions extending beyond the individual to the community at large.

4.3 CONCEPTUALISATION AND CLASSIFICATION OF CONCEPTS

The concepts were conceptualized using the survey list of Dickoff, James and Weidenbach (1968:422-434). The survey list is an inventory of factors that affect movement towards a goal or purpose (Chinn and Kramer, 2008:53). In this study, the goal was to develop strategies to facilitate community-based health care for severely and persistently mentally ill persons. For this reason the survey list described by Dickoff et al. (1968:423) was used to classify the concepts that were utilized in the development of strategies. The survey list included the agent, recipient, context, dynamics, procedure and terminus. The following six questions correlated with the six concepts in the survey list (Dickoff, et.al., 1968:423) and were discussed in Chapter two.
Table 4.1: Six concepts and six questions of the survey list (Dickoff et al, 1968:423)

<table>
<thead>
<tr>
<th>Concept</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent</td>
<td>Who or what performs the activity?</td>
</tr>
<tr>
<td>Recipient</td>
<td>Who or what is the receipt of the activity?</td>
</tr>
<tr>
<td>Context</td>
<td>In what context is the activity performed?</td>
</tr>
<tr>
<td>Dynamics</td>
<td>What is the energy source or the activity?</td>
</tr>
<tr>
<td>Procedure</td>
<td>What is the guiding procedure, technique or protocol of the activity?</td>
</tr>
<tr>
<td>Terminus</td>
<td>What is the end-point of the activity?</td>
</tr>
</tbody>
</table>

The researcher has chosen the survey list of Dickoff et al. (1968: 423) as the conceptual framework that will guide the development of the strategies to facilitate the community–based mental health care services for persons living with SPMI and their families.

- The **agent** is the person who performs or facilitates the activity that is designed to attain the desired goal. In this study, the agent described in this conceptual framework is the PHC nurses who are co-coordinating the mental health care services in PHC clinics in the rural areas. The families act as sub-agents when they assume responsibilities for their mentally ill relatives.
- The **recipient** is a person who receives action from the agents or who is receptive to the activity that has a specified terminus. In this study, the recipient is persons living with SPMI and their family members who utilized the PHC services.
- The **context** is a framework in which the activity takes place. In this study the context is the PHC clinics that are widely dispersed in rural areas of Emalahleni LSA in Chris Hani District where the study was conducted.
- The **procedure** is a general rule, the function of which is to offer guides and safeguards with respect to activity. The aspects of the procedure emphasize the path, steps or pattern according to which the activity is performed. The
procedure will be the process to meet the mental health care needs of persons living with SPMI.

- The **dynamics** emphasise the power source of that activity. It includes the agents, recipients, resources and the context.
- The **terminus** is the end point or accomplishment of the activity. In this study the goal is to have persons living with SPMI who are functioning to their maximum level and are well adjusted to rural living in a family context.

Each aspect of the above activity will be discussed individually below.

### 4.3.1 The agent

In order to deal with the theme: ‘the PHC nurses experience the integration of mental health care services into PHC as challenging’ the researcher came up with the following experiences for PHC nurses, as sub-themes:

- In spite of a policy of a comprehensive approach, PHC nurses tend to focus on curative care.
- Lack of managerial support to assist nurses hinders the functioning of rural PHC services.
- Time constraints due to a high workload cause the PHC nurses to spend inadequate time with the patients.
- Mentally ill persons who default on treatment or those who are home bound, are not visited at home due to staff shortages and transport constraints.

The researcher came up with strategies to deal with these experiences for PHC nurses. The agent is the nurse and the family member as the caregiver. According to Dickoff et al. (1968:425) the agent is the person who facilitates the activity that is designed to achieve the desired goal. For the purpose of this study the agent is a facilitator who could be a PHC nurse. Orem emphasizes that all individuals have self-care needs and that they have the ability to meet these needs, except when their ability is compromised. The self-care agent is the person who meets the self-care needs. It may be the person itself or it may be a family member or the nurse (agent). The agent assists the persons with mental illness towards care, treatment and rehabilitation. The ability to engage in self-care is affected by basic conditioning factors. Nursing is
required when persons living with SPMI are incapable of or are limited in their ability to provide continuous effective self-care. On the other hand, the PHC nurse at the community-based mental health services supports the family in times of stress and supplies information about community resources and social services that are available to help families provide the care (de Haan, 2011:26).

In this study the PHC nurses working in the PHC facilities based in the rural communities are the agents. They will also co-ordinate the contributions of the members of the inter-professional team where necessary. The agent for the provision of community-based health care is thus the PHC nurse serving the community. The performance of the activity includes the necessary skills, attributes and attitudes that are fundamental for the agent’s function.

The researcher has identified the following roles which the PHC nurse has to fulfil in the rural areas:

![Figure 4.1: A SCHEMATIC PRESENTATION OF THE ROLES OF PHC NURSE (compare McEwen 2002)](image)

The researcher describes some of the roles for nursing practice in the PHC setting in the rural areas as depicted in Figure 4.2.
Direct Care Provider

The direct care provider role involves the direct delivery of care. Performing tasks or skills for which the PHC nurse has been trained and that are typically associated with nursing practice in the rural areas such as patient assessment, giving out the supply of medication and taking of vital signs that are the essence of the role of direct care. Although direct care provision is an important part of community-based nursing practice, this task tends to occupy less time than in acute care settings (McEwen, 2002:15-16).

The PHC nurses in the rural areas provide direct care to persons living with SPMI and their families. The PHC nurses have the ability to provide an integrated approach to health care especially with people who have mental illness. The PHC nurses as direct care providers:

- Consider the needs of persons living with SPMI and their families in the rural areas to assess the mental health needs, formulate diagnosis-related plans and implement and evaluate nursing care.
- Collaborate with other stakeholders in the rural areas and inter-professional partners to provide persons living with SPMI and their families with information to make informed decisions about their health.
- Identify and respond to persons living with SPMI and their families in the rural areas who are most vulnerable to mental health problems.
- Motivate and enable persons living with SPMI and their families in the rural areas to take responsibility for their health and to make healthier choices.
- Provide on-going information and education to persons living with SPMI and their families in the rural areas about current and emerging mental health issues.
- Promote community acceptance of people with mental health problems to reduce the stigma.
- Provide outreach programmes for persons living with SPMI and their families in the rural areas and link them to PHC services.
- Provide liaison function with the hospital and the emergency department to support persons living with SPMI and their families in the rural areas when they return home.
**Educator**

Regardless of the setting, health education is an essential component of quality nursing care. Although mental health education is an important role for nursing in the mental health care setting, it is often the most significant role of the nurse working in community settings in rural areas. Teaching individuals, families and groups about the maintenance of health, threats to health and relevant lifestyle choices that affect health is an integral part in all community-based settings in the rural areas. The information presented in health education should allow persons living with SPMI and their families in the rural areas to make informed decisions on health matters and to direct self-care to follow treatment regimens. Whether the information is instruction concerning potential side effects of prescribed medication it must be presented appropriately for the persons living with SPMI.

The PHC nurses as health educators should consider such factors as patient’s developmental stages, learning readiness and perceived learning needs. Additionally, the nurse must evaluate the learner’s level of understanding accurately and reinforce it accordingly (McEwen, 2002:16). The PHC nurses should facilitate empowerment of the persons living with SPMI and their families in the rural areas about mental illness in his/her role of educator. In this role the PHC nurse provides education to persons living with SPMI and their families on a variety of mental illness issues using the principles of adult learning appropriate to the persons living with SPMI and their families. The PHC nurse working in the community can be a resource who should share specialized knowledge and expertise that comprises best practices and facilitates their application in practice settings. He/she should provide consultation and education to persons living with SPMI, other health care professionals and community-based health care organizations (Earle and Baker, 2008:6).

**Counsellor**

Using the therapeutic relationship, Earle and Baker (2008:6) propose that the PHC nurse in the rural areas performs the role of counsellor to:

- help persons living with SPMI and their families focus on their goals or outcomes.
help persons living with SPMI and their families develop strategies that support self-care and enable individuals and their families to take responsibility for and participate in decisions about their health.

- provide a range of services including education, research and knowledge sharing; evidence informed practices and communication.

- provide an opportunity for people to work towards living in a more satisfying and resourceful way.

- use a range of counselling skills based on counselling models such as interpersonal psychotherapy, cognitive-behavioural therapy and solution-focused therapy to improve persons living with SPMI and their families functioning and quality of life.

- help people to be supported, to gain insight and to bring about changes in thoughts and feelings.

A PHC nurse in the role of counsellor listens to patients and their families encourages them to explore issues and options and enables them to manage their personal situations. Counselling represents an important component of quality community-based nursing care settings in the rural areas. In contrast, nurses in mental health care settings in the rural areas typically spend considerably less time counselling persons living with SPMI and their families. Exceptions may include nursing care in mental health settings in the rural areas, where counselling might constitute the greater percentage of the nurse’s time and nursing care for families of a very seriously ill person with mental illness for whom the family must weigh options on treatment and long term care (Uys, 2010: 266-268).

**Counselling**

Counselling helps a person to interpersonal and intrapersonal patterns in order to understand and improve them. It is an interpersonal process in which the counsellor (PHC nurse) facilitates the exploration of a feeling or situation which the counselee (Person living with SPMI and their family) is experiencing (Uys & Middleton, 2010:266).
Characteristics of a Counselling interview

A Counselling interview has a few characteristics that distinguish it from an ordinary social encounter (Uys and Middleton, 2010:266):

- The counselee usually already has a relationship of trust with the counsellor since people seldom share their problems with a person they do not know or trust.
- The topic is usually directly related to something the counselee is currently experiencing.

A Counselling interview can take place in any situation if the counsellor recognises the need of the counselee and structures the situation so that an in-depth conversation can take place. For instance it can happen when the person comes for a scheduled clinic visit or on a home visit or it can happen between colleagues or friends in their homes or in the tearoom (Uys & Middleton, 2010:266). In this study, counselling can happen between the PHC nurse and Person living with SPMI or the family member of the mentally ill person in the rural areas whether it occurs during the visit to the clinic or during a home visit. The counsellor should not only show understanding of the person’s experiences and recognise his/her feelings but also give accurate empathetic responses as soon as the feelings are expressed (Uys & Middleton, 2010:266).

Stages of Counselling

A successful counselling conversation moves through the following stages (Uys & Middleton, 2010:268):

- The counselee describes the situation and the feeling, while the counsellor responds in a supportive way.
- The counsellor deals with the feeling first to decrease anxiety.
- The counsellor then encourages a thorough exploration of the situation focusing on different aspects of the situation.
- At this stage of the interview it is important to give positive feedback about the strengths the counselee has shown.
- Once the feeling and the situation have been thoroughly explored, it may be appropriate to move into problem solving.
• The counsellor and counselee identify which strategies have been tried. It might be useful to determine why strategies that looked promising have failed since that could assist with future planning.

• The counselee is then assisted to choose an alternative for implementation.

• Implementation is encouraged through homework, assignment, planning rewards and so on.

In this study, although the PHC nurse should possess these counselling skills none of the PHC nurses ever referred to them.

**Advocate**

PHC nurses working in the community are advocates for the mental health care needs of persons living with SPMI. These nurses should challenge the structures that contribute to people’s mental distress or are a barrier to their recovery. Together with inter-sectoral partners, e.g. justice, education, community-based organizations and other health care providers, the PHC nurse (Earle & Baker, 2008:8):

• Protects the rights of persons living with SPMI and their families as set out in the Mental Health Care Act (Act No 17 of 2002).

• Acts on behalf of clients who are in need of particular skills on which their lives depend.

• Ensures that an optimal level of mental health care is available and accessible to all people.

• Takes responsibility to resolve the conflict that might exist between the needs of the organization and those of the persons living with SPMI and their families.

• Educates the public and other health care professionals to eliminate stigma and to dispel myths of mental illness.

Uys (2010:98) explained that advocacy means ‘to plead in support of’ something or somebody. A nurse is one who acts on behalf of, or intercedes for the patient. Frequently the mentally ill persons in the rural areas are unable to obtain needed care and services with today’s health care system. Nurses act as advocates in all settings. In community settings in the rural areas, the nurse’s role as an advocate is vital because they often work with a vulnerable population. Advocacy implies taking action
to achieve a goal on behalf of another and in nursing it is directly related to patient care. As a patient advocate the PHC nurse should continuously strive to ensure the quality and continuity of care and to ensure that persons living with SPMI’ needs are being met and also those of their families in the rural areas. The following concepts are used in advocacy:

- **Understanding advocacy as an ethical concept.** In nursing, advocacy is an ethical practice based on the individual’s values and on the nursing code of ethics.
- **Understanding the place of advocacy within nursing practice.** PHC nurses must recognize that advocacy is an important component of basic practice standards.
- **Analysing personal communication skills.** PHC nurses should recognize their own strengths and weakness in interpersonal skills and develop them as needed.
- **Identifying situations in which advocacy is necessary.** PHC nurses should follow their own values and ethical perspectives in identifying advocacy situations but they should also recognize differing perspectives and adapt accordingly.
- **Taking action.** Advocacy involves taking some type of action whether physical, written or verbal and PHC nurses should be willing to take action when appropriate.

**Advocating for service improvement**

It is often not possible to link patients to services because the appropriate services do not exist. In such cases the case manager, who is a PHC nurse in this study, acts as an advocate for persons living with SPMI and their families in the rural areas in order to improve the level of community-based mental health services available to them. Advocacy means that the PHC nurse uses various methods to urge the decision-makers to improve the quality of services provided for mental health services. (Uys & Middleton, 2010: 288).

**Manager**

The role of the PHC nurse in a community-based setting in the rural areas is a most significant one. Nursing care in the community-based settings in the rural areas involves management of the patient care, the nurse’s time, limited resources, other
personnel and programme organization and as well as co-ordination. The management role includes planning, organizing, coordinating, evaluating and care delivery (Keltner et. al, 2011:232).

**Collaborator**

The PHC nurse in the role of the collaborator participates in the process of making decisions regarding health care management with individuals from various disciplines and working with the persons living with SPMI and families as caregivers to jointly determine the course of care. Interaction, discussion and coordination enable goals to be set and a plan of care to be formulated to meet the goals. The nurse must work with other health care providers to deliver the most comprehensive care for persons with SPMI. Successful collaboration with all stakeholders in providing comprehensive mental health care requires PHC nurses to recognize their skills, acknowledge the contributions of other team members involve the SPMI and their families in the rural areas in problem solving and be knowledgeable about resources (Keltner, Bostroni and McGuiness, 2011:125).

When persons living with SPMI and their families in the rural areas recognize their problems and have the need and desire to change and when they ask for assistance, the PHC nurse is able to work with them on goals and plans. Collaboration produces more effective and enduring change than coercion or simple compliance. Unfortunately situations arise in relation to mental illness in the rural areas during which this is not possible, such as when patients have an obvious disturbance in their thought processes in the form of severe hallucinations or delusions. Mentally ill persons might be incapable of collaborating with the PHC nurse in their care until these problems subside. The persons living with SPMI might only be able to agree to small changes (Keltner, Bostrom and McGuiness, 2011:68).

The PHC nurse in the rural areas must work with persons living with SPMI, families and colleagues in providing care and helping families reach their goals. This requires that PHC nurses collaborate with the inter-professional team, for example by means of a referral system, to advocate for persons living with SPMI and their families and to achieve positive outcomes. Firstly, the PHC nurse in the rural areas should engage persons living with SPMI as collaborators in planning, delivering and evaluating their
care. Secondly, the families of mentally ill persons who are caregivers should be involved in all aspects of care. The PHC nurse should work with all sectors of service delivery system. The focus on collaboration in this study demonstrates that the inter-professional collaboration is essential for the delivery of quality mental health care (Keltner, Bostrom and McGuiness, 2011:125).

**Researcher**

To ensure that mental health care is of the highest quality, the PHC nurse as researcher should:

- Identify and use evidence-based research in decision-making and share this research with clients to support them to make well informed choices.
- Participate in research projects to yield qualitative and or quantitative evidence pertaining to nursing practice, administration, education and research.
- Develop a programme of research into outcomes associated with improved integration of mental health and primary health care.

In the role of a researcher, the PHC nurses in the rural areas should critically review research findings and should determine care accordingly. Similarly, PHC nurses working with new families should share findings about for example, mental health problems. Often the persons living with SPMI and their families are unaware of recent discoveries and innovations related to mental health care and it is the responsibility of the nurse to share these with them when relevant. Occasionally a nurse in community-based health care may be part of a research study in the rural areas. Identifying problems or questions for investigation, participating in approved research studies and disseminating research findings to clients and other professionals are appropriate actions for all nurses.

**Leader**

Leadership refers to the ability to influence the behaviour of others. In community settings in the rural areas, the nurse may assume the role of a leader with patients and their families, other health care providers, local leaders and employers. The leader should be the role model to other PHC nurses in the rural areas especially when they need her/him to assist them with some of the problems encountered in the clinics.
According to Booyens (2008:242), a role model is a person who demonstrates an action or behaviour that is learned by other health professionals. Role modelling is both unconscious and conscious and nurses in settings demonstrate to others both positive and negative actions and attitudes related to health and health care. In community-based practice nurses in the rural areas serve as role models to persons living with SPMI, their families and other PHC health professionals. As a leader, the nurse may work with others to identify and assess threats to health and intervene when necessary (Booyens, 2008:242-243).

Skills will differ in application depending on the context of care and the severity of mental illness of the person living with SPMI. As a professional nurse, the PHC nurse is required to possess knowledge and skills that enable her to make clinically sound decisions in the rural areas. The PHC nurse, as a professional nurse in the rural areas, uses the professional scope of practice and practical experience in performing his/her duties. Furthermore, for the PHC nurse to carry out his/her roles there is a need to observe a number of qualities that assist in establishing a therapeutic nurse-patient relationship (Bynum-Grant & Travis-Dinknis, 2010; Fro, Herrick & Hu, 2011, in Velikoshi-Indingo, 2013:83):

- Genuineness where the facilitator is aware of her inner feelings and able to communicate in a relaxed and appropriate manner.
- Trust and acceptance which involve respecting an Person living with SPMI’s rights and acceptance of the SPMI as human beings without being judgmental.
- Empathetic, understanding health-care, the needs of persons living with SPMI and their families.
- Establishing therapeutic nurse–patient relationships with the SPMI and their families.
- The ability to motivate and guide the families of persons living with SPMI in the learning process.

The PHC nurses would need to be educated and to have a strong career framework and leadership structure in order to work comprehensively in the rural areas. They would share core knowledge and a skill set as well as developing skills in specialised areas such as mental health care, potentially taking on expanded roles with greater
autonomy and responsibility. They would have significant input into, and influence on, decisions relevant to their practice in the rural areas. The PHC nurses would need the resources and expertise to refocus their work more towards community-based disease prevention, appropriate screening, opportunistic health education and early interventions in the rural areas. A community-based approach requires health professionals to take a broader approach to mental health care, recognising the need to prevent and manage mental illness and to promote mental health for their communities in the rural areas.

Three key areas of focus are needed to achieve this vision for PHC nursing. These increase the capability of PHC nurses (skill, experience and qualifications), their capacity (the size and demographic extent of the PHC nursing workforce, environmental opportunities and barriers), and their collaboration with other members of the PHC team and other health providers (Finlayson, Sheridan and Cumming, 2009:8).

The focus on patient-centred care, holistic practice and providing value for money means that there is a greater need to ensure that PHC nurses have the knowledge and skills to improve and develop primary health care services in the rural areas and meet the health care needs of persons living with SPMI and their families. All of these initiatives require PHC nurses to learn and apply new skills in the rural areas. While health care organisations such as public and private institutions initiate a number of strategies to improve care and respond to changing regulatory and policy requirements such as Mental Health Care Act (Act No. 17 of 2002), PHC nurses practicing in the rural areas have not received training on quality and safety as a part of their education. Research suggests that a lack of knowledge and skills among PHC nurses in the rural areas is a significant barrier to improving the quality in health care of mentally ill persons and their families. Training PHC nurses in basic mental health care has the potential to impact positively on attitudes, knowledge and behaviours of the persons living with SPMI and their families in the rural areas.

The PHC nurses in the rural areas currently face significant challenges. The integration of mental health care into PHC, the focus on patient-centred care, holistic practice and providing value for money means that there is a greater need to ensure
that PHC nurses have the knowledge and skills to improve and develop mental health care. All of these initiatives require PHC nurses to learn and apply new skills.

In this study, the activity would be any nursing activity that contributed to a nursing goal, for instance as identified in the terminus (Dickoff, et al., 1968:425). The agent is someone who has the intention of a goal and propels actions to achieve that goal. The PHC nurse establishes a relationship with the families of mentally ill persons and empowers them with skills and knowledge that enable them to gain independence and competency in the care, treatment and rehabilitation of their persons living with SPMI, to be self-sufficient, self-reliant and be able to make their own decisions. The PHC nurse has to fulfil a variety of roles in the course of everyday activities. The PHC nurse has the strongest role in respect of custodial care (Uys, 2010:39-40).

4.3.3.1 **The sub-agent**

Dickoff et al., (1968:425-426) recognize that the role of the agent may be more efficiently filled by a person other than the professional nurse. During data collection in the rural areas, the researcher recognized that there are family caregivers who are highly motivated to take care of their loved ones with mental illness. They are able to take an active role and make responsible decisions regarding the care of their mentally ill persons in the absence of the agent. These family members could be defined as sub-agents as opposed to recipients as described in this conceptual framework. Coming to terms with the care-giving responsibility, the families of persons living with SPMI as recipients of mental health care accept the responsibility of becoming sub-agents. In this study the sub-agents refer to the family members who are caregivers and who also became agents when they assumed responsibilities for the health care needs of the persons living with SPMI at home to a mentally ill relative. Embedded in this caregiving role is the importance of supporting the family caregivers as sub-agents by providing them with sufficient knowledge and ongoing support. The sub-agent executes and continues with some of the activities towards the terminus.

The benefits of the family member as a sub-agent:
• Families are a source of information about the illness of the mentally ill relative, especially the person’s behaviour, symptoms and family history. A large amount of information can be obtained from family members.
• Families can be involved in therapy by supporting the mentally ill person to attend their therapy appointment and make sure that they adhere to their treatment regimen.
• Families can be taught to help with therapy, for example, stress management
• Families can influence the attitude of the person with mental illness towards the therapy.
• Families can be a source of information for persons living with SPMI.
• Families can be involved in the care of persons living with SPMI regarding self-care and time management.

The philosophy of family care is supported by WHO’s (2003) mental health policy and service guidance notes. These notes stress that the needs and rights of families should be balanced with the needs and rights of the individual with mental disorders (WHO, 2003).

The role of the sub-agent
The families of people with mental illness usually shoulder the greatest part of the burden of care for their loved ones who are mentally ill. The family is the main resource of the person living with SPMI. Families act as caregivers and sub-agents and they also support other families with similar problems, they teach and educate them. They advocate for improved mental health services for persons living with SPMI. Sometimes caregiving becomes a family affair with multiple caregivers in the home, a system that allows the primary caregiver time of relief from caring (Uys and Middleton, 2010:88).

Issues in working with families and sub-agents
In recognition of the changing needs of the persons living with SPMI and their families there has been a paradigm shift in service provision so that the focus of the care provided to persons living with SPMI and their families has moved to a strengths approach rather than the deficit approach. From this perspective there is openness to recognizing the attributes of families as sub-agents (Darbyshire & Jackson, 2005, as cited by Elder et al., 2009:413). This offers a framework for communicating and
working together with persons living with SPMI and their families. This approach acknowledges that while problems exist, subagents are the best judge of their circumstances. This assists PHC nurses to work with sub-agents on the strengths, competencies and resources they need to deal with mental illness. Using the strengths-based framework encourages the development of further skills for sub-agents in management of their own situation. This in turn encourages PHC nurses to view families as active sub-agents and decision makers in their own care rather than as passive recipients of the services PHC nurses provide (Elder et al., 2009:413).

4.3.2 The recipient

The notion of recipient embraces not only the sick persons who receive the activity of the agents but also any person receiving the activity of agents whose activity contributes to the goal (Dickoff et al., 1968:426-427). The recipient is the consumer of mental health care service. The recipient could be a person with a mental health illness or the family member with a caregiving problem. From this study, results revealed that persons living with SPMI experienced some challenges, as reflected in the themes discussed previously. Participants observed that the long distance to access services was cumbersome and costly and that the lack of money for transport to hospital meant that they cannot always access the necessary care. Some families of mentally ill persons reported that they could not afford the cost of transporting themselves and the mentally ill person to the clinic as required and that lead to a relapse of the person living with SPMI’s mental condition. Most of the persons living with SPMI and their families are not working and are dependent on the social grant that the person living with SPMI receives. The disability grant given to persons living with SPMI is not usually adequate.

Thus, activities designed by the agent are directed towards addressing the challenges encountered by the persons living with SPMI and their families. These are the experiences identified as shortfalls: mentally ill patients experience a crisis, there is no 24 hour service to help the patients or family, the ambulances and police service are not helpful, when patients need access to mental health services, the mental health information given to mentally ill persons and their families is inadequate, when a SPMI patient needs to be referred to a member of the multi- professional team, the service
can only be accessed in large metropolitan areas, family members are not included in the treatment plan of their mentally ill family members, The specific pharmaceuticals that were prescribed for mentally ill patients may not be available during regular clinic visits leading to non-adherence and relapse, when visiting a PHC service, the mentally ill person may feel stigmatised by both the community as well as nurses, Participants are dissatisfied with long queues and long waiting periods, Rural clinics have not initiated support groups or any specific projects focusing on the needs of mentally ill person and their families.

Therefore persons living with SPMI were recipients of the activities. In addition, persons living with SPMI are autonomous beings who can make their own decisions and manage their own lives with the support of the families. The recipients are persons living with SPMI and their families who needed sharing of information, resources, care and support from PHC nurses in order to deal with problems and to participate actively in the care of persons living with SPMI. In this study the persons living with SPMI and their families need information and development, assessment of health resources and support in their care, treatment and rehabilitation and full participation in their treatment plan. These strategies will be applied within the community-based mental health services in the rural areas. The recipients should be counselled, supported, trained and given an opportunity to verbalize their feelings. The PHC nurses must provide the necessary care, support and education to the persons living with SPMI in the rural areas.

A person is viewed as an integral whole or unit, functioning biologically, socially and symbolically (Fitzpatrick and Whall, 2005:180). Person, or human being, refers to both the recipient of care and the giver of care. Self-care deficit nursing theory includes the whole reality of human beings, singly and in social units as the material object of nursing. This includes individuals, dependent units, and multi-person units such as families and communities and their relationship to nursing as a profession and as a discipline. Orem considers the individual person to be self-reliant and responsible for self-care. Orem emphasizes that all individuals have self-care needs and that they have the ability to meet these needs, except when their ability is compromised. The self-care agent is the person who meets the self-care needs. It may be the person itself or it may be a family member or the nurse. In applying this concept to this study,
the person living with SPMI as a recipient, should be considered for improving and promoting his health care needs. This will enable him to cope with family roles and emotions and be able to manage his own needs.

4.3.3 The context

The context is the framework in which the activity takes place. In this study the context is the PHC clinics in the rural areas of Emalahleni LSA in Chris District as mentioned before.

Figure 4.2: MAP Emalahleni LSA – Chris Hani District

The study was conducted in Emalahleni LSA of Chris Hani District Municipality situated in the heart of the Eastern Cape. It comprises eight LSAs, Emalahleni LSA being one of them. Emalahleni is inhabited by Xhosas, who are the main ethnic group that consume health services. It stretches over 3442.20 square kilometres, with a
population of 122 423. Much of the municipal area is in the former Transkei. It is one of the poorest areas in Chris Hani District. The population lives below the poverty line. Some villages lack roads, electricity and safe drinking water. A small percentage of the population has access to a health facility within 5 kilometres of their home. The municipality is mainly rural and settlements are predominately dispersed, traditional rural villages. The quality of life in rural villages is generally poor, marked by poverty and lack of access to services and amenities. Unemployment is high and most households rely on social grants and remittances from family members working elsewhere.

There are thirty-five medical and primary health care facilities in the Emalahleni LSA. Health services in the LSA are the responsibility of Chris Hani Health District and the Department of Health. Health services are provided by five level one hospitals, one community centre and 29 PHC clinics. This is where the implementation of strategies to facilitate community-based health care services of persons living with SPMI and their families will occur. PHC services cater for all age groups.

There is a vast difference in the culture, norms, values and needs associated with being in the rural area compared with the metropolitan area, even within the same ethnic group, for instance, the sense of belonging to one’s local community is stronger in rural communities than in the metropolitan communities,. Geographical isolation, distance to health services, limited entertainment, employment or further education opportunities are further shortcomings in this rural area. Such social difficulties in the rural areas can precipitate anxiety, depression, family breakdown, grief, anger and other mental health problems especially in young people. There also tends to be clear cultural differences from community to community in rural areas that act as barriers to mental health care. A culture of self-reliance that exists in many rural and remote communities does not promote help-seeking behaviours for social and emotional problems. Some people may be reluctant to seek support because of stigma about mental health issues and concerns about confidentiality in small communities, as was mentioned previously.

There is a strong feeling in rural communities that they are different from cities. Sociologists describe this quality as “gemeinschaft” which is normally translated as
“community” and refers to the closeness of social relationships said to be found in the community as moral worth (Tonnis, 1925:67, in Hughes, 2013:1). Rural areas are managed by a tribal authority, local government and a civic association. In smaller rural communities there is a community conception of being part of one big family. The city and government are seen as distant.

Contrasted to “gemeinschaft” is the concept of “geselleschaft” which means “society” or “association” where reference is only to the objective fact of a unity based on common traits and activities. It is maintained through individuals acting in their own self-interest. It emphasizes secondary relationships rather than family or community ties and there is less individual loyalty to society (Tonnis, 1925:67 in Hughes, 2013). This is more likely to be a feature of urban areas.

Every geographic environment in the rural area has its own distinguishing features, including culture. Rural culture is different from urban culture which implies that sociocultural linkages are important in any community. History, traditions, culture and value system are very important in the rural areas. The communities of the rural areas share the same values and cultural norms. The PHC nurses should consider the cultural beliefs and activities of the persons living with SPMI and their families, for example use of traditional medicine together with psychoactive medication.

The PHC nurses should also respect the cultural values of the community. The family structure is viewed as a place of care. Families take care of their vulnerable members such as persons living with SPMI by looking after them at home. If a family encounters difficulties, the significant others as well as members of the community will, in solidarity, offer their assistance (Makhele and Malaudzi, 2012:105). This view is supported by the African philosophy of Ubuntu. “Ubuntu” is an ancient African worldview based on primary values of intense humanness, caring, sharing, respect, compassion and associated values, ensuring a happy and qualitative human community life in the spirit of family (Broodryk, 2006:17).

The term “Ubuntu” is derived from a Xhosa idiom “umntu ngumntu ngabantu” which is translated into English as “a person is a person through other persons” (Broodryk, 2006:17, in Makhele and Malaudzi, 2012:105). There is almost always an extended family to rely on in the rural community-based settings. The persons living with SPMI
usually stay with their extended families who are always willing to help the persons living with SPMI. Only in extreme cases of violence or extremely deviant behaviour will persons living with SPMI be excluded from their families. The community can assist by giving support, advice and visiting where there are problems such as mental illness. Chiefs and traditional leaders ensure the continued respect for the maintenance of traditional culture, norms, traditions and values. Church leaders should work with families, pray for the people with mental illness and involve them in church activities such as bible studies (Blignaut, Bunde-Birouste, Ritchie, Slove and Zwi, 2009:12).

The context is any environmental health care service within community-based health care services in the rural areas. It is the immediate setting where the actual health care activities are performed. People living in remote and rural areas face significant disadvantages. These rural and remote communities are disadvantaged by reduced access to health services due to transport constraints, leading to lower utilisation of health care services and the consequent poorer health status of rural residents.

The rural residents’ inability to access health care services when required results in health needs not being adequately met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes. According to Fortney (2008:1), Americans with mental illness who live in rural areas are less likely to receive any type of treatment for their mental illness problems. A survey conducted by Gamm, Stone and Pittman (2010:102) found that utilisation of mental health service is lower in the rural areas and the degree of unmet treatment needs for severe and persistent mental illness may be higher in the rural areas.

In view of the above discussion it was evident that the lack of adequate mental health services in the rural areas may delay entry of persons with mental illness into the mental health system until their condition becomes more serious. Despite the differences between urban and rural areas, the key themes in rural health are the same around the world. This has been confirmed by a study conducted by Strasser (2005:459) who reported that access is the major rural health issue; even in countries where the majority of the population lives in rural areas, the resources are concentrated in the cities. He further stated that almost all rural areas have difficulties
with transport, communication and they almost all face challenges of a shortage of nurses and other health professionals such as social workers, doctors and psychologists in the rural areas. Strasser (2005:459) explained that the provision of health services in rural areas is affected by limited funding.

Community-based mental health services include a range of services that provide care to people with mental health disorders in the communities where they live and work (Lund and Flisher, 2009:1041). In Western countries, community-based mental health services are now becoming the preferred mode for delivery of mental health care in contrast to the more traditional psychiatric hospitals (Lund and Flisher, 2009:1041). Compared to the Western world, an African community is much more tightly knit with both stronger family cohesion and greater social support (Office of Rural Health and Primary care, 2007:15-19).

From the survey conducted by Alem, Jacobsson and Hanton (2008:54-57) on the basic elements required for a community based mental health service approach for Africa, many respondents endorsed principles of mental health care provisions such as accessibility and comprehensibility. In a therapeutic environment these elements are not considered a part of the usual background to treatment but have critical influences on therapy (Elder et al., 2009:393). The principal components of the therapeutic milieu are:

- A belief that the environment is the treatment agent
- The participation of persons living with SPMI and staff in decision making
- The use of a inter-professional treatment team
- Open communication
- Individualized goal settings with SPMI

A therapeutic environment is not only intended to meet a person’s needs for mental health care but also their need for recreation, occupational and social interaction (Elder, et al., 2009:393). The environment refers to all the internal and external factors or influences surrounding human beings. The influence of the environment on the individual may have positive or negative results. When asylums were instituted for the care of persons living with SPMI in earlier times, people believed that patients should
be placed in an environment that would have a healing effect on them. One of the most important therapies was the environment itself. The tremendous growth of these asylums led to them losing their therapeutic effects. There was overpopulation and standards were inadequate resulting in a non-therapeutic environment that had a detrimental effect on the mental state of some patients (Uys and Middleton, 2010:261).

The WHO (2001) set the following standards for a therapeutic environment (Uys and Middleton, 2010:262):

- The individuality of the patients should be upheld
- The humanity of the patients should be accepted by ensuring privacy and giving them living standards equal to those of general patients.
- The fact that a patient poses a considerable degree of responsibility and initiative should be accepted.
- Activities and a proper workday are essential for all mentally ill persons

In this study, the environment is viewed as the context in which the person living with SPMI interacts with both external and internal stimuli. The individual responds uniquely to a particular environment and reacts differently in another environment. The presence of certain events in an individual’s daily life may need one to adjust or cope with the situation as it presents itself or which may be visible to the people that one interacts with. The common stimuli are stressors that emanate from the external environment.

The environment is used as the context and as a platform on which the mentally ill person interacts with family, friends, community as well as the health professionals in the rural areas of Emalahleni LSA, at Chris Hani District. In rural areas there are at times physical barriers to a clinic though it may be within 5 kilometres of the clinic. Sometimes the family members will transport their mentally ill person in a wheelbarrow or a donkey cart to the clinic. At times the parents are old and not physically strong enough to push the wheelbarrow, the distance is too far for them to walk and the hills are too steep for them to manage a wheelbarrow (www.ajod.org/index.php/ajod/article/view/19/34).
Sometimes it takes the whole day by foot for patients to get to the clinic which is far away from where they stay. One of the participants explained that they have to take a four hour walk on the narrow gravel roads to the nearest health clinic. The roads are steep and at some places there are only paths to climb up and down. Sometimes, as the mentally ill patient needs to be accompanied by a family member, transport expects to be paid for an extra person. The person living with SPMI and the family cannot afford this, hence they default their treatment. In some areas mobile clinics used to be available, but because of bad roads they broke down resulting in non-availability. Geographic barriers include rivers, lakes, bad roads, valleys and mountains.

Figure 4.3: Rural areas of Emalahleni LSA

This is also a barrier to access service in the rural areas which can make it difficult for mentally ill persons to go to the clinics resulting in non-adherence and relapse of mentally ill persons as mentioned previously.
In the study conducted by Kitty (2007:14) regarding transport, participants pointed out that everybody is spread out in the rural areas; lack of transport is a huge barrier to access health care services. At times it becomes very hard for mentally ill persons in rural areas to go to the hospital when referred because a person who does not behave in a social acceptable manner will not be allowed to board a bus.

The required resources for the implementation and utilization of strategies to facilitate the multifaceted role of the PHC nurses will be obtained from the PHC services where the PHC nurses are employed. It should also be noted that the strategies to facilitate the community-based health care of persons living with SPMI and their families will be developed and implemented in PHC services in the rural areas.

The person and the environment are seen to be in constant communication. Orem calls it the person-environment interaction (Fitzpatrick and Whall, 2005:180-181). The person and the environment within which persons exist are inseparable but factors about the environment and the human relationship can be isolated and described. From the viewpoint of self-care deficit nursing theory, a significant meaning of environment is as a basic conditioning factor. Environment conditions the person’s need for self-care, the actions selected and the setting within which care is given, the opportunity to engage in those actions and the restricting influences which interfere with that engagement.

4.3.4 Dynamics

Dickoff et.al, (1968:431) describe the dynamics of an activity as the power source or energy. The power source can be physical, biological, chemical or psychological. These dynamics involve aspects that facilitate the relationship of the nurse and the persons living with SPMI and their families to achieve the goals and the purpose of the goals. The dynamics are motivating or driving forces in performing activities to realize particular goals. The dynamics take place between the PHC nurses and the persons living with SPMI as well as their families. The dynamics involves aspects that facilitate the process of therapeutic relationship of the PHC nurses, persons living with SPMI and their families to achieve the objectives and the purpose of the study. In this study, the persons living of the SPMI and their families experience challenges regarding community-based care and PHC nurse experience the integration of mental health
care services into PHC as challenging. In this study, the PHC nurses needed information for growth and development and to be rewarded with positive performance while persons living with SPMI and their families needed access to resources and support in the care, treatment and rehabilitation for their mental illness to enable them to function at an optimal level of self-care.

In this study the motivation to perform the activities came from the two themes reflected at the beginning of this chapter as obtained from the study. These themes are the driving force to achieve the goal. To ensure that challenges were addressed, facilitation entails a PHC nurse assisting the Person living with SPMI and their families to identify and develop their personal strengths in order to deal with the challenges (Petersen and Bredow 2011, in Velikoshi, 2011:87). Communication comprises the exchange of information between the PHC and the persons living with SPMI and their families. The development of strategies is viewed as a response to the identified challenges (themes) which are aimed at achieving the goal (terminus) (Antai-Otong, 2007, in Velikoshi, 2013:88)

Dynamics is the energy source and takes place between the PHC nurse and persons living with SPMI and their families. Dynamics involve aspects that facilitate the social process of the relationship of PHC nurses and the persons living with SPMI and their families that achieves the goal. The active participation of the PHC nurse, persons living with SPMI and their families (needing knowledge and skills) facilitates autonomy and independence. The families need access to resources and support in the care and rehabilitation of their mentally ill relatives. The families also need full participation in decision-making about the treatment plan of their mentally ill relatives. The agent should be motivated and energetic with a good therapeutic relationship between the agent and the recipient in order to reach terminus. The agent, sub-agent and the recipient also contribute to the dynamics of the process of the relationship which will be discussed below.

4.3.4.1 Therapeutic relationship

A therapeutic relationship supports a positive link between the therapeutic relationship and improved outcomes for persons with mental illness. A therapeutic relationship is an enabling relationship that supports the needs of the person with a mental illness.
The nurse is entrusted to understand their needs and then become empowered in their lives. A therapeutic relationship is based on rapport establishing a connection with the mentally ill person and developing trust. Therefore the principles of rapport also need to be extended to include families and caregivers of people with mental illness (McAllister et al., 2004, in Elder et al., 2009:409).

The function of the therapeutic relationship is to provide a platform for interaction between the PHC nurses and the persons living with SPMI. This interaction allows the PHC nurses to act as mental health educators, to assess the mental health needs of persons living with SPMI and their families for support and for advocacy, to assess the needs of the individual Person living with SPMI for referral to other members of the inter-professional team and to act as coordinator of mental health care.

The therapeutic relationship can also be used to provide support as well as learning about problem solving techniques and coping strategies. However, the reality of time constraints experienced by nurses working in PHC facilities is a negative factor in facilitating an effective therapeutic relationship. As high workloads are experienced, the time spent with each patient is limited.

**Therapeutic use of self**

Therapeutic relationships are the foundation upon which all other activities are based. Therapeutic use of self is firstly an interpersonal process that uses the self as the means of developing and sustaining nurse-patient relationships. It involves using aspects of the nurse’s personality, background, life skills and knowledge to develop a connection with a person who has a mental health problem or illness. The purpose is to establish a therapeutic alliance with the person with mental illness because in mental health service patients also suffer from isolation. Mentally ill persons may be scared of talking to others because they fear being rejected; this makes it difficult for them to formulate relationships. (Elder, Evans and Nizette, 2009:4-5). In the process the agent and sub-agent develop a dialogue with the recipient in order to feel safe enough to disclose personal and distressing information.
Empathetic understanding, as a contributing dimension of a therapeutic relationship

Empathy is a key component of a therapeutic relationship. Empathy exists when the nurse to some extent experiences what life is like for the patient as if she/he is looking through the patient’s eyes. With empathetic understanding, the nurse communicates that they understand what the patient is actually saying and shows a willingness to listen. According to Roger’s theory (1975, in van de Heever, 2012:15), empathy is also a way of thinking with the patient and not for the patient.

The nurse-family relationship

The nurse-family relationship is interpreted as an environment that is enabling, purposeful sharing of information and nurturing. The dynamics for a community-based health care service for persons living with SPMI and their families in rural areas is referred to as the nurse-family relationship. The PHC nurse must engage the persons living with SPMI and their families to promote interaction in order to develop meaningful, purposeful, goal-directed and professional relationships. This relationship is fundamentally reciprocal and considered important in promoting persons living with SPMI’ and their families’ participation in care. This relationship can become a vehicle to exchange information. The relationships are preceded by trust and rapport. Nurse-family relationships are viewed as being as being critical to health care and nursing contributing to the whole person’s health, well-being, recovery and quality of decision-making (Shattell, 2004:712-722).

In literature, nurse-family relationships are referred to as nurse-patient interactions. These relationships are interpreted as an interpersonal activity in which the nurse is able to see the person in the patient and the patient sees the person in the nurse (Shattell, 2004:712-722). Peplau’s Interpersonal Theory of Nursing is specific to practice and outlines the therapeutic relationship between the nurse and patients. (Elder et al., 2009:129). According to Peplau, the PHC nurse does not perform therapy on the persons living with SPMI and their families but rather the PHC nurse IS the therapy. This heralded a shift in nursing practices from doing to an Person living with SPMI to being with the persons living with SPMI and their families. Peplau conceptualized the theory of developing nurse-patient relationships within a social and psychological dimension. Critiques of Peplau’s theory suggested that in advocating for
interpersonal relationships, Peplau was promoting the use of empathy to facilitate appropriate nursing care.

The nurse does not only build a relationship with the primary patient but also with the family or primary caregivers. This relationship is built on the same competencies as that of the nurse patient relationship. When the family is in high stress during an acute episode of mental illness with the relative, they appreciate the availability of health professionals. The availability of the nurse should include early information about the condition of the mentally ill person, treatment options and protection during frightening events. During the periods when the mentally ill person is not acutely ill, the mental health nurse needs to provide opportunities for sharing, so that the treatment and rehabilitation team co-ordinate their efforts with that of the family and planning and information is shared between families and teams. As the patient moves towards recovery, the mental health nurse should focus on empowering the family with information (Uys and Middleton, 2010:187-188).

Dynamics denotes the energy source or motivation for the activity (Dickoff et al., 1968). The dynamics are motivating or driving factors in performing activities to realize a particular goal. In this study, the motivation to perform the prescriptions came from themes and sub-themes obtained from the study results, which needed to be addressed:

- Emotional challenges to the families of persons living with SPMI
- Attempt to cope with mental illness
- Expression of difficulties in taking care of persons living with SPMI

To ensure that these challenges and problems were addressed, a dynamic collaboration between the PHC nurses and the families of persons living with SPMI was undertaken. This entailed PHC nurses assisting the families of persons living with SPMI to identify, develop and mobilise their personal strength in order to deal with the confronting problem. Collaboration comprises the exchange and processing of information between the PHC nurses and the families of persons living with SPMI. The teaching-learning process is viewed as dynamic and interactive, and involves deliberate convention of information to the families as sub-agents in response to the
identified challenges and problems (themes and sub-themes), which are aimed at achieving the goals/terminus. Therefore, collaboration forms an interpersonal relationship between the PHC nurse and the families of persons living with SPMI, which is essential for effective learning and mental health care to take place.

4.3.5 The procedure

The procedure in the most obvious sense of the term suggests the steps to be taken towards some accomplishment that is, achieving the terminus. The procedure may be governed by principles, rules, routine or protocols (Dickoff et. al., 1968:430). Procedure refers to a series of steps to be undertaken to bring about the desired goal. The strategies addressed the challenges identified. Procedure is the technique of the activity. It indicates the protocol of the activities to be followed. The procedure involves a two-way process of interaction between the PHC nurses and persons living with SPMI and their families. For the procedure to be effective, the environment should be enabling or conducive. Elements needed are identification of the problem, sharing of common goals, active involvement in accessing knowledge and skills resources and information and support to achieve independence, self-care and autonomy and becoming self-sufficient in dealing with the challenges of persons living with SPMI and their families.

The procedure described in cogitation map (Figure 4.3) requires development of strategies to assist the PHC nurses to facilitate community-based health care of persons living with SPMI and their families in the rural areas. Proposed strategies may require implementation at a more personal level and, as a result, may be classified as functional strategies (Ehlers and Lazenby, 2010:199). Functional strategies in this context are those strategies that the PHC nurses may implement on an individual basis in everyday practice when dealing with persons living with SPMI and their families.

The strategies which will be developed are required to influence the therapeutic relationship and support between the persons living with SPMI, their families as well as the PHC nurses in the rural areas. The strategies identified during data analysis and the comprehensive literature search address the health care needs identified by the persons living with SPMI, their families as well as PHC nurses in the rural areas. The four strategies are as follows: supportive-supervision, collaboration, mentoring
and capacity building. Each strategy incorporates an activity that will be used to facilitate the multifaceted role of the PHC nurses in the rural areas. The activities are: Coordination, Action, Reflection and Education. These activities form the “CARE” approach to facilitate community-based health care of persons living with SPMI and their families in the rural areas. The researcher derived “CARE” from the first letters of the activities of each of the strategies. The following table demonstrates the four identified strategies and their four activities:

Table 4.2: The four identified strategies and four activities:

<table>
<thead>
<tr>
<th>THE ACTUAL STRATEGY</th>
<th>THE CORE ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive supervision</td>
<td>Coordination</td>
</tr>
<tr>
<td>collaboration</td>
<td>Action</td>
</tr>
<tr>
<td>Mentoring</td>
<td>Reflection</td>
</tr>
<tr>
<td>Capacity building</td>
<td>Education</td>
</tr>
</tbody>
</table>

In this study, the procedure consists of strategies for community-based health care for persons living with SPMI in the rural areas of Emalahleni LSA and the provision of knowledge and skills to persons living with SPMI and their families. In chapter five of this study the researcher will present proposed strategies and the concept of “CARE” to facilitate the community-based health care for persons living with SPMI and their families.

A community-based mental health care system may be described as one that provides mentally ill persons with maximum health benefits at a reasonable cost. Mental health care is an integrated and coordinated system of health care. It is a system that sees the persons living with SPMI as belonging to a family and a community and operating in a specific social and physical environment, which has a profound influence on the health of an Person living with SPMI. In this system, use is made of all community resources and the participation of a community member in the planning, organization and evaluation of the services is encouraged (de Haan, 2011:23).

Social dysfunction is a characteristic of many mental illnesses. This is particularly true of persons who have been treated over long periods of time. The Person living with SPMI is often socially isolated and a member of the family network. To re-integrate the person in the social world, it is essential that social skills training be part of the
treatment and rehabilitation programmes. It is designed to help families of the Person living with SPMI develop skills to understand and cope with a family member with SPMI. Skills are specific and behaviour is modified which is totally appropriate in one situation and may not be acceptable in another (Uys and Middleton, 2010:255).

4.3.6 Terminus

The terminus refers to the situation to be produced at the end of the process, that is, the end point of an activity. The terminus brings about a feeling of satisfaction in the performance of an activity. To regard activity from the aspects of terminus is to consider the activity from the point of view of what is accomplished by the activity (Dickoff, et al., 1968:428). In the present study, the terminus will make the activity more attainable for both the agent and the recipients. The terminus refers to the Person living with SPMI who becomes mentally stable after intervention programmes such as health education, social skills teaching, support groups, therapeutic use of self by the agent, the nurse patient relationship, psycho-education and other intervention activities. The terminus is the achieved goals for the persons living with SPMI and their families.

The strategies to facilitate community-based health care of persons living with SPMI will be practicable and acceptable for the agent and the recipient. Dickoff’s concepts and survey questions are schematically applied to the development of the conceptual framework of this study as depicted below:
4.4 CHAPTER SUMMARY

Chapter Four, which constituted Phase Two of the study, focused on the development of the conceptual framework for the development of strategies to facilitate community-based healthcare of persons living with SPMI in the rural areas of Emalahleni LSA. The intention for conceptualisation was to guide planned actions towards the goal to...
be achieved and conceptualise the survey list. The Dickoff’s model was used to link the findings of the study to practical healthcare thus providing a foundation for the development of strategies.
CHAPTER FIVE

STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR PERSONS LIVING WITH SEVERE AND PERSISTENT MENTAL ILLNESS

5.1 INTRODUCTION

Chapter four described the development of a conceptual framework on which strategies that the PHC nurse may utilize to facilitate the development of community-based mental health care services for persons living with SPMI and their families in the rural areas of Emalahleni LSA in Chris Hani District. The survey list of Dickoff et al. (1968:422), as described in chapter four, was used as the basis for the strategies. According to Dickoff et al. (1968:422), the survey list provides the future prescription for activity towards the goal identification of concepts of agent, recipient, procedure, dynamics and terminus that are an integral part of the survey list and will serve as the cornerstone that guide the implementation of the proposed strategies. However implementation of the emerged strategies is not part of this study. The strategies will be driven by the PHC nurse as a primary agent. The sub-agent who is a family member of the Person living with SPMI may assist with help and guidance from the PHC nurse.

5.2 IDENTIFICATION OF STRATEGIES TO BE USED TO FACILITATE THE MULTIFACETED ROLE OF PHC NURSES IN RURAL AREAS

A strategy refers to a pattern or plan that integrates an organization’s major goals, policies and action sequences into a cohesive whole. A strategy is a road map that is utilised to achieve the goals (Machapalala, 2010:11). David (2009:36), in Machapalala (2010:15), defines strategic development as the art and science formulating, implementation and evaluating of decisions that enable an organisation to achieve its objectives. This implies that any decision-making process culminates in formulating strategies. The strategies are developed in order to achieve goals and objectives which is the ultimate aim of the strategic development process. According to David (2009:37, in Machapalala, 2010:15), the development of strategies is directed towards the future.

Thompson and Strickland (2003:365) argued that strategy implementation is an integral component of the strategic management process and is viewed as the process
that turns the formulated strategy into a series of actions and then results to ensure that the vision, mission, strategy and strategic objectives of the organisation are successfully achieved as planned. Strategy implementation requires establishment of annual objectives, devise policies, motivate employees and allocate resources so that formulated strategies can be executed (Thompson and Strickland, 2003:365). Implementation is not part of this study.

Strategy development includes developing a strategy-supportive culture which consists of shared values, beliefs and attitudes, the way of doing things, thinking patterns and behaviour, perceptions and assumptions thus creating an effective organizational structure that indicates how objectives and policies will be established. Secondly, it dictates how resources will be allocated, redirecting market efforts, preparing budgets, developing and utilizing information systems, and linking employee compensation to organizational performance. Strategic implementation often is called the “action plan” of strategic management (Thompson and Strickland, 2003:365).

The strategies were formulated in relation to the themes that emerged from data analysis on the lived experiences of PHC nurses, persons living with SPMI and their families. The first step in the development of the strategies was the consideration of the conceptual framework as outlined in chapter four. The concepts in the framework were applied to provide the structure in each strategy. Therefore included in each strategy is the agent, the recipient, the context, the dynamics, the procedure and the terminus. The second step was the actual phrasing of the strategies based on the conclusion of the themes.

The findings from the interviews have been used as evidence to develop the strategies that will be utilised to increase capacity and skills of PHC nurses in order to render optimal care to the persons living with SPMI. In this study a strategy was developed after analysing data obtained from the interviews. Analysis and synthesis of themes led to the identification of four strategies that would facilitate the multifaceted role of the PHC nurse in the rural area of Emalahleni LSA.

The four strategies identified are:

- supportive-supervision
The identified four strategies listed above have four activities that are required for their implementation namely: Coordination, Action, Reflection and Education: “CARE” approach. “CARE” is derived from the first letters of the activities of each of the strategies. See the table in chapter four.

The concept care is defined as “the provision of what is necessary for the health, welfare, maintenance and protection of someone or something; serious attention or consideration applied to an action or plan; look after and provide for needs of” (SA Concise Oxford Dictionary, 2002:172). The Collins SA School Dictionary (2004:121) defines the concept care as a concern or worry; care of someone or something, looking after someone or something; if you do something with care, you do it with close attention”. It is often said that care is a universally accepted concept attributed to the nursing profession (Keogh and Gleeson, 2006:1172) and it is also considered to be its hallmark, therefore it is the central ethic in nursing (van der Wal quotes Klimeck (1990) in Pera and van Tonder, 2005:121). Caring for someone in a nursing context is purposeful interaction intended to promote health.

Mental health care consists of transpersonal human to human attempts to protect, enhance and preserve humanity by helping persons living with SPMI and their families find meaning in mental illness, suffering, pain and existence; to help another gain self-knowledge, control, and self-healing in which a sense of inner harmony is restored regardless of the external circumstances (Watson, 1985 as quoted by van der Wal in Pera & van Tonder, 2005:15).

In order for this goal to be attained, Co-ordination of activities is necessary to make collaboration with other stakeholders possible. Action on a number of different levels is required, Reflection encourages understanding and self-awareness in PHC nurses and Education of PHC nurses, persons living with SPMI and their families is important to achieve the goal.
Functional strategies are those strategies on a micro level which a PHC nurse is able to implement in everyday practice and will be discussed in greater detail than grand strategies. It is possible for grand strategies to be influenced to some extent by the PHC nurses. The PHC nurses may not always be in a strong position to directly influence political or legislative action and the development of policies personally, but have the potential to influence those who will do so. It is, therefore, possible for PHC nurses to find themselves in a position to lobby for changes which will positively affect their ability to assist the persons living with SPMI and their families by implementing strategies.

5.3 BACKGROUND TO STRATEGIES TO FACILITATE THE MULTIFACETED ROLE OF THE PHC NURSES IN RURAL AREAS.

Rural health care is characterized by diversity of patients, variety of service models, limited resources, poor access to professional development opportunities, high prevalence of chronic diseases and traumatic injuries. Some of the characteristics and challenges of rural practice may be similar across nursing practice however PHC nurses in rural areas are more likely to work in sole charge positions or in settings such as in the clinic where there is an absence of other health professionals (Sheppard, 2005, in Roots, 2011:70-74). The challenges noted by PHC nurses included staff shortages, work load and a lack of professional support (Wielandt & Taylor, 2010, in Roots, 2011:70-74). In rural PHC services the nurses practice as generalist nurses (Sheppard, 2005, in Roots, 2011:70-74). Being a generalist nurse means that the PHC nurse should display the multifaceted roles in rural practice to enhance skills and fundamental levels of competences across the full scope of practice. The essential knowledge, professional and clinical skills required to practice as a generalist nurse can be viewed as an area of specialisation (Sheppard & Neilson, 2005:135-136).

The complexity of SPMI patients’ needs coupled with limited resources in rural communities requires PHC nurses to practice proficiently to the full extent of their scope of practice. The scope of practice refers to the range of roles, functions and responsibilities and decision-making capabilities and is based on the PHC nurse’s education, training, development and competencies (Devine, 2006:205-206).
researcher echoed this observation noting that PHC nurses in the rural areas should be equipped with skills to understand and influence them. PHC nurses in rural areas required knowledge of rural health issues in addition to their skills. Another important element of PHC is a team-based approach to health care delivery (Devine, 2006:205-206).

In this study, participants’ understanding of rural were characterized by geography, access to all human needs, poverty in all aspects, restricted access to health care services and determinants of health. This rurality influences the way in which rural PHC practice is enacted and the health care context in which PHC practice occurs. Rurality results in PHC nurses specialising in multifaceted roles and stretching their role to meet the mental health care needs of persons living with SPMI and their families. The ways in which the PHC nurses enact their roles are embedded within the larger context of PHC (Ross, 2008 in Roots, 2011:70-74). All PHC nurses who participated in the study agreed that their roles are general, extremely varied and cover all aspects of nursing within their scopes of practice. Their role context required them to deliver services in multiple settings and to have a variation of skills for rural practice. Some of the PHC nurses had worked in an urban area such as in Komani Hospital and Frontier Hospital as well as Life Care Private Hospital and were able to compare rural practice with urban practice in which practitioners could choose a more focused area of practice.

Features of general practice included the complexity of mental health problems in rural areas and limited access to other health professionals. Maintaining a general practice, in other words, an integrated health approach was considered by many PHC nurses as a necessity to ensure the provision of equitable services. They felt that focusing in one area and narrowing their roles would be denying health services to the community in need. The need to apply a one-stop shop approach to meet the needs of the population was one of the features of rural practice that PHC nurses felt needed to be recognized by other nurses. PHC nurses noted that to meet the demands of the rural context required a variety of skills and knowledge from all areas that is the application of the one-stop shop approach in executing their health services.
PHC nurses explained that the lack of resources and service of rural practice required them to stretch their role and work to their full scope of practice. In this context the scope of practice refers to the tasks and services legally offered by a profession to the community. The scope of practice includes reserved acts that are not exclusive to them and may include areas that overlap with the scope of another profession. The PHC nurses felt they could offer effective health services through using the broad range of skills in their scope of practice and stretching their role beyond what might normally be expected of them (www.health.gov.bc.ca/leg/hpc/review/termsref.html). Stretching of roles allowed PHC nurses to meet the persons living with SPMI needs. This occurred in particular where there was only one PHC nurse. While they identified a number of barriers to providing a team-based approach such as shortages of staff, limited capacity due to time constraints and high workload, they referred to stretching their roles as a means to overcome these limitations. As a result PHC nurses stretch their roles by providing social support to the persons living with SPMI and their families as a crucial aspect of patient care.

5.4 DESCRIPTION OF THE STRATEGIES TO FACILITATE THE MULTIFACETED ROLE OF THE PHC NURSES IN RURAL AREAS

Rural PHC nurses are required to be multi-skilled generalist nurses capable of providing a wide range of nursing care to a diverse range of patients. A number of factors that influence the role of the PHC nurses include the impact of shortage of work force and workplace reality, knowledge and skills expected of a professional nurse and the available support system. Integration of mental health care into PHC holds specific benefits to all relevant role players. This type of approach is seen to be more democratic and politically correct (Heunis and Schnieder, 2006:274). Even though the integrated approach provides less certain outcomes as it emerged from the themes of this study, there is a need for rendering integrated care especially in more rural areas to strengthen the health system (Heunis and Schneider, 2006:275). The integration of mental health care into PHC services demands competent nurses to improve the quality of health care offered to the mentally ill persons.

The WHO (2008:79) stated that competencies encompass knowledge, skills and changes in attitude that a person develops as she/he goes through education and
training and work experience that can be used to describe the multifaceted role against which an individual performance may be assessed. In order for the needs (as discussed in chapters 3 and 4) of the persons living with SPMI and the families to be met the PHC nurses need to be multi-skilled to be able to provide integrated services especially when using a one-stop shop approach. In the light of integration and comprehensive PHC all nurses working in the clinics need to be well equipped with the knowledge and skills needed to meet the needs of persons living with SPMI and their families in the rural areas. Lack of knowledge and skills in mental health care affect the PHC nurses’ practice in the rural areas. The philosophy of PHC consists of eight elements or components. One of the elements of this global strategy involves the rendering of primary curative or primary medical care which includes the assessment of the patient, the diagnosis of the condition and the prescribing of the appropriate treatment for the patient. Traditionally this service is rendered by medical practitioners on a daily basis (Dennill, King and Swanepoel, 1999:2).

In most rural areas there are either not enough medical practitioners to render health care, or they are not willing to work in the remote rural areas. For this reason PHC nurses in South Africa are expected to stretch their role to perform some of the duties of a medical practitioner. This presupposes that PHC nurses would have the necessary knowledge and skills to render appropriate health care to persons living with SPMI and their families. Health professionals, especially PHC nurses, should therefore be effectively utilised to fill the gap in the rural areas caused by the shortage of doctors and other members of the inter-professional team in the health field.

According to the International Council of Nurses (ICN) (2003:13), nurses are key members of the health care services in every country. Their role and status, their educational preparation, their profession and their working conditions all vary greatly across the world. PHC nurses are now rendering mental health care previously rendered by medical practitioners. They are now not only rendering preventive and promotive health care as they have done in the past, but are expected to provide chronic health care, curative health care, counsel patients, monitor mentally ill persons and are even expected to prescribe psychotropic drugs using available protocols and the Essential Drug List (EDL).
If the PHC nurses are to perform some of the duties done by medical practitioners, when the medical practitioners are not available to render PHC services in the rural areas, she/he should have at least some of the knowledge and skills expected of her/him to be able to substitute in this role. It is therefore important to determine what this would entail. The PHC nurses should be able to provide effective and efficient mental health care independently. The PHC nurses also should have developed the necessary knowledge and skills to judge whether they themselves are competent enough to treat the persons living with SPMI and when to refer them to the next level of health care delivery.

It would be ideal if the PHC nurse could share her responsibilities with other members of the multi-disciplinary team as the philosophy of PHC advocates. With the shortage of the other members of the multi-disciplinary team in the most remote rural areas, the PHC nurse often does not have the opportunity to be part of a multi-disciplinary team. With the development towards a greater comprehensive approach to patient care, nurses are often required to render PHC which includes mental health care, for which they often do not feel properly prepared.

In this study, Orem’s (2001) self-care deficit nursing theory has been applied. According to Orem (2001) self-care is action of mature and maturing PHC nurses who have the power and who have developed or developing capabilities to regulate their own functioning and development in PHC services. Orem describes self-care as human endeavours and learned behaviours that are deliberate purposeful actions in which individuals engage, to influence factors that regulate personal functioning and development. Just as Orem’s model proposes that power for optimal ability and functioning of self-care agency is important to the individual in a parallel manner, Orem (1995) also proposes that power of nursing service is important to the ability and function of PHC care.

According to Orem, a therapeutic self-care agent is defined as a maturing adult or an adult who is the PHC nurse or an agent in this study, who accepts and fulfils the therapeutic self-care demands of others, that is persons living with SPMI and their families. According to Orem person as agent - PHC nurse is central to those actions in which a person engages for the purpose of promoting and maintaining life, health
and well-being. Orem’s theory of self-care represents PHC nurses’ work regarding nursing as a field of knowledge (Orem, 2001:20). The overall purpose of Orem’s theory is not just to view the person as a whole, but to utilise nursing knowledge to restore and maintain the persons living with SPMIs’ optimal health. The researcher saw it necessary to use Orem’s theory because of its relevance to the study. According to Orem, this theory is not an explanation of a given situation or individuality specific to nursing practice, but a combination of characteristics common to all nursing circumstances as a general theory. This theory may be appropriate for nurses involved in nursing clinical practice, the development and validation of nursing knowledge and the teaching and learning of nursing (Orem, 2001)

From the findings of the data analysed, it is evident that PHC nurses find themselves less able to render their services as required, as depicted in their experiences. The identified themes were seen as viewpoints on how the PHC nurses could be capacitated to deal with the persons living with SPMI and their families and to deal with the environment in which they are working. The PHC nurses are task with facilitating the health care of persons living with SPMI so that they can function at their highest level of capability. While being charged with these responsibilities, PHC needed to receive capacity building to acquire the skills and competencies needed to function effectively and render quality patient care. In this study, PHC nurses are the recipients who have the quest for capacity building. Capacity building starts with the activities for growth in their multifaceted roles.

The results of the study revealed that a lack of capacity among PHC nurses in relation to mental health care results in skills gaps as a major obstacle. Some of the PHC nurses are not trained in mental health care and the trained ones lack the modern concepts of mental health care practices. Although in principle, PHC requires inter-sectoral coordination and community participation, they are often lacking when put into real practice. These findings demonstrated a need for capacity building in order to equip the PHC nurses to optimise their roles. The views expressed indicated that the PHC nurses needed to be empowered through capacity building to equip them with competences that were related to enhancing their ability to care for the persons living with SPMI and their families. Capacity building was seen as a strategy that could assist these PHC nurses to optimise their clinical practice. The aspects of activities proposed
by Dickoff et al, (1968:245) in the survey list consist of agent, recipient, context, dynamics, procedure and terminus. The purpose of each of the four strategies was:

- To facilitate appropriate practices which foster supportive mental health care and the therapeutic relationship between the PHC nurses and the persons living with SPMI and their families.
- To empower the persons living with SPMI and their families to develop skills to be able to function at an optimal level to take responsibility of their own health care.

The strategies that are going to be used to facilitate the multifaceted role of the PHC nurses are now discussed below. These strategies list four dimensions of facilitation of the multifaceted role of the PHC nurse namely, supportive supervision, collaboration, mentoring and capacity building. The following table summarizes the strategies:
Table 5.1: Summary of strategies for facilitation of the multifaceted role of the PHC nurse using care approach

<table>
<thead>
<tr>
<th>1. Coordination (core activity)</th>
<th>Supportive-supervision Strategy</th>
<th>Proposed outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the action necessary to convert vision into action. This includes services to be provided</td>
<td>Support, educate and develop PHC nurses in the rural areas to enhance the quality of clinical practice</td>
<td>Supportive supervision will develop the skills of PHC nurses, address the areas of need and encourage high standards of clinical practice</td>
</tr>
<tr>
<td><strong>Functional strategy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish a supportive programme for PHC nurses with clear and specific programme objectives.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Action (Core activity)</th>
<th>Collaboration Strategy</th>
<th>Proposed outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination provides integration of activities and responsibilities to ensure that available resources are used most efficiently</td>
<td><strong>Collaboration</strong> is a strategy of coordinating health services to provide persons living with SPMI and their families with maximum benefits</td>
<td>Effective collaboration with inter-professional team, other government departments such as education, justice and labour to shape the mental health care around the needs of persons living with SPMI and their families in the rural areas.</td>
</tr>
<tr>
<td><strong>Functional strategy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working in partnership with the inter-professional team, and other government departments such as education and labour, and community-based organisations such as churches, traditional leaders, traditional practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Reflection (core activity)</td>
<td>Mentoring strategy</td>
<td>Proposed outcome</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>It is a practice of reviewing an experience in order to describe, analyse, evaluate and inform learning about practice</td>
<td><strong>Mentoring strategy</strong> creates a mentoring programme that will focus on the developmental needs of PHC nurses throughout their professional career</td>
<td>PHC nurses will have access to a mentoring programme that is relevant to their developmental needs to improve the multifaceted role of PHC nurses as well as increasing their self-awareness and ability to critically reflect.</td>
</tr>
</tbody>
</table>

**Functional Strategy**

Mentoring improves the multifaceted role of PHC nurses as well as increase their self-awareness and ability to critically reflect by implementing appropriate mentoring system.
### Each strategy forms the umbrella term which may be described as follows:

- Rationale
- Explanation of the strategy
- Objectives
- Action steps

### 5.4.1 STRATEGY ONE: SUPPORTIVE-SUPERVISION

**Core Activity: coordination**

**Coordination activity** provides integration of activities and responsibilities to ensure that available resources are used most efficiently. The coordination of activities on a national, regional and local level is essential to improve mental health care of persons living with SPMI and the families in the rural areas.
Co-ordination of resources requires implementation on the macro, meso and micro levels in order to provide adequate health care resources. These strategies are examples of those that need to be in place to enable the professional nurse to deliver the required care to the individual person living with SPMI. Creating strategies requiring co-operation and networking between different departments or organizations or between health care providers can lead to more effective implementation of care for persons living with SPMI and their families. Co-ordination of services and activities is recognized by the World Health Organization as an important method of improving health care service delivery in low and medium income countries (World Health Organization, 2008a:2). However, the report states that “coordination” must be seen as beneficial to persons living with SPMI and their families to obtain the mental health care they need in order to achieve a high level of functioning.

**Care coordination**

Coordination of care is the basic principle of the inter-professional team approach to mental health care, yet there is lack of coordination as well as limited mental health care in PHC services in the rural areas. The PHC nurse as a coordinator must try to improve the health and well-being of persons living with SPMI and their families by promoting self-care and independence. Mental health education is essential for persons living with SPMI and their families because it emphasizes continuity of care for mentally ill persons who need complex health care (Stanhope and Lancaster, 2008:794). The delivery of health care involves disciplines and organization such as PHC clinics, hospitals and local public health.

Care coordination can be challenging in a large rural population with scarce resources and mental health care services that must cover a vast geographical area. Care coordination, referrals and knowledge of where such services can be obtained is important (Office of Rural Health and Primary Care, 2007:15-19). In South Africa, at policy level, the National Department of Health has committed itself to a comprehensive community-based mental health service that is integrated into general health care (Department of Health, 1997 in Lund and Fisher 2009:1041). Community-based mental health services were grouped into three types of facilities:
• Outpatients and emergency services which comprise PHC clinics, mobile facilities, community health centres and outpatients emergency services in hospitals.

• Residential care facilities which consists of homes, boarding houses and halfway houses. In the rural areas there are no boarding houses and halfway houses, most of the persons living with SPMI are staying with their families and extended families within their communities sharing a home.

• Day care centre facilities which provide sheltered employment, supported independent living, social or recreational clubs, home-based care or support groups.

In this study, the above mentioned types of facilities form part of the primary health care services that are needed by the community as their community-based services. According to Merzel and D’Afflitti (2003:557-574), community-based health care is integrated and comprehensive, not limited to medical care settings and systematically involve the community programmes taking place in the community. Participants in this study saw clear and complementary roles for community members, community leaders, churches and non-government organizations across the spectrum of interventions in the rural areas, from mental promotion to prevention and care for those with mental health problems (Blignaut, Bunde-Birouste, Ritchie, Slove and Zwi, 2009:12). They emphasize a need for collaborative approach for the local chiefs and churches to work together to help the vulnerable individuals with mental illness.

The WHO (2001) proposed the development of community-based mental health care services through integration of mental health into the existing PHC system and mobilization of community resources.

**Functional strategy**

Functional strategies are necessary to ensure effective use of the available resources. The professional nurse facilitates the implementation of functional aspects related to the coordination strategy. In order for a strategy to be successful, it has to be correctly and effectively implemented in the manner intended. Successful implementation requires making use of all available resources as well as co-ordination of those resources. The available facilities require coordination for efficient mental health care
delivery to occur in order that persons living with SPMI and their families are able to access that care easily and effectively. Participants from both groups felt that the mental health care in the wide-ranging levels of service in PHC is often inefficient in the provision of adequate mental health care and resource.

**Functional strategy for this study**

Establish a supportive program for PHC nurses with clear and specific program objectives.

**RATIONALE**

The rationale of community-based mental health care is the notion that individuals cannot be considered separately from their social milieu and context and that health care should incorporate multiple interventions extending beyond the individual level. Supportive-supervision strategy supports, educates and develops PHC nurses in the rural areas to enhance the quality of clinical practice. Supportive supervision is a process that focuses on the clinical work of the nurse. It provides an arena in which the PHC nurse can reflect with another experienced PHC nurse who is the supervisor. Supervision is to oversee or to view another’s work generally. Others may posit that supervision is to check whether someone is correctly performing a particular activity or intervention (Elder et al., 2009:9). Supportive supervision is concerned with the professional development of the PHC nurses to improve the care of the persons living with SPMI and their families. Underlying supportive supervision is the notion that PHC nurses are growing in competence. The PHC nurse is aware of the ongoing supportive supervision to achieve increasing levels of mastery of clinical practice. Supportive supervision not only reviews one’s clinical care but can serve as a support system for the mental health care in the rural areas.

**EXPLANATION OF THE STRATEGY**

Supportive supervision is defined as the sensitivity, empathy and flexibility provided by a supervisor to assist a subordinate in achieving balance (Foley, Linnehan, Greenhaus and Weer, 2006:421 in Hanson, 2011:16). Ryan and Kossek (2008 in Hanson, 2011:16) suggest that supportive supervision includes both instrumental or
tangible support and emotional support. Hammer and colleagues (2009 in Hanson, 2011:16) expanded our understanding of supportive supervision to include four dimensions: emotional support, instrumental support, role modelling and creative work management. Examples of emotional support may include inquiring about an employee’s (PHC nurses) family or offering a kind word when a PHC nurse relates a difficult family experience. Examples of instrumental support may include making a PHC nurse aware of work policies and arranging meetings in a way that facilitates changing work schedules to better meet the PHC nurse’s needs. Examples of role modelling would include the supervisor’s own use of organisational benefits and personal strategies to effectively manage their own work and personal lives and making this visible to their PHC nurses. It is not uncommon for supervisors to believe that accommodating PHC nurses’ work life needs will cause organizational performance to suffer.

Supportive supervision emerges out of interactions in the supervisor-PHC nurse dyad. Despite some variability in the amount of support offered to individual PHC nurses there is a certain level of supportive supervision that is shared at the PHC service level by all PHC nurses who interact with the same supervisor. At this level supportive supervision will likely be affected by supervisor and organisational level factors. In addition, since data was only collected from one source, PHC nurses, little is known about factors at the supervisor or organizational level that might impact supervisor support.

While this current study focused on PHC nurses and supervisor level factors that might shape supportive supervision, it is important to keep in mind factors at other levels that might influence supportive supervision as well. The study conducted by Sundin et al., (2006 in Hanson, 2011: 18) found that a supervisor’s characteristics such as a lack of knowledge and skills and low interpersonal trust were related to less general supervisor support (Sundin et al., 2006 in Hanson, 2011:18). This is supported by the findings of this study as discussed in chapter three.

In the literature it is believed that increased supportive supervision will lead to a variety of positive organisational outcomes either by directly reducing work conflict or by positively impacting on organisational culture, which will in turn help to reduce work
conflict, improve outcomes of mental health care, and better organisational outcomes, such as job satisfaction, job performance, organizational commitment and motivation (Thompson et al., 1999 in Hanson, 2011: 16 - 18).

Supportive supervision is a support mechanism for the PHC nurse in which they can share clinical organisational development and emotional experiences with one another in a secure, confidential environment in order to enhance knowledge and skills about mental health care. This process will lead to an increased awareness of accountability and reflective practice. In many ways the process of supportive supervision parallels the nurse-patient relationship that is, the relationship between the PHC nurses, persons living with SPMI and their families. Both involve a learning process that takes place in the context of a meaningful relationship that facilitates positive change (Stuart and Laraia, 2005:195).

There are four common forms of supervision:

1. The dyadic or one-on-one relationship in which the supervisor meets the PHC nurse in a face-to-face environment.
2. The triadic relationship in which a supervisor and two PHC nurses of similar experience meet for supervision.
3. Group supervision in which several supervised PHC nurses meet for a shared session with the supervisory nurse.
4. Peer review in which nurses meet without a supervisor to evaluate their clinical practice.

All four forms listed above have a similar purpose, namely exploring the strengths of the ones being supervised (Stuart and Laraia, 2005:195). The organizational climate, mission, policies and regulations, management system and resources play a role in structuring and shaping the work environment (Booyens, 2008:228-229). Supportive supervision has three functions: educative, supportive and administrative. The educational functions aim to improve the PHC nurse’s capacity to do the job effectively and to meet the mental health care needs of persons living with SPMI and their families, by supporting PHC nurses to develop professionally and maximizing their practice knowledge and skills. This involves teaching the necessary knowledge,
skills and attitudes and involves interaction with the persons living with SPMI and their families (Kardushin and Harkness, 2002 in Kopper 2009:19). The **supportive** function is to ensure that PHC nurses possess a sense of psychological wellbeing and in turn they can communicate the same hope and wellbeing to persons living with SPMI and their families (Tsui, 2005:81). The **administrative** function provides the PHC nurse with a context in which to perform their work effectively and to implement organisational objectives. Common tasks associated with the administrative function in the clinic are mentoring, evaluation, coordination and performance monitoring (Tsui, 2005:15).

The supportive supervision needs are linked to the challenging nature of the PHC nurses’ work. PHC nurses became clearer about their roles and about defining their scopes of practice after supportive supervision. Their multifaceted roles helped them realize that their roles were so much more than their titles in the rural areas. Supportive supervision also supported PHC nurses to develop their roles by way of study and workplace development activities. This has been identified as a necessary focal point for education (Golding and Gray, 2007 in Kopper, 2009:14).

The goal of supportive supervision is to encourage reflection, understanding and self-awareness in PHC nurses. The aim of supportive supervision is to enhance clinical practice and its effectiveness in the best interest of the persons living with SPMI and their families (Golding and Gray, 2007 in Kopper, 2009:14). Winstanley and White (2003) provided the following summary of common features of supportive supervision:

- A focus on reflective practice enhancement through self-evaluation and development.
- A means to generate learning knowledge.
- Providing empathic support to improve therapeutic skills.

Supportive supervision will develop the skills of PHC nurses, address the areas of need and encourage high standards of clinical mental health care practice

**OBJECTIVE OF THE SUPPORTIVE SUPERVISION STRATEGY**

Establish clear and specific programme objectives to guide the supportive supervision programme activities and to address the knowledge gap of PHC nurses.
Supportive supervision programme

The strategies should be planned according to the needs of the mental health care services, persons living with SPMI and their needs. Six key issues should be considered when planning a supportive supervision programme (Skinner, Roche, O’Connor, Pollard and Todd, 2005:2). These are:

- Identify and engage with PHC nurses
- Establish clear goals and objectives for the supportive supervision programme
- Develop recruitment strategies for supervisor and supervisees (PHC nurse)
- Develop a supervisor-supervisee matching strategy
- Ensure sufficient training and support for supervisees (PHC nurses)
- Establish a clinical supportive, supervision organizational policy.

During preparation, the supervisor finds out as much as possible about the content of the PHC services (Booyens, 2008:237). This helps the supervisor to build an understanding of expectations of both the PHC nurses and persons living with SPMI and their families. The general context includes factors such as policies and the current legislative framework. There are some underlying protocols or procedures that should be followed when implementing supportive supervision (Skinner et. al, 2005:3):

- Confidentiality
- Professional boundary setting and conduct
- Therapy for supervisees’ (PHC nurses) personal issues is not to be conducted
- Supervisors should not force the adoption of a theoretical orientation
- Dispute resolution protocols should be clearly defined.

Supportive supervision should be documented carefully otherwise the multifaceted role of PHC nurses cannot receive adequate attention. During the supportive supervision, the supervisor gets to know the supervisee (PHC nurse) both professionally and as a person. Supportive supervision intervention includes the development, monitoring and counselling of staff. The multifaceted role of the PHC nurse is direct patient care, education of persons living with SPMI and their families and management of PHC services in the rural areas. The supervisor structures the
contact sessions to address all the multifaceted role of the PHC nurses (Booysen, 2008:238).

According to Uys, Minnaar, Simpson, Brysiewicz and Ribeiro (2003:33), the effective supportive supervision intervention includes aspects such as staff development performance evaluation, monitoring and staff counselling. Proctors' (1986) Model of Supervision comprises what she terms the restorative, formative and normative elements. Kardushin and Harkness (2002 in Kopper, 2009:19) term these elements as supportive, educational and managerial. In this study these terms are relevant for this strategy to facilitate the multifaceted role of the PHC nurses.

**ACTION STEPS**

**STEP 1: Planning**
Each management level should develop an annual plan and budget for its supervision of the lower levels for which they are responsible. This planning should cover integrated supervision requirements. This supervision schedule should be communicated to the PHC nurses so that it can be taken into consideration when developing their own work plan (ESHE, 2007:12).

**STEP 2: Preparing for supervision**
Supervisors should prepare for supervision by targeting specific areas of need as follows (ESHE, 2007:13):

- Reviewing previous reports of the PHC services to be supervised for the last 6 months
- Compare achievements with the annual targets to identify any performance gaps which will need to be followed up during the supervision visit
- Checking with other departments to see if there are other issues that they would like to have followed up during the supervision
- Reviewing the completed supervisory checklist from the last supervisory visit together with the feedback report sent back to the office and the agreed follow up Action Plan
- Based on the review of the items above, the supervisory team should agree on the priority areas that should be addressed during the planned supervision
The supervisory team should make the following arrangements in advance of the supportive supervision visit:

- Ensure that they have sufficient copies of the Supervisory Checklists for each member of the supervisory team, plus some spare copies for the office or health facility to be visited
- The necessary transport should be organized
- If any allowances are due to the officers who will conduct the supervision, the necessary arrangements need to be made for them to receive these allowances.

**Supervisee Preparation**

The staff of the office to be supervised should also prepare for the planned supervision visit by:

- Reviewing their reports for the current year, the progress achieved towards their annual service delivery targets and the actions they have taken when performance has faltered
- Reviewing the previous supervisory report and associated action plan that was completed during the previous supervision visit
- Checking whether they have completed the items that were documented in the last action plan
- Conducting a self-assessment by the supervisee if this has not been done since the last supervisory visit and taking any necessary actions to tackle deficiencies identified.
- Making arrangements to ensure that all PHC nurses will be present for the supervisory visit.

**Self-Assessment by PHC nurses**

Self-assessment is when the staff members carry out their own assessment of their performance and the status of their facility and decide for themselves on the actions that they need to take to make improvements. Involving health workers at all levels in the supervisory process will ensure that the process becomes more participative, thus promoting health worker commitment to quality improvement. It is expected that, at a minimum, each PHC service and health facility should have conducted a self-
assessment at least one week before a supervisory visit from the level above is to be done.

In conducting a self-assessment, the PHC nurses should do the following:

a) Use the Supervisory Checklist to assess current performance status with the involvement of as many staff as possible

b) Review the report and the associated follow-up action plan of the previous supervisory visit to check whether the agreed action points have been carried out by both the level above and the facility itself, and to identify those that still need to be acted upon

c) Review the annual plan to identify the level of implementation against what should have been implemented

d) Prepare a summary report of findings indicating where the office or health facility is doing well, what constraints have been experienced during the period under review and where there is need for improvement and further support.

**STEP 3: Conducting supportive supervision**

Behaviours that are helpful in gaining the commitment of those being supervised to make efforts to improve their performance are given in.

(ESHE, 2007:14).

**STEP 4: Starting the supervision**

The supervisory team should arrive at the office to be supervised as scheduled and on time. The visit should start with introductions, including descriptions of each person’s position and responsibilities. The supervisory team should explain the objectives of the visit and agree how the supervision will proceed and, together with the supervisees, set the time required for interviews, record review, discussion and action planning. The supervisors should ensure that the supervisees have a copy of the checklist and then both teams should complete the identification section of the checklist.
STEP 5: Follow-up of issues from previous supervision
There should be a joint review of the findings of the last supervisory visit and the resulting Action Plan that was developed so that the supervisees can explain the actions they have taken. If the PHC service being supervised has conducted a self-assessment since the last supervisory visit, then the results of this assessment and the actions taken should also be reviewed.

STEP 6: Review of progress in plan implementation
Both teams should spend a little time reviewing the progress against the targets set in their operational plans. This will provide the supervisory team with the overall performance of the office being supervised.

STEP 7: Interviews and record reviews
This stage involves the completion of the checklist tool and should last about two and a half hours. All questions on the checklist should be completed and the supervisors should make notes in the comments column to ensure that the reasons for the assessments made can be referenced in the future. Both supervisor and supervisee should complete the checklist. Before making a judgment on each item on the checklist, the supervisor should verify the situation by reviewing relevant records or documents. If a scored checklist is being used, the supervisor should add up the total scores assigned and calculate the percentage performance achievement at the completion of each section of the checklist (ESHE, 2007:15).

STEP 8: Problem-solving and action planning
This stage usually takes between 2–3 hours as it involves a lot of discussion and consensus building. The supervisor/s and the supervisee should jointly identify problems. They should prioritize problems by using the criteria of magnitude of the problem, the impact of the problem on health services, the feasibility of solving the problem, and the resource needed to solve the problem. They should jointly analyse priority problems to determine the underlying causes. If this is not done, the wrong solution may be identified to solve a problem. They should jointly identify appropriate solutions to the problems, remembering that both the supervisors and the supervisees may need to contribute to the solution. Once all priority problems have been analysed, the supervisor/s and supervisees should jointly complete a follow-up action plan,
detailing who is going to do what and by when in order to fix the problems identified. Each party should prepare a copy of the action plan and both copies should be signed by each team. Each team will keep a copy as a record for future reference (ESHE, 2007:15).

**STEP 9: Recording and reporting the supervisory findings**

*Supervisor Level*

As part of the supervision process, the supervisors should give immediate feedback to the staff of the facility as well as help the facility to develop a follow-up action plan to address any shortcomings that are identified. In addition, the supervisors should enter a brief summary of their findings and recommendations into the Supervision Report Book at the facility. Within 3 days of completing a supervisory visit, the supervisor/s should complete a short report of the findings of the supervision. This report should highlight any special achievements and/or problems found and a copy of the agreed follow-up action plan should be attached. This report should be sent to the facility that was supervised as documentary feedback. The report should also be presented at the next management meeting so that all officers at the supervisory level are given feedback on the findings and agreed follow-up actions.

*Supervisee Level*

The site that has been supervised should ensure that the supervisors write a brief summary of their findings and recommendations in the facility’s supervision report book. In addition, the completed checklist and the associated follow-up action plan should be filed at the facility for future reference. Members of the facility management committee and other staff who were not able to be present during the supervision should be briefed on the findings and the agreed follow-up action plan so that all members are made aware of what needs to be done (ESHE, 2007:17).

**STEP 10: Follow up after supportive supervision**

The follow-up action plan agreed upon during the supervision will contain actions that the supervisee level and, perhaps, the supervisory level, have agreed to implement. After the supervision, both levels should ensure that they review the action plan to ensure that all their obligations are fulfilled. Following supervision some actions may be identified that need to be taken at the supervisory level. The supervisory level
should decide upon the frequency of follow up before the next formal supervision. On the other hand, the supervisee level should share supervisory findings at its level and determine to do a self-assessment, using the checklist, so that they can monitor and improve their own performance (ESHE, 2007:17).

5.4.2 STRATEGY TWO: COLLABORATION

Core activity: Action

**Action** activity is plan of action necessary to convert vision into action and includes services to be provided. An action strategy is necessary for effective mental health care to be implemented on macro, meso and micro levels to positively influence development of strategies for community-based health care of persons living with SPMI and their families in the rural areas. A variety of actions on a number of levels are required in order for persons living with SPMI and their families to receive the appropriate care and to facilitate the development of strategies to optimise the multifaceted role of PHC nurses. Functional strategies include the implementation of policies at grassroots or micro level. The professional nurse acts as the agent of care to meet the specific health care needs of persons living with SPMI and their families.

**Collaboration** is working in partnership with an inter-professional team and other government departments such as education, labour and community-based services. Essentially, collaboration means working together across sectors such as health, housing and transportation and across provincial, national and municipal jurisdictions. Strong collaboration is required to address the complex factors and conditions that influence the mental health care of persons living with SPMI and their families living in rural and remote areas. The benefits of such collaboration include framing a comprehensive response, improving communication, making effective use of limited resources, and reducing duplication and gaps (Rural health and rural hands, 2002:67).

**Functional strategy**

Working in partnership with the inter-professional team, and other government departments such as education and labour, and community-based organisations such as churches, traditional leaders, traditional practitioners.
RATIONALE
Collaboration is a strategy of coordinating health services to provide persons living with SPMI and their families with an optimal level of health care. The PHC nurses’ practice requires a coordinated, ongoing interaction between consumers and clinicians to deliver comprehensive services to the persons living with SPMI and their families. The PHC nurses should be able to articulate their professional abilities and area of expertise to others. Collaboration involves the ability to negotiate and formulate new solutions with team (Stuart and Laraia, 2005:198). The literature refers to the importance of establishing professional identity and role clarity to ensure effective utilization of PHC nurses (Bailey, Jones & Way 2006, in Burgers and Purkis, 2010:3). The PHC nurses employed various communication strategies, from informal interactions to formal presentations, in order to clarify their scope of practice and to negotiate role overlap with other health providers.

Collaboration interactions thus helped PHC nurses to gain power in decision-making about the health-care services by sharing empowering information, advocating for improved mental health care for persons living with SPMI and their families and linking mentally ill persons to various community-based resources. Role clarity is an important step in gaining acceptance from the organisational leaders and the general public during collaboration; in turn acceptance of the PHC nurses’ role upholds incremental deployment and thus improves access to PHC (Keith and Askin, 2008 in Burgers and Purkis, 2010:3). Access to care is particularly significant for our most marginalized populations in the rural areas who are often underserved by PHC.

EXPLANATION OF COLLABORATION STRATEGY
Collaboration is based on trust leading to partnership and involvement and is recognisable when persons living with SPMI, their families and the PHC nurses are considered partners in the nurse-family relationship. It begins with the PHC nurses recognising that the persons living with SPMI and their families have no knowledge of mental illness while the PHC nurse possesses the professional knowledge and competencies necessary for meeting the needs of the persons living with SPMI.

Collaboration is the shared planning, decision-making, problem-solving, goal setting and responsibilities by the PHC nurses working together with persons living with SPMI.
and their families with open communication. The PHC nurses in the rural areas have much potential collaboration with their colleagues or peers (Stuart and Laraia, 2005:198). PHC nurses may collaborate with three different types of teams:

*Uni-disciplinary:* with all team members of the same discipline such as nurses.

*multi-disciplinary:* having members of different disciplines who provide specific services to the persons living with SPMI and their families such as psychologists, social workers and occupational therapists.

*interdisciplinary:* have members of different disciplines involved in a formal arrangement to provide services while maximizing educational exchanges such as churches, traditional leaders, traditional practitioner and other government departments such as education and labour (Stuart and Laraia 2005:198).

Many organized mental health care settings use the interdisciplinary team approach which requires highly coordinated and interdependent planning based on the separate roles of each team member (Stuart and Laraia 2005:198). PHC nurses should be able to move forward in implementing collaborative practice. PHC nurses see collaboration as incorporating complementary practice, equality and working together for the benefit of persons living with SPMI and their families. Leading collaborative team work requires PHC nurses as agents with a sense of professional self-esteem and confidence (Carthew, 2011: 8).

It is essential to ensure the skill mix and appropriateness of care to meet the health care needs of persons living with SPMI and their families presenting with diverse and complex mental health care challenges. Community-based services such as churches, community outreach services, traditional leaders and traditional practitioners need to work alongside the PHC nurses and inter-professional team members such as social workers if mental health outcomes are to improve (Carthew, 2011:21). Hefford et al. (2010 as cited in Carthew, 2011:26) stated that in a review of literature of team based models of care; three distinct types of relationship within teams were identified. These are:
• The core-active relationship where one member of a team is dominant and delegates to others. This happens between PHC nurses and the psychiatrists or between the supervisor and the PHC nurses.
• The competitive relationship where parties are competing for similar roles as is the case with PHC nurses.
• The interactive relationship where shared responsibilities and equality underpins collaboration (Hefford et al., 2010 in Carthew 11:26).

In this study the researcher preferred the interactive approach with collaboration and trust underpinning the working relationships, allowing the inter-professional team working in the traditional model of general practice to reach their full potential.

**Relationship within the inter-professional team**
A team approach is most often preferred in the PHC services. A rural setting is made therapeutic by the inter-professional team working together in collaboration with the person living with SPMI and their families while using a PHC setting to provide a microcosm of the “real” world. The inter-professional team in the community is the vehicle for the delivery of mental health care. The principles guiding the operation of this team are shared tasks and the provision of complementary competencies by different health professionals. In this model of team work, each professional brings specialist skills which, for nursing, are often skills in relation to medication management. This diversity of professional expertise is one of the great strengths because persons living with SPMI and long term mental illness have many needs that cannot be met satisfactorily by a single discipline. This study found that mentally ill persons from the rural areas can only access the services of the inter-professional team through referral to the metropolitan areas (Elder et al., 2009:401-402).

**OBJECTIVE OF COLLABORATION STRATEGY**

The objective of collaboration is to provide an opportunity to reach consensus on areas of collaboration between the inter-professional health practitioners.
ACTION STEPS

Collaboration of health and social care should occur through collaborative responses to meet the needs of persons living with SPMI. Activities that would improve a collaborative response are:

- Creating a forum for collaboration between international organisations such as the World Mental Health Federation, DOH, DSD, NGOs, managers and health practitioners including PHC nurses from the rural areas to enable policy implementation
- Encouraging retired professionals such teachers, nurses and others to coordinate small projects regarding the awareness of care and support needs through societies, projects e.g. handwork, support groups and local churches to run initiatives to generate funds e.g. for food parcels for persons living with SPMI
- Encouraging local newspapers, radio programs and social media to educate the public on how to become involved in the support of persons living with SPMI
- Facilitating the integration of mental health services through DOH to run smoothly
- Inter-professional team, business forums and other key stakeholders should negotiate with DOH to provide the communities with mobile clinics
- Extending opening hours of PHC facilities to enable to enable persons living with SPMI and their families to have easier access and lessen the long queues of people accessing mental health care in the limited hours currently available
- Making use of mobile clinics in areas where it is not practical to build PHC clinics
- Provide a full-time service
- Providing a 24 hour PHC services for on-call service with good referral
- Providing tangible promotional items to promote mental health information by DOH and business people. Examples of promotional items that may be used are marketing items such as water-bottles, key-rings, t-shirts, notebooks, pens and pencils, bookmarks or fridge magnets with motivational messages or contact details for organizations such as Rehabilitation Centres, Alzheimer’s Society (Uys and Middleton, 2010:842,859)
Media advertising in popular TV and radio programmes such as soap operas, where currently a character, Senzo, on the soap opera Generations is on a Detoxification programme following drug abuse.

Inter-professional collaboration does not always proceed smoothly. There are many challenges to inter-professional collaboration including inappropriate education and training of mental health team members such as the PHC nurses, goal and role conflict, traditional organisational structures such as church leaders, traditional leaders, traditional practitioners and others in the rural areas, power and status inequities and personal qualities of individuals. Potential strategies to deal with challenges are structured below, by provincial or local levels (Michel, 2003 in Burgers and Purkis, 2010:17):

**Provincial**

- Develop a coordination and priority setting group with provincial-level players
- At the provincial level, related policy and interest groups need to be brought together in a coordinated way to identify areas for collaboration, develop and prioritise strategies. Members should include, at least, representatives from the Public Health, Medical Officers of Health and PHC nurses
- Monitor, connect to and influence national activities
- Support the development of information technology to enhance communication and sharing of important clinical and population health data (outbreak, reportable diseases and health records)
- Develop and fund collaboration, innovation, implementation and evaluation at the local level
- Interdisciplinary education in the principles of population health and primary health care, and in the determinants of health and community development skills would promote an understanding of roles across health care professionals. In addition, interdisciplinary continuing education would enhance this understanding of roles.
**Local**

- Create a steering committee to consider the local health care needs of persons living with SPMI, their families, and priorities and to develop strategies to meet these needs.
- Promote local joint planning initiatives with the community as well as public health and primary care representatives. This would create partnerships with stakeholders and a common population concern (Gofin, 2004 in Burgers and Purkis, 2010:17). Family and community representation.
- Encourage flexibility in health personnel roles in order to meet priority community health needs.
- Organize funding to be flexible enough to be able to support joint initiatives. Start with small projects where mental health care needs are clearly identified.
- Fully utilize the scope of practice of PHC nurses; they can successfully be integrated into public health programs and structures to provide primary health care.
- Encourage PHC nurses to practice their full scope/range of skills.
- Create opportunities for the articulation of a common set of values from each segment within the inter-professional team.

**Collaboration** is a strategy of coordinating health services to provide persons living with SPMI and their families with an optimal level of health care. PHC nurses’ practice requires a coordinated, ongoing interaction between persons living with SPMI, their families, and members of the inter-professional team to deliver comprehensive mental health care to the persons living with SPMI and their families. The PHC nurses should be able to articulate their professional abilities and areas of expertise to others. Collaboration through coordination includes collaboration with the inter-professional team, government departments such as labour, education, social development and others, community-based organisations such as churches, traditional leaders, traditional healers such as traditional practitioners and faith healers, NGOs.

In collaboration, the PHC nurses are also advocates for persons living with SPMI and their families who need assistance in making their health care needs clear and in accessing both health and social care. Collaboration also involves working with their families, support groups and community leaders who can influence development of
mental health care in the rural areas. It is important that the PHC nurses develop positive relationships with community-based services to assist the persons living with SPMI and their families in accessing available community resources.

Inherent in PHC is a strong emphasis on collaboration and teamwork between PHC nurse and persons living with SPMI and their families. The principles of PHC emphasize the central importance of collaboration (Dennil et al., 1999 in Sibiya, 2009:200). The success of PHC depends on the interactions of persons living with SPMI, their families and the PHC nurses. PHC nurses are important, not just in terms of skill and distribution but in their relationships with communities (Lawn et al., 2008 in Sibiya, 2009:201). The PHC nurses depend on the family members to provide care to mentally ill patients in their homes and to be involved in planning care and in decision-making.

5.4.3 STRATEGY THREE: MENTORING

Core activity: Reflection

Reflection is a practice of reviewing an experience in order to describe, analyse, evaluate and inform learning about the practice. The mentoring strategy generates mutual learning as well as positive growth or development over a period of time

Functional Strategy
Mentoring improves the multifaceted role of PHC nurses as well as increasing their self-awareness and ability to critically reflect.

MENTORING STRATEGY: Create a mentoring programme that will focus on developmental needs of PHC nurses throughout their professional careers.

RATIONALE

Mentoring strategy refers to the generation of mutual learning as well as positive growth or development over a period of time. The purpose of mentoring is to improve the knowledge and skills of PHC nurses in the rural areas, thereby improving the quality of mental health care to persons living with SPMI and their families. Mentoring also enhances the multifaceted role of the PHC nurses by enhancing their commitment and professional growth which in turn strengthens mental health care (Campbell,
In order to develop the PHC nurse’s capacity for empathy, acceptance, nurturing and honest reflection, the supervisor should be able to model these capacities in their relationships with the PHC nurses. According to Campbell (2009:13), mentoring improves the technical and managerial skills of the PHC nurses. The working relationship between the mentor and mentee is strengthened through the process of mentoring between the supervisor and the PHC nurses. Rousten et al., (2005:320 in Campbell, 2009:17) argue that PHC nurses develop competency skills and become resourceful individuals through mentoring. The purpose of mentoring of PHC nurses in the rural areas is often related to the development of practice and knowledge and to facilitate the multifaceted role of the PHC nurse.

It is possible to become competent by several different means for example, full time or part-time, on the job training. The PHC nurse will need mentoring at various stages in the learning process to achieve competency in any particular area. In practical training, mentoring and supervision play a particularly important role in building up the individual’s experiences. This study can be considered a substantive contribution to advancing the nursing knowledge base related to the mentoring of PHC nurses. Knowledge gained from this study may enhance the PHC nurses’ understanding of their multifaceted role.

The implementation of knowledge gained from this study may help to produce positive health care outcomes to persons living with SPMI’ satisfaction. Mentoring allows the PHC nurses to cope with his/her multifaceted role in the changing workplace environment. The specific goal of mentoring programmes is socialization and career development for PHC nurses (McCormark, Gore and Thomas, 2006:97).

The term mentor is derived from the Greek mythology. The story of Mentor is told in Homer’s Odyssey. When Odysseus set of for the Trojan wars he instructed his wise advisor, Mentor, to stay and take charge of his son, Telemachus, serving as a counsellor and advisor. Odysseus recognized that his son needed to be mentored on how to be king while his father was at war. He trusted that his friend would be a good and wise mentor for his son. Therefore the term mentoring was derived (Doherty, 1999:2).
A mentoring strategy refers to a formal structured plan which outlines the purpose, values and resources needed and how these interact with the context in which mentoring occurs in order to achieve the set goals and objectives for the individuals and the organization (Campbell, 2009:5). Mentoring is a special way of transferring information (Byrne, 2002:391). Mentoring is a complex multidimensional process that can be learned over time. It requires reflection, knowledge of self and profession, knowledge of mentoring processes and skills, communication and social skills, practice and support. Although mentoring is a professional obligation and a needed strategy, nurses need to be invited to mentor. They need to be recognized and supported in the role through institutional incentives, educational workshops and ongoing monthly meetings (Wagner and Seymour, 2007:209).

**EXPLANATION OF THE STRATEGY**

Mentoring is an empowering relationship between the novice and experienced nurses and is one best practice that fosters successful nursing careers for nurses. Mentoring enriches clinical practice with deeper holistic focus on nurturing the whole person (Verdejo 2003 in Wagner and Seymour, 2007:201). When guided by a caring framework of trust, commitment, compassion and competence, mentoring as a caring action builds healthy relationships and energies in the environments. It stimulates new perspectives about self and others, new opportunities for action and an expansive vision of possibilities for health care system (Vance and Olson, 1998, in Wagner and Seymour, 2007:201). Mentoring is a broader role that encompasses formal and informal support, guidelines, coaching, teaching, role modelling, counselling, advocating, networking and sharing (Tourighy and Pulich 2005 in Wagner and Seymour, 2007:201).

Mentoring is a method that has been found to contribute to healthy work environments and to the development and professional growth of personnel. It has been found to aid in improving the health and wellbeing of nurses in the health sector (Canadian Nurses’ Associations, 2007). Grossman (2007:2) defined mentoring as a guided non-evaluated experience, formal or informal, assigned over a mutually agreed period of time that empowers the mentee to develop personally and professionally within the auspices of a caring, collaborative and respectful environment. Mentoring
relationships are dynamic, mutually beneficial learning relationships between a more experienced person (mentor) and less experienced person (mentee) (Zachary, 2005:202). In this study the mentor will be a manager or supervisor and the mentee is the PHC nurse. The need for mentoring of PHC nurses in the rural areas has been highlighted by the integration of mental health services into PHC services. There is a need to enhance the multifaceted role of PHC nurses which further confirms the need for mentoring of these nurses.

The mentoring relationship can occur naturally (informal mentoring) or can be contrived in a mentoring programme (formal mentoring). In this study a mentoring programme will be established to capture the benefits of mentoring for the PHC nurses who need it. General benefits for the mentee (PHC nurses) include exposure to a positive role, help to focus on their future and setting academic, social and career goals, exposure to new experiences and fostering increased confidence and self-esteem as well as encouraging emotional and social growth (O’Neill and Hare, 2005:1-2). Mentoring is therefore essential to provide knowledge and skills to ensure the best possible benefits for both the mentors and the PHC nurses as mentees in mentoring relationships (Parra, Du Buis, Neville and Pugh- Lilly, 2002 in O’Neill and Hare, 2005:2).

Mentoring has been an effective strategy in many disciplines including the nursing profession, to develop expertise and leadership within the profession. The traditional concept of mentoring involves a voluntary relationship between an experienced senior professional nurse for the purpose of career development and the enhancement of the profession (Byrne, 2002:391). According to WHO, mentoring is a “system of practical training and consultation that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes. Mentors need to be experienced, practicing clinicians, with strong teaching skills” (WHO, 2006).

Mentoring Programme
A mentoring programme for rural practitioners was seen by participants as critical to assisting the PHC nurses but it was also important to rural practice. Mentoring could harness the wealth of experience and expertise that exists among PHC nurses and enable these to be shared with other members of the profession. Participants
acknowledged the challenges of professional competency in light of the challenges of accessing continuing professional development, the breadth of their scope of practice and working in isolation in rural areas. Mentoring could also assist rural PHC nurses to maintain their competency through ongoing learning activities (Roots, 2011:100-101).

The mentoring process is a longitudinal relationship that develops through at least four stages over time, ranging from months to many years. The stages are initiation, cultivation, separation and redefinition. The first step of initiation involves mentor and the PHC nurses meeting, getting to know each other and setting goals. As a trusting relationship matures the pair moves to the second stage, cultivation, during which the information is shared, joint problem-solving, promotes respectful confrontation of decisions and exploration of alternatives. Successful mentoring empowers the PHC nurse to move forward in his/her career and personal life. This process leads the pair to the third stage of separation from the original mentor to the PHC nurses’ roles and allows for the fourth stage of mutually redefining the mentoring relationship towards long-term friendship or going separate ways (Wagner and Seymour, 2007:202).

Benefits for mentee and mentor (Ferguson, 2005:5) where the mentee:

- Gains a better understanding of how integrated PHC services operate
- Receives support, encouragement and feedback
- Develops interpersonal skills
- Gains knowledge about her/his multifaceted role
- Receives help with clarifying career goals and career pathways
- Gains opportunities to widen professional practice and reduce professional isolation

Benefits for mentor include:

- The opportunity to share one’s experience and wisdom
- Gaining a sense of personal satisfaction
- Developing interpersonal skills
- Gaining experience in a new role
- The opportunity to widen professional practice and reduce professional isolation
• Being recognised for the contribution to colleagues and to the practice as a mentor
• Gaining understanding of the challenges encountered by PHC nurses.

Mentoring programs have clear aims that link to the goals of PHC nurses and shared care goals of nursing in an integrated mental health care practice. It is aligned with other education and training strategies and resources that facilitate professional development such as coaching of PHC nurses in rural areas. Resource materials and structured support processes must be available for mentor and mentees to assist in the establishment, maintenance and closure of mentoring relationships. Clear and accessible application and selection criteria exist for mentors (agents) and mentees as recipients. Regular monitoring, evaluation and review processes occur (Ferguson, 2005:9).

ACTION STEPS

• Make use of policies and procedures and effective mentoring programme on which PHC managers ought to be mentored
• Develop a standardised national training package for mental healthcare on mentoring of PHC nurses in the rural areas and for practicing supervisors and mentors and newly recruited PHC nurses to be instituted through formal and on-the-job training. The sustainability of mentoring activities to be ensured by advocating for the activities to be planned (and budgeted for) at all levels of the health care delivery system.
• Establish a quality improvement (QI) system in line with the national guidelines
• Monitor, evaluate and review processes for mentoring activities to be introduced efficiently and regularly
• Document and share good practices with various stakeholders at various forums.

People responsible for the above-mentioned activities:
Programme managers, administrators from public sectors and partners who implement mental health care, mentors who are responsible for mental health care at
national, regional, local and PHC facility levels, Trainers who provide in-service and
pre-service training to primary health care workers

5.1.4 STRATEGY FOUR: CAPACITY BUILDING STRATEGY

Core activity: Education
An Education activity is a plan that is extensively used to ensure that an educational
message or lesson, either theoretical or practical, is passed from one person to
another to improve the knowledge and skills of PHC nurses. Education is required by
all those concerned with mental health care, whether as Person living with SPMI, a
family member or as a PHC nurse. The quality of mental health care will be enhanced
when PHC nurses are made aware of the progressive nature of the education process.

In recognition of the importance of education, research is being conducted globally
and new initiatives and procedures are continuously being implemented with regard
to integration of mental health care into PHC. Sharing of information between people
is essential for the continuing development of optimal health care. The education
strategy and capacity building is required to provide effective mental health care and
must be in place while action strategies remove barriers to the challenges encountered
by PHC nurses in rural and remote areas and positively influence the implementation
of the identified strategies. A capacity building strategy enhances the professional and
clinical development of PHC nurses in the context of integrated PHC services at
clinical level to improve the quality of mental health care in the rural areas. As a result,
individuals and groups increase their ability to impact on health care in a positive
sustainable manner through education, communication and cooperation. The
Education Strategy requires human and material resources such as venues for
instruction and educational resources, while grand strategies are required on macro
and meso level in order to obtain the resources required to fulfil this function.

Functional strategy
A functional strategy improves the competency levels of the PHC nurses in order to
meet the health care needs of persons living with SPMI and their families effectively
and enable them to function at a higher level of performance. All PHC nurses working
in the rural areas should receive ongoing education and training on the needs of
persons living with SPMI and their families. The PHC nurses as participants felt that
they do not generally have the knowledge required to deal with persons living with SPMI and their families, as reflected in Chapter Three of this study.

**CAPACITY BUILDING STRATEGY:** Improve the competency levels of the PHC nurses through capacity building in order to meet health care needs of persons living with SPMI and their families effectively and enable them to function at a higher level of performance in the rural areas.

Capacity building aims to enhance the skills, abilities, resources and commitment to communities, nurture unique talents and act on challenges and opportunities the PHC nurses face. As a result individuals and groups increase their ability to impact on health care in a positive sustainable manner through education, communication and cooperation. Capacity building in this context includes awareness, skills, knowledge, motivations, commitment and confidence (Cusack and Killoury, 2012:38).

**RATIONALE**

Capacity building enhances the professional and clinical development of PHC nurses in the context of integrated PHC services at clinical and management levels to improve the quality of mental health care in the rural areas. The purpose of capacity building is to improve the clinical performance of PHC nurses in rural areas. Increased capability for PHC nurses as agents means improving skills, gaining broader experience; enhancing knowledge and integrating culturally based practices and relationships. Capacity building also means encouraging PHC nurses to value themselves and their roles and lead the change required of them as change agents, to provide high standards of improved care to the persons living with SPMI and their families in a demanding environment in the rural areas (Finlayson et al., 2009, in Carthew, 2011:26).

Improving the PHC nurses capability has been supported through legislation. Chapter seven of the National Health Care Act, 2004 (No 61 of 2003) is dedicated to human resource planning that will ensure adequate numbers of well-trained health personnel who are distributed between all health care services to meet the people’s needs. This is supported by the health policy in the Southern African Development Community (SADC) which states that clinical nurse practitioners who are sometimes referred to
as PHC nurses are to be trained in diagnostic skills and techniques, in clinical assessment and in appropriate pharmacology and treatment skills. The researcher supports this and will also encourage that PHC nurses should be comprehensively trained to also meet health care needs of mentally ill persons.

The level of capacity building is recognized as involving much more than training and knowledge transfer. It involves people as well as the organization as a whole. It is also dependent on the environment that influences the extent to which the PHC nurses or organisations have the ability to acquire new skills and adapt to new ways.

**EXPLANATION OF THE STRATEGY**

Capacity building is identified as a critical health promotion and community-based approach to address health and illness. A review of the themes supports capacity building as a necessary tool for the development and maintenance of effective and improved quality of mental health care. Capacity building aims to develop capabilities that create or direct action or change within the organisations. It occurs on three levels: individual, organisational and social. This combination creates the long term stability and the strong foundation necessary for individual, organisational and community change.

The PHC nurses had to change their traditional ways of working, to develop and expand their multifaceted role and to adopt new roles in different areas such as mental health care. Capacity building is an evidence-driven process of strengthening the ability of individuals, organisations and systems to perform core functions sustainably and to continue to improve and develop them over time (Cusack and Killoury, 2012:38). It relates to a range of activities by which individuals improve their capacity to achieve sustainable health care.

For the purpose of this research study, capacity building refers to the capacitation of PHC nurses to optimise their multifaceted role in the rural areas. There is evidence to support the notion of a growing need for PHC nurses to gain more knowledge and skills in providing mental health care. Challenging and difficult behaviours in mentally ill persons at times cause alarm in PHC nurses who have limited knowledge and skills in mental health care (Petrie, 2008:242). Capacity building is fairly limited, particularly
in PHC services in rural areas. It is important that capacity building undertakes capacity development on enhancing the multifaceted role of the PHC nurses. In South Africa nurses are expected to keep themselves updated and to sharpen their skills.

**Capacity building process**

Capacity building can be initiated from inside and outside the workplace and take the form of on the job training, coaching and mentoring (Stephen et al., 2006 in Photakoun, 2010:24).

*Institutionalize a strategic capacity building process.* Capacity building requires a logical process. It begins with the assessment of capacity needs of the PHC nurses in the rural areas. Managers need to cultivate support among the PHC nurses. It is important that in an organization there should be a capacity building team or committee.

*Developing a national capacity building plan.* The development of a capacity building plan should be incorporated into the national strategic planning and implementation. Capacity building is characterized by three main activities: skills upgrading, both general and specific, procedural improvement and organizational strengthening (James, 1998:235 in Ngoatje, 2005:20).

This section sets out the steps which need to be considered in any capacity building process as well as guidance on the key tools and techniques that can be used. PHC nurses need to be involved from the outset. How much time is needed will, of course, depend on the size and complexity of the partnerships.

**OBJECTIVE OF CAPACITY BUILDING STRATEGY**

Objective of capacity building strategy is to facilitate individual learning which develops knowledge skills and attitudes and creates a set of capabilities (Department of International Development, June, 2010).

**ACTION STEPS**

The five-step approach is to be considered which is based on the Kolb learning cycle (http://www.businessballs.com/kolblearningstyles.htm).
Five steps of Capacity Building:

Step 1: Assess capacity building and needs
Step 2: Plan and formulate a capacity building programme
Step 3: Implement a capacity building programme
Step 4: Monitor and evaluate the programme
Step 5: Reporting

These key steps are discussed in details as follows:

**Step One: Capacity assessment**
This step is primarily concerned with identifying the main strengths and weaknesses of the individual, organisational and institutional levels. It is an essential part of the inception phase. Such an analysis should focus as much on identifying assets. In general, it is easier to build on the former than to transform the latter. This analysis should, as far as possible, be conducted as a collaborative exercise with key stakeholders. In this study, this step is important for PHC nurses as they have diverse qualifications with some not having the mental health care knowledge and skills needed by persons living with SPMI and their families in the rural areas.

**Step Two: Strategise and plan**
This step involves planning the detailed activities required to deliver the programme outcomes; costs and timescales and monitoring and evaluation arrangements which will include organisational mapping and establishing a capacity baseline. Planning a capacity building intervention should initially be structured around the desired outcomes from the programme. This requires taking each programme outcome and constructing a list of key activities to deliver the outcome.

**Step Three: Implementation**
This section sets out the key roles of the partners in supporting capacity building processes and highlights some examples of actions at each of the three levels - individual, organisational and institutional - that can contribute to effective capacity building.
**Step Four: Monitoring and Evaluation**

This section sets out the key principles to be followed in monitoring and evaluation, as well as some examples of indicators that may be used to judge the effectiveness of capacity building. Capacity building is not a stable target, people change and contexts change. The approach to monitoring and evaluation for capacity building must be flexible enough to adapt to all the changes inherent in capacity building, and must ensure that learning is captured. Thus consideration must be given to both organisational learning and external accountability requirements. Monitoring and evaluation systems should be able take account of processes as well as outcomes. At the same time, monitoring and evaluation systems need to be kept simple in order to avoid burdening organizations with complex and time consuming demands that may lose support.

**Step Five: Reporting**

The analysis, the plans, the implementation and the monitoring and evaluation of the capacity building plan need to be written up in reports. In addition to the traditional requirements, annual reports should include a capacity building section providing:

- An update on progress of the Capacity Building Strategy, and reporting against the capacity building plan which derives from the Strategy.
- An update on progress measured at the individual and organisational levels and as far as possible the institutional level.

Activities which may facilitate capacity building on a macro or meso level to improve health care persons living with SPMI and their families are as follows:

- Creation of a National Mental Health Strategy should specifically address capacity building of PHC nurses in the rural and remote areas to improve health care of persons living with SPMI and their families
- Partnerships between relevant parties in mental health care to be negotiated to provide more efficient and cost-effective health care services, for example, private/public enterprises (Crisp, Swerissen and Duckett, 2000:102)
- Decentralized locations such as mobile services to provide facilities closer to home for persons living with SPMI and their families
Responsible persons for the above mentioned activities:

*Policy-makers at macro and meso levels, policy-makers in medical aid schemes and business partners, managers of local health care facilities and NGOs.*

- Provision of basic resources for mental health care in all PHC clinics in the public sector
- All the supplies used in mental health care to be available

Responsible persons: *Management of local health care facilities*

- Pharmaceutical companies that win tenders to supply drugs to clinics should be required to provide training on the optimal use of their products to all staff who utilise them in performance of their duties
- Training to include: action and side-effects of psychotropic drugs and other medication utilised to treat persons living with SPMI.

Responsible persons: *Management of pharmaceutical supply companies.*

The curriculum is designed to optimize the multifaceted role of the PHC nurses in the rural areas and to empower them to render quality mental health care to persons living with SPMI and their families. They should be able to:

- take the history of a mentally ill person
- conduct a focused physical examination and mental status assessment of the mentally ill person
- make a correct diagnosis of the mental illness symptoms
- refer mentally ill patient appropriately if necessary
- render emergency care to mentally ill persons in crisis situations
- give mental health education
- write correct clinical notes on mentally ill persons, provide comprehensive care to mentally ill persons of all ages including health promotion and disease prevention, supportive, curative, rehabilitative and palliative care
• in primary care settings, curative care may involve diagnosis and treatment of acute common mental illnesses, and monitoring/management of stable chronic diseases
• in acute care settings, curative care may involve diagnosis and treatment of patients who are acutely or chronically ill
• refer mentally ill persons for diagnostic tests (including X-rays, diagnostic ultrasounds)
• perform specific procedures within their legislated scope of practice such as taking of bloods for laboratory tests
• refer patients to specialists (although there are variations across provinces).

The training approaches may include (The Health Foundation, 2012: 26):

• university courses about formal mental health care approaches
• teaching mental health care as one component of other modules or interspersed throughout a curriculum
• using practical projects to develop skills
• online modules, distance learning and printed resources
• continuous professional development workshops
• simulations and role play
• collaboratives and on-the-job training.

Nurses who are required to render PHC should also feel confident that they are able to render the mental health care as it is intended. They therefore have to be trained properly and allowed enough clinical experiential learning time to practise their newly developed skills and apply their knowledge to become and feel competent to take on this great responsibility.

The PHC nurses operate at the meso level that directly interact and work with the persons living with SPMI, their families as well as the communities. The intervention for capacity building therefore must take a comprehensive approach integrating all the stakeholders. The overall strategy of capacity building could gradually start from the PHC nurses and then move to the persons living with SPMI, their families as well as the communities in order to make sure that the process of capacity building gets
properly rooted and builds synergy across levels. If for instance, at meso level, PHC nurses are trained, they can in turn provide training to the communities. This strategy, if combined with action learning processes and share through learning groups, can facilitate a pragmatic and interactive process of learning and capacity building.

At the meso level, the PHC nurses are required to have the capacity to process the information or the knowledge they acquire from different sources and transfer it to communities through training or other means. At community level this is crucial in promoting general awareness of mental health care and mental illness. In addition, local communities are also in need of capacity development services.

Capacity building can be characterized as the approach to community development that raises mentally ill people’s knowledge, awareness and skills to use their own capacity and that obtained from available support systems. Capacity building helps them to communicate more effectively at different health care levels and to take decisions, eventually instilling in them a sense of confidence to manage their own health (http://heapro.oxfordjournals.org). Thus, capacity building aims to transform the persons living with SPMI and their families from passive recipients of health care to active participants. Underpinning this approach is the notion that the most successful programmes are those that are initiated and run by the members of the local community.

PHC nurses can serve as support to families of mentally ill persons in both treating and preventing mental health problems. PHC nurses can promote a therapeutic collaboration by acting as a family educator on the needs of persons living with SPMI and their families within a inter-professional team, reinforcement of family strengths and facilitation of the transition to rehabilitation. Such programmes not only speed recovery but also enable the persons living with SPMI and their families to manage illness better with fewer relapses. Effective education of persons living with SPMI and their families requires knowledge of learning styles and the ability to present information in a variety of ways such as through oral and written communication, pictures and stories. The most successful educators adapt information to the preferred methods of learning (Keltner, et al., 2011:124).
Psycho-education

Psycho-education is education concerning the mental health status and treatment given for the client’s mental illness. It is aimed at promoting wellness and providing an opportunity for SPMI patients to gain insight into their condition (Elder et al., 2009:479). Psycho-education is considered an intervention designed to reduce the impact of the illness on the mentally ill person. Psycho-education programs are suitable for community-based mental health care in rural areas because they are usually run in groups over several weeks. They may however, also be organized around the needs of individual families. The benefit of several families coming together in a group is defined as sharing of information. The support they provide each other and the experience of universality, that is, recognition that they are not alone in having these problems, greatly assists SPMI patients. Supportive family education programmes need to attempt to reinforce strengths and promote resilience. A comprehensive psycho-education program will provide information not only about mental illness but also about the available resources in the community (Elder et al., 2009:446).

5.5 EVALUATION OF THE DEVELOPED STRATEGIES

The developed strategies were evaluated by an external panel of experts in the field of mental health care and PHC care who have subject knowledge of the planned strategy. It is essential that the strategy be evaluated after development to ensure the trustworthiness of the study as described in Chapter two. The external panel of experts consisted of a social worker with a Master’s Degree in mental health and experience in working in a mental hospital and clinics; an experienced nurse educator who is an academic facilitating Psychiatric Nursing Science in a four year comprehensive diploma course in a Nursing College; two professional nurses with advanced psychiatric nursing working at Komani Hospital and a dedicated professional nurse who is a specialist in PHC and mental health care.

The comments and suggestions of the expert panel were integrated into the context of key tasks of the strategy where applicable. Specific criteria used for the evaluation of developed strategies were adapted for the evaluation of the strategy. The criteria chosen to be applied to the evaluation of the developed strategy dealt with both the external and the internal validity of the proposed theories or models according to
criteria established by Fawcett (1995:47-52), McKenna (1997:227-235) and by Pearson, Vaughn and Fitzgerald (1997:218-221). The common aspects in the criteria of these authors were selected to be used in the evaluation of the developed strategy. The following criteria were selected as those common to the above authors which evaluate both the internal and external validity of the strategies and are presented together with the comments of the Expert Panel.

5.5.1 Clarity of the strategies

The strategies were evaluated for semantic clarity and structural clarity. Semantic clarity questioned the theoretical meaning of concepts. While structural clarity reflects the connection between the concepts in the theory and the rest of the study. Of importance was to provide clarity on the language use to develop the strategies, the meaningfulness of the strategies was verified with the promoters. Accordingly the strategies were clearly stated and were related to the purpose.

5.5.2 Simplicity of the strategies

The strategies were evaluated to establish their applicability to the facilitation of the multifaceted role of the PHC nurses. The strategies are simple to implement with achievement of the desired outcomes. Simply implementable strategies comprise a few logically organized and clearly written statements.

5.5.3 Generality of the strategies

Generality refers to the breadth of the scope and purpose of the strategies. The strategies were developed to facilitate the multifaceted role of the PHC nurses. The strategies have been compiled in the context of Emalahleni LSA, Chris Hani District Eastern Cape. It will be possible, however, to transfer the strategies to other geographic areas as required. The strategies will be able to be implemented in other rural and remote areas.

5.5.4 Usefulness/utility of the strategy

The work presented here is a foundation for facilitating the multifaceted role of the PHC nurses. The strategy will be used in the clinical practice in rural areas. The strategies will be of use in practice and give clear methods of implementation.
However, the strategies may be reworked for implementation in primary health care for facilitation of the multifaceted role of the PHC nurses.

5.5.5 Significance of the strategy

Further development in this work will make a significant contribution to nursing knowledge. Further research is required to evaluate the effectiveness of the strategy and sub-strategies in practice. The strategies will be able to positively influence nursing practice, education and research. Implementation of the strategies will have a positive effect on quality of care delivered to persons living with SPMI and their families.

5.6 CHAPTER SUMMARY

In Chapter Five, the strategies are aimed at facilitating the multifaceted role of the PHC nurses in the rural areas. The desired outcome of each strategy was given together with a rationale for the inclusion of the strategy. Action steps of implementation of the strategies were described. An evaluation of the strategies was presented. The final chapter, chapter six, will present the conclusions of this study together with limitations and recommendations for nursing practice, nursing education and nursing research.
CHAPTER SIX

CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

6.1 INTRODUCTION

In Chapter five, strategies were developed to facilitate the multifaceted role of the PHC nurses delivering PHC services in rural areas. Literature control was conducted to support the findings. This Chapter will focus on the conclusions, the limitations and recommendations for nursing practice, nursing education and nursing research. This final chapter of the study will also give an overview of the research questions, the objectives of the study, the paradigmatic perspective used, the emerging themes, and the strategies that were developed.

6.2 CONCLUSIONS

The purpose of this research study was to explore and describe the health care needs of persons living with SPMI and their families and to utilize the data collected to create a conceptual framework which would form the basis of strategies to enhance the multifaceted role of the PHC nurses in the rural and remote areas and, in turn, to assist the PHC nurses in the provision of quality mental health care of persons living with SPMI and their families. To guide the research process the following objectives were identified:

- To explore and describe the persons living with SPMI, their families and primary health care nurses’ experiences of community-based health care provided by primary health care services.
- To develop nursing strategies for a community-based care for persons living with SPMI, their families and primary health care nurses.

Orem’s self-care model for nursing (Pearson, Vaughan and Fitzgerald, 1997:89) was employed as the paradigm for this study in order to capacitate the persons living with SPMI with the skills to manage or cope with mental illness and its effects. This model focuses on the concept of “self-care”. Although this concept seems to be common sense, it was a radical shift from the prevailing notion where nursing care was considered to be “care for” the person and when “bedside nurses” let alone patients...
made few decisions regarding nursing therapy (Pearson, Vaughan and Fitzgerald, 1997:89).

The two main themes identified from the data analysis were:

- Persons living with SPMI and their families experience challenges regarding community-based health care.
- The PHC nurses experience the integration of mental health care services into PHC as challenging.

Each objective mentioned above will be individually reviewed to assess whether it was achieved during the research study.

To explore and describe the persons living with SPMI, their families and primary health care nurses’ experiences of community-based health care provided by primary health care services.

Analysis of data obtained from the participants during interviews yielded a considerable amount of information. Extensive discussions of the aforementioned experiences provided the researcher with the understanding that most of the participants who used PHC services had both positive and negative experiences relating to how their mental health care needs were met. All three groups of participants expressed the need for a more comprehensive form of health care, inclusive of mental health care, to be rendered in the PHC services in order to address the diverse range of health care needs of persons living with SPMI and their families. The PHC nurses were overwhelmed by their incompetency in rendering mental health care to persons living with SPMI and their families. A need to capacitate PHC nurses about mental health care was identified.

The objectives of the research study were achieved with a description of the themes presented in Chapter Four of this research study.

To develop nursing strategies for a community-based care for persons living with SPMI, their families and primary health care nurses.
Phase Two consisted of three steps. Step one was the compilation of a conceptual framework. This was done with reference to the survey list identified by Dickoff et al. (1968:422). The aspect of the survey list that was used in the creation of conceptual framework was context, agent, recipient procedure, dynamics and terminus. During development of the conceptual framework, the concept of a family member as a sub-agent was also included. Step Two consisted of the development of strategies, making use of the conceptual framework, to assist PHC nurses working in rural areas to optimize their multifaceted role in nursing practice. Step three included the review of strategies by the expert panel and the changes that had to be effected to the final strategies. The strategies, which are closely related and inter-linked included: supportive supervision, collaboration, mentoring and capacity building to facilitate the multifaceted role of the PHC nurses and to assist them in their health care delivery.

**Summary of developed strategies**

*Supportive supervision* is a support mechanism for PHC nurses within which they can share clinical organisational development and emotional experiences with one another in a secure, confidential environment in order to enhance knowledge and skills about mental health care. This process will lead to an increased awareness of accountability and reflective practice. In many ways the process of supportive supervision parallels the nurse-patient relationship that is, the relationship between the PHC nurses, persons living with SPMI and their families.

Across all sectors of health and social care there is a growing need for more *collaboration* between professionals, providers and above all with the people they seek to serve. The significant challenge is how to create, within the existing and future workforce, the capability to work in inter-professional teams capable of effective collaboration in the rural areas. The scale of challenges facing health systems will not be addressed by simply improving the collaborative practices between existing healthcare practitioners. There will also need to be a serious examination of the workforce that is necessary and relevant to the needs of communities. As the demands for services increase so the workforce will need to continue to evolve making new forms of practitioner and new forms of care delivery inevitable.
All levels including individual, family, community, facility, district and provincial, national and global have a role and responsibility. The incorporation of visits to clinics by doctors and other health professionals in support of the PHC team, particularly nurses, improves collaboration between health professionals. An effective PHC can only be achieved through teamwork (Tumbo et al., 2006 in Sibiya, 2009:200). Teamwork means that everyone involved needs to understand the mental health care system, their own role in it, and appreciate and acknowledge the importance of everyone else. The final outcome of this involvement will be better mental health care for persons living with SPMI and their families.

Collaboration must consciously enhance the involvement of persons living with SPMI and families as caregivers in the development, implementation and evaluation of the strategy. If these goals can be achieved, the integration of mental health care into primary health care settings will be more successful in meeting the needs of persons living with SPMI and their families, ultimately improving the mental health and well-being of the community.

**Mentoring** which was a reflection strategy is the practice of reviewing an experience in order to describe, analyse, evaluate and inform learning about a practice. A mentoring strategy refers to a formal structured plan which outlines the purpose, values and resources needed and how these interact with the context in which mentoring occurs in order to achieve the set goals and objectives for the individuals and the organization (Campbell, 2009:5). It requires reflection, knowledge of self and profession, knowledge of mentoring processes and skills, communication and social skills, practice, and support.

**Capacity building** is an educational aspect that was devised to optimise the competencies of the PHC care nurses who provide mental health care to persons living with SPMI and their families living in rural areas. Capacity building is to develop capabilities that create or direct action or change within the organizations. A review of the themes supports capacity building as a necessary tool for the development and maintenance of effective improved quality mental health care.
The multifaceted roles of PHC nurses have expanded and diversified, with multiple roles and responsibilities increasing with the integration of mental health care. Lack of time and support were identified as barriers to meeting professional development needs. However, the conditions and opportunities available for career development whilst working in these areas do not promote professional advancement. The lack of supervision, mentorship and attendance at career enhancing activities could lead to sub-optimal nursing practice skills and an inability to keep pace with the current demands on health service. The four strategies and the activities were presented in Chapter Five.

The PHC nurses described a range of barriers to their development. There is a strong call for strategies for developing the multifaceted role of the PHC nurses. While education has long been recognised as integral to PHC nurses’ development in the rural areas, this study also points to a need for an equal focus on individual career development in mental health care. When education, mentoring, collaboration and supportive supervision are simultaneously undertaken within a coordinated workforce development initiative, PHC nurses will be able to optimally use their skills in mental health care provision for persons living with SPMI and their families, thereby meeting their needs holistically.

In a country such as South Africa with such inequities in the distribution of health services and related enabling factors such as staff adequacy and infrastructure, a supermarket or one-stop shop view of PHC underpins practice and is always going to be a function of the context in which the PHC practitioners have to operate. Of essence, is that the patient, the practitioner and the service should find meaning in what works for all concerned. However, it is clear that the PHC continues to be a fundamental component of health policy and health systems in South Africa.

Chapter Five also included an evaluation of the strategies by an expert panel to ensure trustworthiness of the study as described in Chapter Two of this research study. The criteria suggested by Chin and Kramer (2008:205) were used to evaluate the strategies.
In the light of the above discussion, it can be concluded that the objectives of the research study were met.

6.3 LIMITATIONS OF THE STUDY

- The initial plan was that individual interviews be conducted at the homes of the persons living with SPMI and their families but due to the bad condition of the roads the researcher could not access the homes of some participants. Therefore the study was restricted to the accessible rural areas.
- Persons living with SPMI and families were not fully aware of what kind of service should have been provided to them and therefore could not express their needs.

6.4 RECOMMENDATIONS

Based on the findings of the study, the researcher makes the following recommendations for psychiatric nursing practice, nursing education, and nursing management/administration, and further research.

6.4.1 Nursing practice

The finding of this study revealed that the level of knowledge and skills on the management of mental illness at home by the persons living with SPMI and their families is inadequate. This is confirmed by the quotes from the participants interviewed, as discussed in Chapter Three of this study. Therefore there is a need for PHC nurses to strengthen health education to persons living with SPMI and their families on the management of mental illness and its treatment in a more simplified manner for their level of comprehension.

The inclusion of family members in health education and self-care practices promotes further understanding of mental illness. The observations made by the researcher during data collection were that some persons living with SPMI may have the potential for self-care practice through supportive and educative nursing from the PHC nurses and the support from the family members as their sub-agents. This would be beneficial to their health needs. The strategies to facilitate the multifaceted role of the PHC nurses should be presented as part of the in-service education programmes to PHC
services, including community-based services and should also be utilised when planning for comprehensive health services. It is further recommended that the strategies to facilitate the multifaceted role of the PHC nurses be implemented at all levels, including national level, to facilitate recruitment and retention of PHC nurses in the rural areas in all the provinces.

The supervisors and the managers should identify the needs of the PHC nurses working in the rural and remote areas, plan how the needs could be met and mobilise resources to meet these needs. The PHC nurses work in collaborative practice environments and share knowledge with other health disciplines, with community-based service organizations, and with a well-informed population.

6.4.2 Nursing education

Continuing education and advanced practice education are critical to obtaining and maintaining the knowledge and skills needed to continuously improve the quality of PHC services. This specialised knowledge can be acquired through a variety of educational experiences including:

- conferences, in-service education, presentations at symposia, refresher courses, and short courses for PHC nurses who work in the rural and remote clinics, particularly those caring for the mentally ill persons and their families.
- Certification in Psychiatric-Mental Health Care

6.4.3 Nursing research

The purpose of this study was to develop strategies to facilitate community-based health care of persons living with SPMI and their families in the rural areas. The researcher did not use all the concepts of Orem’s self-care model (2001). On further studies there will be a need:

- to implement these identified strategies and evaluate their effectiveness
- to explore more factors that influence self-care practices of persons living with SPMI and their families. Therefore, further studies would help to explore more on the health care needs of persons living with SPMI and their families. This could enhance more knowledge and broaden the scientific knowledge.
to conduct as many research studies that will bring better strategies for improving the multifaceted role of the PHC nurses and encouraging all nurse supervisors and managers to advocate properly for capacity building of the PHC nurses working in the rural and remote areas and to ensure proper monitoring and evaluation strategies in managing the rural areas.

- to replicate this study in other areas to allow for generalisations about the needs of persons living with SPMI.

- Research is needed regarding effective strategies to maintain long term adherence to self-care practice requirements for treatment of mental illness.

### 6.5 Chapter Summary

The burden of mental illness remained high as people had problems adhering to treatment because of stigma, medicine-related side-effects, lack of knowledge about mental illness, lack of access to pharmaceutical supplies and the non-availability of support groups in the rural areas. The purpose of the study was to develop strategies to facilitate the community-based health care of persons living with SPMI and their families in the rural areas.

The study utilized Orem’s Self-care nursing model (2001) as a conceptual framework which demonstrated the supportive–educative nursing function. The supportive-educative nursing function was selected as it explained how the nursing agency used it to empower the persons living with SPMI to overcome their self-care deficits. Self-care practices will increase when the persons living with SPMI and their families are empowered with knowledge and skills on management of mental illness at home, treatment and the side-effects of medication so that the persons living with SPMI are able to report side-effects as soon as they notice them. A self-care agency was said to be developed when one was able to engage in practical operations such as taking decisions to keep appointments and taking correct doses at the same time daily.

This chapter concluded the study, presented the researcher’s conclusions, discussed the limitations, and made recommendations for nursing practice, education, nursing administration and for further nursing research. The strategies could be implemented by PHC nurses, especially professional nurses, working in primary healthcare clinics, in order to optimise comprehensive health care and support for persons living with
SPMI and their families. The strategies will optimise the multifaceted role of the PHC nurses for the benefit of persons living with SPMI and their families.

Bakibinga, P. 2012. The Experience of Job Engagement and Self-care among Ugandan Nurses and Midwives University of Bergern


Bird, P., Omar, M., Doku, V., Lund, C., Nsereko, R.N. and Mwanza, J. 2010. Increasing the priority of mental health in Africa: findings from a qualitative research in Ghana,


Brodarty and Donkin. 2009. Family caregivers of people with dementia. Primary Dementia Collaborative Research Centre and School of Psychiatry University of New South Wales, Sydney, Australia

Broodryk, J. 2006. Ubuntu Life-coping skills from Africa Randburg Knowres Publishing


Campbell, B.B. 2009. A mentoring strategy for nurse unit managers in Private Hospitals in Gauteng. Faculty of Health Sciences, University of Johannesburg


Carthew, M. 2011. Practice nurses’ perception of opportunities and barriers to the expansion of nursing role within contemporary general practice. A qualitative descriptive study. Auckland University of Technology


Comprehensive Service Plan: Healthcare 2010


Coomer, R. 2011. Experiences of parents of children with mental disability regarding access to mental health care, University of Western Cape


Cusack, E and Killoury, F. 2012. A vision for Psychiatric/mental Health Nursing Changing practice to support service delivery Clinical strategy and Pogram Directorate, Health Service Executive, Dr Steeven's Hospital, Dublin, Ireland


Department of International Development. 2010. “How to note – A DFID Practice Paper


Hanson, G.C. 2011. A Multi-level Study of the Predictors of family Supportive Supervision. Portland State of University


Harris, M. 2008. The role of primary health care in preventing the onset of chronic diseases with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol Center for Primary Health Care and Equity. UNSW.

Harris, M and Lloyd, J. 2012. The role of Australian primary health care in the prevention of chronic diseases Center for Primary Health Care


Humphery, J. and Wakerman, J. Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform. A discussion paper Monash University School of Rural Health, Bendigo.


Kapungwe, A., Cooper, S., Mayeya, J., Mwanza, J., Mwape, L., Sikwese, A. and Lund, C. 2011. Attitudes of primary health care providers towards people with mental

Kilty, H.L. 2007. Rural Health: A qualitative research approach to understanding best practices for rural health setting. Haldimand-Norfolk Health Unit. Brock University


Kolwaphi, X. X. 2009. A study on the knowledge and skills of police officers in handling mentally ill persons in Mdantsane in the Eastern Cape Province of South Africa University of Fort Hare.

Koper, M.A. 2009. Clinical supervision in the Alcohol and Other Drugs sector as conducted by external supervisors under a social work framework: is it effective? RMIT University


Machapalala, S. N. 2010. The Integration of Strategy Formulation and Implementation in the greater Sekhukhune District Department of Basic Education, Limpopo Province University of Limpopo

Mahamba, N.D. 2009. Factors influencing relapse of psychiatric outpatients in the rural communities of the Eastern Cape Province. University of South Africa

Makhele, M. F. and Mulaudzi, F.M. 2012. The experiences of Batswana families regarding hospice care of AIDS patients in the Bophirima District, North West Province, South Africa.

Maritz, J. 2010. Follow-up of Mental Care Users by Nurses in the Primary care Settings in South Africa University of Johannesburg. Journal of Psychology in Africa 20 (1) 61-68


Mfuko, N. 2010. An assessment of primary health care services from the perspective of the recipients in the Khayelitsha Community Health Centre. University of Western Cape


Mnisi, D.M.A. 2011. The characteristics, attitudes and perceptions of informal caregivers caring for a mentally ill family member: a study in Dennilton. University of South Africa


Mokoena, J. D. 2012. Construction of a model for human rights education in the health profession University of Limpopo, South Africa

Molefi, S. 2009. Families' experiences with schizophrenia Stellenbosch University

Moodley, T. 2011. Retention and turnover policies for professional nurses at Inkosi Albert Central Hospital Graduate School of Business University of KwaZulu-Natal


Mphelane, M.L. 2006. The role played by families in support of their mentally ill relatives in a rural community in Limpopo Province. University of South Africa
Mthembu, L.B. 2004. The role of the environment in the recuperation of the mentally ill patients in Manguzi health ward University of Zululand


Ngoatje, M.F. 2005. Capacity building and sustainable development with reference to the Pietsburg/Polokwane Municipality Rand Afrikaans University


Office of Rural Health and Primary care, Minnesota, 2007


Photakoun, V. 2010. The role of capacity building for livestock extension and development in LAO PDR Charles Sturt University


Rural health in Rural hands Strategic directions for rural, remote, northern and Aboriginal communities. Ministerial Advisory Council on Rural Health


Sariah, A. 2012. Factors influencing relapse among patients with schizophrenia in Muhimbili National Hospital: the perspective of patients and their caregivers. Muhimbili University of Health and Allied Sciences


Sekhukhune, D. 2005. A Model to facilitate a quest for emotional maturity of Psychiatric nurses through capacity development in promoting their mental health. University of Johannesburg

Seloilwe, E.S. 2006. Experiences and demands of families with mentally ill people at home in Botswana. Journal of Nursing Scholarship; an official publication of Sigma Theta Tau International Honor Society of Nursing/Sigma Theta Tau July 1, 2006 Volume 38, page 262


Sibiya, M.N. 2009. A model for the integration of primary health care services in Kwazulu-Natal, South Africa Durban University of Technology


Alcohol and other Drugs field. National Centre for Education and Training on Addiction Flinders' University, Adelaide, Australia


South African Federation for Mental Health. Making mental health a South African priority July awareness campaign

Ssebunya, J., Kigozi, F., Kizza, D. and Ndyanabangi, S. 2010. Integration of Mental Health into Primary Health Care in a rural district in Uganda Mental Health and Poverty Project (MHaPP). Makere University, Kampala, Uganda


Tembani, N.M. 2009. Strategies to facilitate collaboration between allopathic and traditional health practitioners Nelson Mandela Metropolitan University

The Mental Health Care Act (Act No. 17 of 2002). Government Gazette, South Africa

The National Care Act, 2004 (61 of 2003)


Thutse, RJ. 2006. The professional nurses’ perceptions of working in remote rural clinics in Limpopo Province. University of South Africa


van De Heever, A.E. 2012. Nurses' own perceptions of their therapeutic relationship in providing care to patients with mental health disorders. Faculty of Nursing Science; University of Johannesburg


van Dijk, D. 2008. Beyond their ages. African Studies Center; Netherlands


Velikoshi - Indongo. E.N. 2013. Investigations into experiences of mothers who delivered and are caring for preterm babies in Northern Namibian State Hospitals: A discharge Health Educational support Programme University of Namibia


WHO-AIMS Report on Mental Health System in South Africa, WHO and Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa, 2007

Wildschut, A and Mqolozana T. 2008. Shortage of nurses in South Africa: Relative or absolute? Department of Labour: HRSC.


www.health.gov.bc.ca/leg/hpc/review/termsref.html

http://www.businessballs.com/kolblearningstyles.htm

http://heapro.oxfordjournals.org
LIST OF ANNEXURES

ANNEXURE A: Approval from REC-H

4/9/2015 RE: new consent form Yahoo Mail!

RE: new consent form

Tuesday, June 30, 2009 10:26 AM

From:"Strumpher, Nita (Prof) (Summerstrand Campus North)"
<Nita.Strumph@nmmu.ac.za>

To:"'Ntembie Shasha'" nontembeko.shasha@yahoo.com

Tembi,

The REC – H (ethics committee) met last week and accepted your ethics request but you will have to make some corrections. I will still send you their formal list of changes but will tell you about the ones I was able to write down so long.

- They suggested that you change the title to take out and persistently (I must say that I have given up trying to fight this battle – they feel that the patients may feel stigmatized. I explained that the name was developed to break away from the stigmatizing term …chronically ill but I think, just change it to take these words out.

- Heading 1, 1k – look at dates of when you will start, length of study (totally wrong at the moment)

- In Methodology – describe how participants will be contacted to gain permission (Gaitkeeper) will contact ….ask if they will be prepared to talk and only after that will the researcher be given contact details

- Must state clearly that you are aware you are dealing with a vulnerable population (patients) and that you will immediately terminate the interview should you become aware that the participant (especially patient) is experiencing stress

- 4e: you state here that you have already obtained permission for the DoH – they want to see the evidence, a copy of the letter.
9 – Your statement incorrect – IAM NOT aware …. 

In document you refer to gatekeepers – make sure that you use academic language 

Look at consent form and simplify it. As it is at the moment the participants will have difficulty understanding form. Take out information which is not relevant to your population. You should have at least two different consent forms. The ones for PHC nurses should not be simplified but the ones for patients / family should include all the information but use simplified language 

On section 2.2 on consent form (procedures) add that you will use a tape recorder 

Whole document must be edited as there are quite a number of spelling / language problems 

Regards, 

4/9/2015 RE: new consent form Yahoo!

file:///G:/FW%20Extract%20REC-H%20minutes%20dd%2024%20Jun%202009%20-%20Yahoo%20Mail.htm 1/3
FW: Extract: REC-H minutes dd 24 Jun 09
Tuesday, June 30, 2009 1:38 PM
From: "Strumpher, Nita (Prof) (Summerstrand Campus North)"
<Nita.Strumpher@nmmu.ac.za>
To: 
"Ntembie Shasha" <ntembieshasha@yahoo.com>
Tembi,
Here are the formal REC-H comments
Prof
From: Spies, Ursula (Mev) (Summerstrand Campus South)
Sent: 30 June 2009 01:15 PM
To: Strumpher, Nita (Prof) (Summerstrand Campus North)
Cc: Longe, Kirsten (Ms) (Summerstrand South Campus); Ahmed, Nouwaal (Mrs) (Summerstrand Campus South)

Subject: Extract: REC-H minutes dd 24 Jun 09
HUM09.46.2 New application: [H09-HEA-NUR-001] A community-based health care model for severely and persistently mentally ill patients (PRP Prof J Strümpher / PI Ms NG Shasha) [D]

RESOLUTION OF REC-H: That protocol [H09-HEA-NUR-001] be granted ethics approval on condition that the following recommendations be addressed and implemented:
1) Application form section 1(k): date of commencement (01/02/2006) to be corrected.
2) Application form section 9: the wrong default option has been selected.
3) Application form section 4(e): copy of the consent letter to be provided.
4) Application form section 1(n): sample size – candidate should state that this is dependent on data saturation.
5) Informed consent form section B: to be completed.
6) Informed consent form to be simplified to suit the various target groups represented in the sample. Applicant to specify the different groups, which would take part in the study.
7) Informed consent form section C: translation section to be deleted.
8) Informed consent form section A.1 2.2: applicant to indicate that a tape recorder will be used.
9) Letter and informed consent form to indicate that the participant may withdraw at any time and the candidate to address specifically the termination of the interview when the primary participants display signs of stress.
10) Recommended that the title be amended to read as follows: “A community-based health care model for severely mentally ill patients” to avoid stigmatisation.
11) Applicant to indicate how privacy would be managed during the interview process in the home environment.
12) Recommended that par 7.2.1.1 referred to in the proposal be synchronized with the information provided in section 6(f) of the application form.
13) Recommended that application/proposal be language edited.
14) The applicant to liaise with Ms K Longe (RCD) once the abovementioned recommendations have been addressed.
(An approval letter would be drafted once Ms K Longe has submitted verification of the amendments to RCD and the REC-H secretariat.)

MS K LONGE
Ursula Spies
file:///G:/FW%20Extract%20REC-H%20minutes%20dd%2024%20Jun%2009%20-%20Yahoo!%20Mail.htm 3/3
Committee Officer
Dept: Governance Administration (Secretariat)
PO Box 77000 - NMMU - Summerstrand Campus (South) - PE - 6031
Tel: +27 041 504-3140
Fax: +27 041 504-1940
Email: ursula.spies@nmmu.ac.za
□ please consider the environment before printing this email

NOTICE: Please note that this eMail, and the contents thereof, is subject to the standard NMMU eMail disclaimer which may be found at:
http://www.nmmu.ac.za/disclaimer/email.htm
ANNEXURE B: Request to conduct research

Lilitha College of Nursing
Queenstown Campus
Queenstown
04. 08. 2008

The District Manager
Chris Hani District
Queenstown

Dear Madam,

SUBJECT: Request to conduct research

I am a Doctoral student at the Nelson Mandela Metropolitan University, Department of Nursing Science. As a requirement for my studies, I am engaged in a research study titled “A Community-based health care model for severely and persistently mentally ill (SPMI) patients from the selected rural area of Emalahleni LSA in the Eastern Cape.”

The research study is supervised by Prof. J. Strumpher as a promoter and Prof. M. Van Rooyen as a co-promoter.

To complete the research study, I have to conduct individual interviews with SPMI patients and focus groups with their families as well as Primary Health Care (PHC) nurses as service providers. These interviews will be audiotaped and transcribed for verification with independent coder as well as promoters of the study. The interviews will take 40 minutes per person. It is envisaged that data collection will be completed as it reaches saturation.

The objectives of the study are to:

- Explore and describe how SPMI clients and their families experience community-based health care provided by PHC services.
- Explore and describe what the health care needs of SPMI clients and their families are.
- Develop a nursing model to facilitate community-based health care relevant to the needs of SPMI patients and their families.

I undertake to safeguard the following ethical principles throughout the research process:

- Seeking informed consent to participants
- Assure voluntary participation without coercion and freedom to withdraw when the participant feels uncomfortable.
- Observe confidentiality and anonymity by not using the names during interviews and during publication of results of the study and limit the raw data and field notes to the researcher, independent coder and promoters only and destroy the data that is in the tapes as soon as possible after use.
- Conduct interviews at the homes of SPMI clients and workplace of PHC nurses to avoid financial implications for participants.

Purposive sampling of target population will be done according to criteria set for inclusion in the research study.

Participation in the study will benefit the participants by affording the opportunity to verbalize their experiences of community-based health care services as well as their perceived health care needs and give input towards the nursing model to facilitate community-based health care of SPMI clients and their families. I will provide you with feedback regarding the results of this research study.

Thank you,

........................

N. Shasha (Mrs) RN, BCur, MCur, Reseacher.
Contact No. 045- 8392414/8392482 (W)
8386482 (H)
0723098980 (cell)
045- 8392414 (Fax)
Ref:
Contact person: Nontembeko G Shasha

Dear Participant

You are being asked to participate in a research study. We will provide you with the necessary information to assist you to understand the study and explain what would be expected of you (participant). These guidelines would include the risks, benefits, and your rights as a study subject. Please feel free to ask the researcher to clarify anything that is not clear to you.

To participate, it will be required of you to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions.

You have the right to query concerns regarding the study at any time. Immediately report any new problems during the study, to the researcher. Telephone numbers of the researcher are provided. Please feel free to call these numbers.

Furthermore, it is important that you are aware of the fact that the ethical integrity of the study has been approved by the Research Ethics Committee (Human) of the university. The REC-H consists of a group of independent experts that has the responsibility to ensure that the rights and welfare of participants in research are protected and that studies are conducted in an ethical manner. Studies cannot be conducted without REC-H’s approval. Queries with regard to your rights as a research

Date 11 May 2009
subject can be directed to the Research Ethics Committee (Human), Department of Research Capacity Development, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

If no one could assist you, you may write to: The Chairperson of the Research, Technology and Innovation Committee, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.

Participation in research is completely voluntary. You are not obliged to take part in any research. If you choose not to participate in medically related research, your present and/or future medical care will not be affected in any way and you will incur no penalty and/or loss of benefits to which you may otherwise be entitled.

If you do partake, you have the right to withdraw at any given time, during the study without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination in order to terminate the research in an orderly manner.

If you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes that it is not in your best interest to continue in this study, or for administrative reasons, your participation maybe discontinued. The study may be terminated at any time by the researcher, the sponsor or the Research Ethics Committee (Human).

Although your identity will at all times remain confidential, the results of the research study may be presented at scientific conferences or in specialist publications.

This informed consent statement has been prepared in compliance with current statutory guidelines.

Yours sincerely

Nontembeko G Shasha
RESEARCHER
ANNEXURE D: Permission to conduct research

Province of the Eastern Cape • Iphondo IleMpuma-Koloni

ISEBE LEZEMILO DEPARTMENT OF HEALTH
Private Bag / Ingxowa Eyodwa P.O. Box 1661, Queenstown 5320
CHRIS HANI HEALTH DISTRICT OFFICE

BATHO PELE: PEOPLE FIRST: ABANTJU KUQALA

Ref No: 
Referensi: Telephone: 045-807100
Enquiries: Faksimile: 045-8071189
Imibizo: Ifokisi:

E-mail: vatiswa.ruka@impilo.ecprov.gov.za

2 September 2008

Mrs N. Shasha
Liilitha College of Nursing
Queenstown Campus
QUEENSTOWN

Dear Madam

PERFORMANCE OF RESEARCH STUDY AT EMALAHLENI SUB-DISTRICT

Permission is hereby granted to perform the research study at Emalahleni Sub-District.

Kindly liaise with the Sub-District Manager for more information and logistics.

You are expected to maintain and observe confidentiality at all times.

A report on the study is expected to be submitted to the above office.

Yours in service

DISTRICT MANAGER
CHRIS HANI HEALTH DISTRICT
## RESEARCHER’S DETAILS

<table>
<thead>
<tr>
<th><strong>Title of the research project</strong></th>
<th>Strategies for community-based health care of severely and persistently mentally ill persons and their families in the rural areas of Emalahleni LSA, Chris Hani District, Eastern Cape.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reference number</strong></td>
<td>203055616</td>
</tr>
<tr>
<td><strong>Principal investigator</strong></td>
<td>Nontembeko G Shasha</td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>57 PRINCE ALFRED STREET, QUEENSTOWN</td>
</tr>
<tr>
<td><strong>Postal Code</strong></td>
<td>5319</td>
</tr>
<tr>
<td><strong>Contact telephone number</strong></td>
<td>0723098980</td>
</tr>
</tbody>
</table>

### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT

<table>
<thead>
<tr>
<th>I, the participant and the undersigned</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ID number</td>
<td></td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>I, in my capacity as (parent or guardian)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>of the participant (full names)</td>
<td></td>
</tr>
<tr>
<td>ID number</td>
<td></td>
</tr>
<tr>
<td>Address (of participant)</td>
<td></td>
</tr>
</tbody>
</table>
A.1 HEREBY CONFIRM AS FOLLOWS:

I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Nontembeko G Shasha from (NMMU, Faculty of Health Sciences, Department of Nursing Science) Of the Nelson Mandela Metropolitan University.

<table>
<thead>
<tr>
<th>THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1</strong> Aim: <strong>The investigators are studying:</strong></td>
<td></td>
</tr>
<tr>
<td>To explore and describe how severely and persistently mentally ill patients and their families experience community-based health care provided by PHC services and to explore and describe the health care needs of severely and persistently mentally ill patients. The information will be used to develop a nursing model for community based care to address the health needs of severely and persistently mentally ill patients</td>
<td></td>
</tr>
<tr>
<td><strong>2.2</strong> Procedures:</td>
<td></td>
</tr>
<tr>
<td>I understand that the participant will be individually interviewed at the participant’s place of residence</td>
<td></td>
</tr>
<tr>
<td><strong>2.3</strong> Risks:</td>
<td></td>
</tr>
<tr>
<td>The SPMI patients might be stressed during the individual interviews.</td>
<td></td>
</tr>
<tr>
<td><strong>2.4</strong> Possible benefits:</td>
<td></td>
</tr>
<tr>
<td>As a result of my participation in this study Debriefing will be done to minimise any possible harm that arose during the interviews and to rectify misconceptions</td>
<td></td>
</tr>
</tbody>
</table>
that might have been unintentionally inflicted.

2.5 Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.

2.6 Access to findings: Any new information or benefit that develops during the course of the study will be shared as follows: it will be available in a publication form to both participants and PHC nurses.

2.6 Voluntary participation / refusal / discontinuation: My participation is voluntary.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle.

<table>
<thead>
<tr>
<th>TRUE</th>
<th>FALSE</th>
</tr>
</thead>
</table>

3. THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:

(Nontembeko G Shasha)

<table>
<thead>
<tr>
<th>language</th>
<th>Afrikaans</th>
<th>English</th>
<th>Xhosa</th>
<th>Other</th>
</tr>
</thead>
</table>

and I am in command of this language, or it was satisfactorily translated to me by

(name of translator) N/A

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.
5. Participation in this study will not result in any additional cost to myself.

A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:

<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th>on</th>
<th>20</th>
</tr>
</thead>
</table>

Signature or right thumb print of participant

<table>
<thead>
<tr>
<th>Signature of witness:</th>
</tr>
</thead>
</table>

Full name of witness:

B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

<table>
<thead>
<tr>
<th>1.</th>
<th>Nontembeko Grycelda Shasha</th>
<th>declare that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have explained the information given in this document to (name of patient/participant) and / or his / her representative (name of representative)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>He / she was encouraged and given ample time to ask me any questions;</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>This conversation was conducted in Afrikaans English Xhosa* Other</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>And no translator was used OR this conversation was translated into (language) by N/A</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I have detached Section D and handed it to the participant YES NO</td>
<td></td>
</tr>
</tbody>
</table>

Signed/confirmed at on 20

<table>
<thead>
<tr>
<th>Signature of witness:</th>
</tr>
</thead>
</table>

Full name of witness:

Signature of interviewer
C. DECLARATION BY TRANSLATOR (WHEN APPLICABLE)

<table>
<thead>
<tr>
<th>I,</th>
<th>(full names)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID number</td>
<td></td>
</tr>
<tr>
<td>Qualifications and/or Current employment</td>
<td></td>
</tr>
</tbody>
</table>

confirm that I:

1. Translated the contents of this document from English into (language)

2. Also translated questions posed by (name of participant) as well as the answers given by the investigator/representative;

3. Conveyed a factually correct version of what was related to me.

Signed/confirmed at on 20

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential.

<table>
<thead>
<tr>
<th>Signature of translator</th>
<th>Signature of witness:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full name of witness:</td>
</tr>
</tbody>
</table>
D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT

Dear participant/representative of the participant

Thank you for your/the participant's participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(indicate any circumstances which should be reported to the investigator)

<table>
<thead>
<tr>
<th>Kindly contact</th>
<th>Nontembeko Shasha</th>
</tr>
</thead>
<tbody>
<tr>
<td>at telephone number</td>
<td>0723098980</td>
</tr>
</tbody>
</table>
ANNEXURE F: Interviews

GROUP 1: persons living with SPMI

INDIVIDUAL INTERVIEWS

I - Tell me your experiences about the service that you get from the clinic?

P - The problem of the clinic is that there is usually no medication and we do not get them regularly and that is why we use the other clinic that is on the other side of the village. Even if you come for headache tablets, you hardly get them. I feel that this clinic has been neglected by the government.

I - So you are saying the problem with this clinic is that there is usually no medicines for mental ill patients. Have you ever asked sister about this problem as a community?

P - Yes, there is always no medicine in this clinic for everybody. Yes, they said there were told by the office (District Office) that there is no transport to deliver medicines to the clinic.

I - You mentioned that you sometimes get medicines from the clinic on the other side of the village. How far is that clinic from here?

P - It is a walkable distance although it is a bit far from here. But there is nothing we can do, we walk to that clinic. The nurses in that clinic usually tell us that we are not budgeted for in their clinic, our budget is with our clinic. That is why sometimes I prefer going to the hospital because in the hospital you get everything.

I - Can you explain what do you mean by getting everything?

P - I mean in the hospital you are seen by the doctor and you also get medicines.
I - Besides medicines what else can you tell me?

P - This clinic is closed at night, so we do not have a health service during the night. The other day I got sick during the night I had to hire a car from the neighbor to take me to the hospital which is expensive because the owner of the car charged me a special trip. During the night there is so much that can happen and yet we are so far away from the hospital. The clinic is supposed to be opened 24 hours. It is worse not to have the clinic even over the weekend. Ambulances or police take time to come when called and that also our roads are bad they are not keen to come.

I - Mhm! please continue

P - The nurses are very friendly towards us. They do everything to help, even if it is not about medicines for mental illness. Like sometimes I come to the clinic for, for example, for wound dressing or flu I get help from the nurses. The nurses here are trying by all means. Although sometimes you will find that there is only one sister on duty in the clinic which makes us to wait for a long time before you are helped. We are told that the other sister sometimes has gone for a meeting or holiday. The only problem is that you cannot walk to the hospital.

I – Is there any other experience that you would like to share with me?

P – No there is nothing so far.

I – Tell me what are your health needs as a mentally ill patient?

P – There is no doctor and no social worker in this clinic. We need to have them visiting at least once a month so that we do not go to hospital as it is expensive travelling to hospital and you have to wake up early and stay the whole day in hospital and come back late.

I - Mhm!
P – I also wish that the mentally ill patients can be checked fully just like other patients to pick up some other problems that we are not aware of. Patients that are not mentally ill are examined from head to toe every time they come to the clinic, that is, the nurses check their blood pressure and sugar.

I – What happens to you when you come for your treatment?

P – With us you are given your pills without being checked unless you complain with some illness either than mental illness, something like stomachache to make an example.

I – How do you spend your day?

P – I just stay at home with my mother although I have my own house. I sometimes go to events that are taking place in the community. On Sunday I attend my Zion church. I like the sound of the drums and I like singing.

I – How is your family helpful to you?

P – My sister is the one who is looking after all of us at home. She cooks and does washing for all us. She always reminds me of the date for taking my treatment from the clinic.

I – Is there any other experience that you would like to share with me?

P – I think I told you everything now.
I – Thank you I will contact you when necessary.
GROUP 2: Family Members

INDIVIDUAL INTERVIEWS: Family member

I – Tell me about your experiences of the mental health service that you receive from the clinic?

P – It was really scary when he first became mentally ill of course the police were called because we could not control him. I was disheartened with the way that we have to use to get help from the clinic and from the hospital. It highlighted the difference between finding help from a physical illness and mental illness. When a person has physical illness he/she is able to quickly get a doctor and information regarding his/her illness. In the case of a mentally ill person it is often necessary to contact a police officer in order to get him/her to get a mental health service. Once the mentally ill person arrive at the clinic or hospital there is very little information given to the family members about the process of admission or how long they should expect their relative to be admitted.

I – You mentioned that you were disheartened with the way that was used to take your son to hospital, can you explain that further?

P – My son had a bad experience being taken off in a police van as a criminal meanwhile he is sick. The police officer actually handcuffed his feet together as well as his hands while in the police van.

I – You also mentioned that when a person has physical illness he/she is able to quickly get a doctor, can you expatiate on that?

P – In the clinic we do not get urgent help. We have to restrain him ourselves. When it happens that he runs we have to run after him and nobody helps us not even a security guard.

I – What do you want to see happening?
P – I wish we can get urgent help as soon as we come to the clinic. I wish there could be people helping us when we come to the clinic or if he can immediately get an injection that will calm him because he becomes aggressive and violent.

I – What else do you want to share with me?

P – I wish we can get his treatment because sometimes we do not get his treatment. We are told it is out of stock. It takes a long time for the treatment to be available and also take a long time for him to be admitted in the hospital. Sometime he is not admitted which becomes a problem to us because when we bring him to the clinic it means we need help therefore he should be kept in hospital until he is calm,

I – Mhm!

P – As a family we wish that he must be cured, he must be given treatment that is going to cure this mental illness because it is not easy to stay and care for a mentally ill person. Sometimes you are just called by community members that he is somewhere being aggressive and violent either destroying peoples’ property or fighting with people. It becomes a problem really. When you call an ambulance many a times it does not come immediately. I wish emergency help can be available to these people (mentally ill).

I – Continue, I am listening.

P – I think it would be better if there is 24 hour emergency help for families in situations that occur over night and how to handle those situations and be able to take informed decisions in certain situations. For example if your person relapses at night, one does not know what is the right thing to do and that becomes tough. As family members we need to have information at hand so that we know how to handle your family member who is mentally ill appropriately should a need arise.

I – What else would you like to tell me?
P – The other day my son relapsed, so I called the clinic and explain what the problem was and that we needed to come to the clinic. The nurse said there is no need because our son may not be taking treatment regularly as he has been in the clinic two weeks ago. I do not know whether that nurse listened to what I said. As a family member you get to a point where you do not know where to go or who to ask for help.

I – Is there anything else that you want to say?

P – I mean mental illness is every day and every minute in your home. It is like having a mentally handicapped child. It is constant and can take your energy away. How do you react to your child when she says; someone is talking to her through a light fitting? We were not given any instruction. For the first few months I did not know how to interact with her anymore. It was just like a foreigner has come to my house and we could not communicate with her as we used to anymore.

I – You mentioned that you were not given instruction and that you did not know how to interact with your son, can you explain that?

P – I was encouraged to write down the behaviours that my son was displaying and share with the nurses. I felt that to help my son they have to involve the family fully. At times my son will request me to go with him to the clinic and he will go in the consulting room first and tell them that I have asked my mother to come with me today and I would like you to talk to her too. That is working well and usually I am able to help when my son is having a difficult time.

I – Mhm!

P – The mentally ill peoples’ sense of awareness is not very good and they are unable to make decisions but the nurses leave all the decision making to them. It is not that we want to hear confidential information. We want to know what is going on about our family members who are mentally ill.
I – What else do you want to say?

P – I wish that they (mentally ill people) can be occupied. Like I saw in another clinic that they have a support group where they get together share whatever, do hand work and sell those items that they do or do gardening and vegetables are sold to the community so that they see themselves as people who can still do something in the community just to boost them up.

I - Any other health care needs that you may think of?

N - There is nothing else that I may think of. I think I have said everything that I wanted to say.

I - Thank you very much for your time. I will contact you when necessary.

N - Thank you.
GROUP 3: PHC nurse

KEY: I= Interviewer
     N= Nurse

PRIMARY HEALTH NURSE

I - Tell me, how do you experience rendering of health care services in the clinic?

N - I think we are trying our best to provide a quality health service. A lot is being done for the patients and we are trying by all means to improve the provision of health care service to our patients. We believe that the PHC nurse has to have the knowledge of everything to be able to take care of a patient. We therefore try by all means to keep up to date by attending workshops and consulting people that can help us. We are not looking only at their needs; we are also looking at how to address their needs. We also encourage the patients to tell us about their health care needs so that they can be taken into consideration. We need to know their needs; we are here because of their needs. We are trying to communicate with them to understand what their needs are. A lot of them come to the clinic from afar as this is the only clinic in this village. We sometimes do not attend to them as we wish because we are only two registered nurses in this clinic and as a result they (patients) sometimes become angry towards us.

I - You mentioned that you sometimes do not attend to them as you wish, what do you mean?

N - We deal with a large number of clients daily that are coming to the clinic for help. The clinic is always full. The statistics has gone high. We are working very hard because people are coming in numbers every day even if a person was treated yesterday. This is putting a lot of strain to us. The implementation of free health services has led to a rise of patients that we have to attend to in the clinic. Due to this workload sometimes, you do not have much time to examine the patient thoroughly because you have a long queue that you have to attend to. So you have to hurry up to finish the patients. It is worse with mentally ill patients
because they cannot stand in a queue for a long they become frustrated and angry.

I - How do you handle that situation?

N - We sometimes check how many of the mentally ill patients are standing in the queue and if they are many, I usually request the other sister to quickly help them. I ask the permission from other patients first, some do agree because they are scared of them and some will grumble of course.

I - How would you describe your day’s work from the time you come on duty until you go off duty?

N - Every day when we come on duty, there would be some patients waiting to be attended to. While we are taking the report from the nurse who was on call during the night, the caregivers will start attending to the patients, taking the patients vital signs. We do not attend to psychiatric patients separately. They join the queue like any other patients. Most of my day is spent attending to patients with different problems such as minor ailments, family planning, assessing and prescribing medication to patients including mentally ill patients.

I - You mentioned that you render quality service, tell me more.

N - It means improving the level of care by involving the community. We also attend to the patients’ needs. We try by all means that medication is never out of stock. We are negotiating with our managers to give us a doctor at least once a month to review the chronic patients. That is what I meant by a good quality service. There are some things that are also lacking but we are attending to the patients.

I - Can you give me an example of those things are lacking?

N - We would like to have a social worker visiting the clinic because our people have a lot of social problems that might be contributing to their illness. For psychiatric
patients, there is a lot that need to be attend to, for example, some patients do not have disability grants, accommodation and support from their families. Some families only care for them towards month-end when it is time for them to get their disability grant. These patients are also subjected to physical and sexual abuse by their relatives, neighbours and strangers. This is the role of the social worker to see to those problems.

I - You mentioned that you are two registered nurses working in this clinic, how many nurses are you supposed to be having?

N - We are only two registered nurses, two nursing assistants, three caregivers and two cleaners. The job that we are doing is more curative than preventive and promotive. We would like to have somebody to do health education. We would like the government to employ the staff nurses. Our role as PHC providers is to concentrate a lot on preventive and promotive. We do not do that because people come in being sick and we have to treat them. We do not have much time to even do health talks to our patients. Also the introduction of supermarket approach to service provision has also contributed to the increased workload because one is expected to render all the services on a daily basis or carry out many separate unrelated tasks like consulting a patient with chest pain, provide family planning, give health education to the same patient and immunize her under-five child. The staff establishment in the PHC services remained the same despite introduction of free health services. The supermarket approach is good where there is enough staff. I believe it is cost effective for the patients because they do not have to wait for a special day.

I - How do you experience working with chronic mentally ill patients?

N - It is different because they have many problems than other patients. They are a bit challenging than working with other groups, so you have to be up to date especially with the Mental Health Care Act and their rights. One should not take them for granted that they are mentally ill therefore they do not understand. You have to always make sure that the information you give to them is accurate.
I - What the health care needs of mentally ill patients and their families are?

N - They need to get their monthly supply of medication, to get the disability grant, their problems to be attended to, to be given information about their treatment and the basic life skills to meet their needs.

I - What type of problems are you referring to?

N - Apart from their treatment, mentally ill patients come to the clinic for many reasons just like any other patients. They come for minor ailments, family planning, dressing of wounds and so on. You will find that some patients come frequently to the clinic especially with free service and especially those that are staying nearer to the clinic.

I - Any other health care needs that you may think of?

N - There is nothing else that I may think of. I think I have said everything that I wanted to say.

I - Thank you very much for your time. I will contact you when necessary.
ANNEXURE G: Letter to the independent coder

57 Prince Alfred Street
Central
Queenstown
5320
26 January 2013

Dr R Jacobs
Elizabeth Donkin Hospital
Port Elizabeth

Dear Dr Jacobs,

Thank you for agreeing to be my independent coder. Kindly receive copies of my transcribed interviews. Data will be analysed according to Tesch’s method as described by Creswell (2003:192). The steps identified by Tesch as the most useful method of providing an analysis of the data are:

- Get a sense of the whole by reading all transcriptions carefully.
- Pick one document to analyse the underlying meaning.
- After completing this task for several documents, make a list of topics clustering those that are similar.
- Assign codes to the topics. Return to the data and assign codes to the appropriate segments.
- Assign categories to the topics grouping them and indicating interrelationships.
- Decide on the abbreviation for each category.
- Perform a preliminary analysis by assembling the data for each category together
- If necessary, recode existing data

Thank you for your help.

Yours faithfully,

Nontembeko Shasha
ANNEXURE H: Letter from the editor

24 Justin Road
Broadwood
Port Elizabeth 6070

TO WHOM IT MAY CONCERN

I, Aileen Gail Klopper, declare that I have assessed and edited the treatise of N G SHASHA entitled:

STRATEGIES TO FACILITATE COMMUNITY-BASED HEALTH CARE FOR SEVERELY AND PERSISTENTLY MENTALLY ILL PERSONS

Submitted in fulfilment of the requirements for the degree of DOCTOR PHILOSOPHIAE in the Faculty of Health Sciences

Any queries related to the editing of this treatise can be directed to me at 074 3209463.

Signed at Port Elizabeth on 30 January 2015.

Ms AG Klopper (MA HWM)
ANNEXURE I: Proposal of the research study

1. INTRODUCTION AND LITERATURE REVIEW

The goal of a mental health delivery system is to allow the individual to achieve the promise of the community living and to assure that the consumers and their families have access to accurate information that promotes learning, self-monitoring and accountability (Stuart & Laraia, 2005: 710)

Community-based health care can be defined as care directed towards specific individuals and families within a community. It is designed to meet the needs of the communities as they move between and among health care settings with an emphasis on a flowing kind of care that does not necessarily occur in one setting. Community-based health care is based on the following concepts.

- The individual and the family have primary responsibility for health care decision
- Health and social issues are acknowledge as interactive
- Treatment effectiveness rather than the technology imperative drives the decisions (Stuart & Laraia, 2005: 710).

In the community-based health care the severe and persistently mental ill (SPMI) person is in his natural environment, in the context of the family and community. Illness is seen as merely an aspect of life and the goals of care focused around maximizing the Person living with SPMI's quality of life. Nursing care in the community is an autonomous practice with nursing interventions decided on by the patient, family and the community. The goal of community-based health care is to encourage self-care in the context of the family and the community with a focus on prevention and continuity of care. The first component of community based- health care is self-care. Self-care challenges the individual Person living with SPMI with primary responsibility for health care decision and actions. Community-based health care focuses primarily on tertiary prevention (Hunt, 2001:15-16).

The trend in PHC is also shifting from that of inpatient care to a focus of community-based care within the community. One of the services of a community-based health
care program is tertiary prevention which aims to reduce the prevalence of mental illness by shortening the course of acute illness and tertiary prevention to reduce the residual defects that are associated with severe and chronic mental illness. To ensure that, a wide range of services, such as rehabilitation programmes, are made available as needed, the community psychiatric nurse has to plan for the needs of the person who are severe and persistently mentally ill (Townsend, 2003:832).

The goal of tertiary prevention is to limit the amount of disability and maladaptive functioning resulting from an illness. The concepts of tertiary prevention are particularly relevant to those with severe and persistent illness. Mostly, nurses care for these persons living with SPMI in community-based services and in the clients’ homes. Tertiary prevention can be achieved through activities such as rehabilitation, which is the process of helping the person return to the highest possible level of functioning. These identified activities include assertive community treatment, supported employment, illness management and recovery, integrated treatment for co-occurring mental illness, family psycho-education and medication management (Stuart & Laraia, 2005:239).

In the first world countries, nursing in tertiary prevention for persons living with SPMI focuses on helping clients learn or relearn socially approved behaviors so that they may achieve a satisfying role within the community. This includes:

- Consideration of rehabilitation process at the time of initial diagnosis and treatment planning.
- Teaching the client daily living skills and encouraging independence to his or her maximum ability.
- Referring clients for various after care services, for example, support groups, day treatment programs, and psycho-social rehabilitation and so on.
- Monitoring effectiveness of aftercare services, for example, through home visits or follow-up appointments in the community-based health care services.
- Making referrals for support services when required, for example, participation in social activities (Townsend, 2003:813).
Community-based care has an opportunity to assert itself in psychiatry because many values traditionally emphasized by mental health care fit within the concept of the continuum of care. For instance:

- viewing the client as a whole
- working with families
- treating the clients in their own homes
- developing a relation over time
- educating families about medication
- assessing the environment for safety, hygiene and support (Keltner et. al. 2003:11).

Using a holistic approach, nurses are able to deliver direct care to help integrate people with mental illness to community living as well as advocate and link individuals to needed services (Keltner, et. al. 1999:82).

The Mental Health Care Act (Act No. 17 of 2002) confirms and enforces the need for promotion of mental health to those at risk of mental illness and eventually the mentally ill persons. The Mental Health Care Act, further, states that programmes should be aimed at promoting the mental status of the service user, in this study the SPMI client whose mental health status has been negatively impacted by mental illness. This should be implemented with regard to mental capacity of the person concerned. It also stresses that a mental ill person has rights: one of them is the right to treatment, care and rehabilitation (The Mental Health Care Act 17 of 2002).

SPMI involves a permanent alteration in the person’s way of life and a need for reappraisal of life and what may hope for in terms of function and health. An individual with a considerable lifestyle change may need a great amount of nursing intervention. The more the disease results in major changes in activities of daily living, the harder it may be for the Person living with SPMI to continue with their life and the more nursing intervention may be needed. The primary health care nurses’ challenges in working with persons living with SPMI in the rural areas is to determine what they view as appropriate functioning, maximize their abilities, enable them to live their illness functioning at maximum capacity.
Community-based health care reduces the functional impairments caused by mental illness in persons living with SPMI and its broadest sense encompasses all forms of treatment of severe and permanent mental illness. Community-based health care addresses Person living with SPMI’s suffering from the most severe debilitating illness, such as, schizophrenia, tend to strike in late adolescence and young adulthood. These individuals are removed from society during those years when their peers complete their education, establish careers, begin families and develop social support systems in the rural areas. Even if the mental illness is completely cured without residual functional deficits, these persons living with SPMI will need an extensive social rehabilitation.

The persons living with SPMI can have a wide range of psychological deficits that impair their ability to interact with others, handle the usual stresses of daily life and achieve their potential. Therefore, community-based health care involves a process in which the psychiatric nurses attempt to address the psychological, social and often medical needs of persons living with SPMI. The persons living with SPMI have continuing community-based health needs which can be broken down into several components such as, treatment, housing and social support. These components should be provided as part of integrated community-based health care plan (Saddock and Saddock, 2000: 3190-3191).

In South Africa, an integrated package of essential PHC services has been made available to the entire population in order to provide the solid foundation of a single unified health care service (Department of Health, 2000:4). The package entails standardized comprehensive services to be delivered at PHC level namely; non-personal health services, disease prevention and control, maternal, child and women’s health, human immunodeficiency virus/ auto immune-deficiency syndrome care, tuberculosis, health monitoring and evaluation, mental health and substance abuse care (van Rensburg,2004: 422).

2. PROBLEM STATEMENT

According to Hunt (2001:100) any episode of illness may involve a lasting change in the person’s level of functioning. The persons living with SPMI and their families in the
rural areas experience stressors as distresses and life leaves the individual with a sense of pervasive helplessness. The more stressors that persons living with SPMI and their families experience in their lives, the more the persons living with SPMI and their families in the rural areas may develop the feeling of hopelessness and depression. The inability to handle life’s daily stress relating illness and treatment regimen can result in exacerbation of the disease or noncompliance with the treatment regimen (Hunt, 2001: 100).

The first problem that faces the persons living with SPMI is the need to maintain independence. Persons living with SPMI who are mentally ill are forced daily to face the reality of the outcomes of the disease, with many of these chronic diseases ending in loss of mental and physical functioning. Compliance can affect the Person living with SPMI’s feelings of independence and control. More often than not, when persons living with SPMI do not follow their treatment plan, the primary health care nurses (PHC nurses) are tempted to label them as noncompliant. The primary health care nurse has medical knowledge that persons living with SPMI do not have and SPMI have a life that is separate from the medical field, and if treatment plan does not fit into the Person living with SPMI’s lifestyle, the persons living with SPMI will probably ignore the treatment resulting to noncompliance (Hunt, 2001:100).

Self-actualization is one of the needs of persons living with SPMI. Even if persons living with SPMI cannot work, they can find some sense of fulfillment, well-being and control over their lives. These areas can impact on one another and are part of how persons living with SPMI respond to their illness and affect their motivation to maintain well-being. There are other challenges facing the persons living with SPMI and their families in the rural areas, such as, lack of education or information about their diagnosis, treatment regimen and available resources and how to access those resources. Persons living with SPMI are also expected to fulfill their roles, responsibilities and self-care demands. Persons living with SPMI also need to be encouraged and guided to maintain social involvement to prevent isolation (Hunt, 2001:100).

The assessment of needs is an important and integral part of health care of the persons living with SPMI and their families in the rural areas. According to Clark
(1999:669) identification and assessment of needs of individuals suffering from mental illness is a neglected, and often a misunderstood aspect. Assessment of health care needs of persons living with SPMI and their families in the rural areas is a dynamic ongoing process that is used to collect information, recognize changes, analyze needs and plan health care. In community-based settings assessment, provide baseline information to help evaluate physiological and psychological normality and functional capacity and to identify factors that may enhance or impair the individual's health status (Hunt, 2001:100).

The researcher became aware of the gradual increase in the number of persons living with SPMI whose conditions worsen when they are discharged into the community. It appears that families and the PHC nurses lack adequate information as to what the health care needs of persons living with SPMI and their families in the rural areas are. There is not enough information as to whether or not the health care needs of persons living with SPMI and their families in the rural areas are being met comprehensively nor if the practitioners rendering community-based health care are knowledgeable and complying with PHC norms and standards developed by Department of Health.

The primary health care nurses have expertise in working with the persons living with SPMI and their families in the rural areas with health or social care needs. They have to understand these needs in the wider context of Person living with SPMI’s family. This team can also play an important role in coordinating assessment and care plan. It has been found that elements of nursing assessment are not valued and that nurses tend to focus on medical diagnosis and cure (Slater & McCormack, 2005: 603). Although PHC support the notion of health care seeking behavior, it is also necessary for PHC nurses to work towards improving and promoting the health care needs of persons living with SPMI and their families in the rural areas.

With reference to the above discussion, the following research question could be asked:

- How do the persons living with SPMI in the rural areas, as health care consumers, and their families experience the health provided by the community-based health care services?
- What are the perceived health care needs of the persons living with SPMI and their families?
- What can be done to facilitate the community-based health care delivery relevant to the health needs of persons living with SPMI and their families in the rural areas?

3. THE PURPOSE OF THE STUDY

The purpose of this research study is to explore and describe the perceived health care needs of persons living with SPMI and their families in the rural areas and to utilize the information to develop nursing strategies to help persons living with SPMI and their families to cope in the community.

4. RESEARCH OBJECTIVES

- To explore and describe how the persons living with SPMI and their families in the rural areas experience community-based health care provided by primary health care services.
- To explore and describe what the perceived health needs of persons living with SPMI and their families in the rural areas are.
- To develop nursing strategies for a community-based health care relevant to the health needs of persons living with SPMI and their families in the rural areas are.

5. THEORETICAL STATEMENTS

Theoretical statements drawn from the paradigm used in this study are as follows:

- People caring for persons living with SPMI must be aware that they are persons who are being challenged to cope with the demands of mental illness physically, socially and psychologically.
- The Person living with SPMI needs to interact with the family and the environment (community).
- The SPMI client who succeeds as a human being in regaining wholeness.
6. CLARIFICATION OF CONCEPTS

Dubin (1969 in De Vos, 2002:29) introduces concepts by stating that those aspects of the world that continue the subject matter of a given scientific discipline, terms must be available. The terms designating the things about which a science tries to make sense are its concepts. The author, further, explain that the students need to orient themselves to the meaning of concepts (De Vos, 2002: 436). Thus theoretical definitions and explanations are given to the following concepts:

- **Primary Health Care**

Primary health care is essential health care based on practical, scientific sound and socially acceptable methods and technology, made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in spirit of self-reliance and self-determination. It forms an integral part of the country’s health system, of it is central function and main focus, and of the overall social and the economic development of the community. It is the first level of contact of the individuals, the family and the community with national health system, bringing health care as close as possible to where people live and work and constitute the first element of continuing health care process (WHO, 1978 in Van Rensburg, 2004:28).

- **Community-based Health Care**

Community-based health care is defined as nursing directed towards specific individuals and families within a community to meet the needs of people as they move between and among health care settings (Hunt, 2001: 15).

- **Health needs**

According to the Concise Oxford English Dictionary (2002:953) a need is a circumstance in which something is absent or requires some course of action or something felt to be necessary. The Penguin English Dictionary (1995: 549) defines a need as a physiological requirement for the well-being of an organism. A need is
referred to as specific areas related to the client’s health identified for intervention (Spradley & Allender, 1996: 673). Health care needs include physical, mental, emotional and social concerns that involve the functioning of the individuals (Sorrel & Redmond, 2002: 29). In this study, the health need will refer to the physiological or psychological requirements for the wellbeing of persons living with SPMI and their families.

- **Severe and persistent mental ill person**

  The SPMI clients is an individual who has been suffering from a serious chronic mental illness over a period of time that resulted in loss of social skills and increased dependency. The individual do not possess adequate skills to live a productive life in the community. Severe and persistent mental illness involves a permanent alteration in the client’s way of life and what may be hoped for in terms of function and health (Townsend, 2003: 812).

- **Rehabilitation**

  Rehabilitation is the range of social, educational, occupational, behavioral and cognitive interventions used to increase the role performance of persons with severe and persistent mental illness and to enhance their recovery (Stuart & Laraia, 2005: 239). Being rehabilitated successfully should lead to an increase in the client’s independency.

- **Deinstitutionalization**

  At patient level, deinstitutionalization refers to the transfer of a patient hospitalized for the extended periods of time to a community setting and at mental health care level; it refers to a shift in the focus of care from long term institution to the community, accompanied by discharging long term patients and avoiding unnecessary admissions (Stuart & Laraia, 2005: 711).
7. RESEARCH DESIGNS AND METHODS

In this research a theory generative design (Chinn & Kramer, 1991: 79-104) that is qualitative, exploratory, descriptive, phenomenological and contextual in nature will be used. According to Chinn & Kramer (1991: 79-104) practice and research are linked and interdependent and should contribute to practice.

7.1. RESEARCH DESIGN

A research design is a systematic plan for finding answers to a research question. It offers a road map or a blueprint for organizing a study, from methods of data collection through methods of data analysis (Wilson, 1993). A theory-generative, qualitative, explorative, descriptive, phenomenological and contextual research approach will be utilized by the researcher to achieve the objectives.

The research design was based on a qualitative, explorative, descriptive and contextual approach.

- **Qualitative research**

Qualitative research seeks to explore and describe an unknown phenomenon from the human behavioral perspective (Field & Morse, 1996: 11). Polit & Hungler (1993: 19) explains that this research approach attempts to capture the dynamic, holistic and individual aspects of human experiences in the entirety and the context of those experiences. This approach will be suitable for holistically describing the experiences of the persons living with SPMI and their families in the rural areas as role players.

- **Explorative research**

Explorative research aims to explore and gain new insight into unknown phenomena (Field & Morse, 1996: 11). According to Mouton (1996: 72) an explorative research approach attempts to investigate whether the phenomenon has deeper meaning rather than to evaluate the meaning. Exploratory research begins with some phenomenon of interest, but rather just observing and recording the incidence of the phenomenon, the manner in which it is manifested and the other factors with which it is related (Polit & Hungler, 1993: 14). The researcher, therefore, intends to explore
and describe what are the experiences and the perceived health needs of persons living with SPMI and their families in the rural areas are and also how they and the psychiatric nurses experience the health care provided by community-based health services.

- **Descriptive research**

A descriptive research approach proposes to obtain complete and accurate data of a phenomenon (Wilson, 1993: 38). A full accurate description of the experiences of persons living with SPMI and their families will be by means of listening, observing, describing and documenting the experiences naturally as their occurred (Polit & Hungler, 1991: 175). This design is relevant for this study because very little information is available on community-based care of persons living with SPMI and their families in the rural areas. A description will be given of the experiences of SPMI clients and their perceived health needs, as well as those of their families. The experiences of the participants will be described as well as the methodology that was followed. The nursing strategies will also be described.

- **Contextual research**

According to Oxford English Dictionary, the context is the circumstances that form the setting for an event, statement or the idea and in terms of which it can be fully understood (Pearsall, 2002: 307). In a contextual research study, phenomena are studied because of their intrinsic and immediate contextual significance (Mouton, 1996: 133). Contextualization of the study will be an important factor in recognizing in the analysis of the experiences of the role players in this study. In this study the immediate context is the family and the homes of the persons living with SPMI and their families in the rural areas as well as the primary health care service where the client receives care.
7.2. RESEARCH METHODS

A combination of theory generation phases, as suggested by Walker and Avant (1995: 39), Chinn and Kramer (1995: 106) and Dickoff, James & Wiedenbach (1968: 423) will be the research method implemented in this study. These phases include:

PHASE ONE: Concept analysis

PHASE TWO: Placing the concepts in relationship

PHASE THREE: Description of the nursing strategies

Each of these phases will be dealt with and applied to this study.

TABLE 1.1: SUMMARY OF RESEARCH METHODS

<table>
<thead>
<tr>
<th>THEORY GENERATION LEVEL</th>
<th>RESEARCH METHOD</th>
<th>DATA COLLECTION</th>
<th>DATA ANALYSIS</th>
<th>REASONING STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1:</strong> CONCEPT ANALYSIS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 1.1:</strong> Identification and clarification of concepts</td>
<td><em>Population</em> Persons living with SPMI and their families who use the community-based health care services to access care for mental illness</td>
<td><em>Coding according to Tesch’s method</em> <em>Independent coder</em> <em>Themes, sub-themes and categories</em> <em>Literature control</em></td>
<td>Induction Analyses Synthesis Analyses Syntheses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Sample method</em> Purposive criterion based sampling</td>
<td>Dictionary and subject definitions of identified concepts Identification of concepts Conceptual definition of main concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Methods of data collection</em> Individual interviews Direct field observations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 1.2:</strong> Definition and classification of concepts</td>
<td>1.1 concept identification from observation and literature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 2:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CONSTRUCTION OF RELATIONSHIP STATEMENTS

*Concepts are placed in relationship to each other to form relationship statements

*Literature review

Concepts from Step are placed in context and relationship statements between the concepts of the model are formed

7.2.1. PHASE ONE: CONCEPT ANALYSIS

Concept analysis is a strategy that allows one to examine the attributes or characteristics of a concept (Walker and Avant, 1995: 37). According to Dickoff, James and Wiedenbach (1968:422) and Chinn and Krammer (1995: 78) identifying concepts from fieldwork and creating conceptual meaning provides a foundation for developing theory. Thus concept analysis will be conducted after relevant data has been collected. The data collection process that will result in concept identification and will include the following:

7.2.1.1. RESEARCH POPULATION AND SAMPLING

Burns & Grove (1997: 293) defines population as the entire set of individuals or elements who meet the sampling criteria. The research population for this study will be persons living with SPMI and their families who use the community-based primary health services as well as members of the multi-disciplinary team who are involved in providing services.

According to Polit & Hungler (1993: 174) sampling refers to the process of selecting a portion of the population to represent the entire population. A sample denotes the selected group of people or elements (Burns & Grove, 1997: 293). A purpose sampling technique will be utilized to sample SPMI clients, their families and primary health care nurses from selected primary health care services. This means that three different research populations will be utilized in this study. The inclusion criteria for each of the three groups included in the study will now be discussed as well as how each group will be approached and sampled.
Group 1: persons living with SPMI

The researcher will request a meeting with the primary health care nurses working in the primary health services to discuss the purpose and objectives of the research and request them to prepare a list of names and their contact details of all health care consumers with severe and persistent mentally illness. The researcher will request the SPMI clients to willingly participate in the research study. The criteria for inclusion of this group of participants will include the following:

- DSM-IV-TR diagnosis of schizophrenia
- Be a person with a history of severe and persistent mental illness for at least 2 years
- Be either a female or a male
- Between 30-45 years
- Unemployed and receive disability grant
- Living with a partner or relative in one home

Group 2: Family member of persons living with SPMI

This group of participants will be selected in the same manner as the first group of participants. The criteria for inclusion for this group of participants:

- Must be related to the Person living with SPMI from group 1 and may be a spouse, blood family member or in-laws living with the identified client in one home.
- Be able to communicate and express him/herself in Xhosa and or English.
- Have been exposed to an Person living with SPMI for at least six months, living in the same home.

Group 3: Primary Health Care Nurses

These participants are employed in the primary health care services. They must:

- Be employed in the primary health care services
- Be employed in the primary health care services for at least one year.
Have an experience in dealing with persons living with SPMI and their families

The primary health care nurses have expertise in working with the persons living with SPMI with health or social care needs. They have to understand these needs in the wider context of SPMI client’s family. This team can also play an important role in coordinating assessment and care plan. It has been found that elements of nursing assessment are not valued and that nurses tend to focus on medical diagnosis and cure (Slater & McCormack, 2005: 603).

7.2.1.2. DATA COLLECTION

- **Individual interviews**

Data will be collected by means of unstructured interviews using an audiotape. Kvale (1996: 1) defines an interview as an attempt to understand the world from the participant’s point of view, to unfold the meaning of people’s experiences and to uncover their lived world before scientific explanations. He, further, explain that in an interview conversation, the researcher listens to what the participants themselves communicate about their lived world, hears them express their views in their own words and learns about their situation. Denzin & Lincoln (1998:36) state that an interview is a conversation, the art of asking questions and listening.

In this study, the researcher will use individual, unstructured interviews using a phenomenological approach, to try to understand the experiences of the persons living with SPMI, their families and the primary health care nurses involved in the PHC services utilized by the clients. The phenomenological approach describes a phenomenon as seen through the eyes of the people who experienced at first hand. It attempts to understand people’s perceptions, perspectives and understanding of a particular situation (De Vos, 2002: 68).

Interviews for members of the group 1 and 2 will take place at the homes of the clients, at a place perceived as convenient and in language preferred by participants. An audiotape recorder will be used to capture data during sessions. Each interview may take 40-60 minutes. The audio-taped interviews will be transcribed within 24 hours of the interview while the information is still fresh in the researcher’s mind. The
researcher will translate the interviews into English to enable the promoters of the study as well as the independent coder, to understand the content of the interviews. The transcribed interviews will form the database of the study.

- **Observations and field notes**

Barbie and Mouton (2001: 293) differentiate between simple and participant observation. The researcher will use the former in this study as additional means of gaining clarity regarding the details of the experiences of the persons living with SPMI and their families related to health care provided by the primary health service. Observations will be suitable for use as an additional data collection method as it enhances the richness of data analysis results. Observation is defined as a qualitative research procedure that studies the natural and everybody setup in a particular community or situation (De Vos, 2002: 280). In participant observation data gathering boils down to the actual observation and taking of field notes. In observation of participants the emphasis is thus both on one’s own and on the participation of others (De Vos, 2002:279). The researcher observes both human activities and the physical setting in which activities take place (Denzin and Lincoln, 2000: 673 in De Vos, 2002:279). Barbie and Mouton (2001:294) state that for the interview to be sufficient the researcher should consider using observation and field together thus use of field notes as a data collection method in this study will now be discussed.

Field notes are detailed reproductions of what has occurred. The researcher will observe the nonverbal communication of the participant when answering questions. Field notes should contain a chronological description of what happens to the setting and participants. Silverman (in De Vos, 2002:140-142) states that there are two practical rules for making field notes namely; record what we see as well as what we hear and expand field notes beyond immediate observations.

According to Wilson (1993:223-224) there are different types of field notes namely:

- **Methodological notes** are instructions to ones self as well as critiques of one tactics reminders about methodological approaches that may be fruitful (Wilson, 1993:222). In this study, the researcher will evaluate her interview
conduct against the proposed research design, methods and methodological notes during analysis.

- Theoretical notes are purposeful attempts to derive meaning from observational notes. The researcher thinks about the behavior, infers, interprets, hypothesizes and relates observations to the other. In this study, the researcher will use theoretical notes to interpret meaning of the phenomenon as viewed from the client’s perspective (Wilson, 1993:222).

- Personal notes discuss the researcher’s own reactions, reflections and experiences. Creswell (1994:152) describes personal notes as an opportunity for the researcher to record personal thoughts such as suppositions, feelings, problems, ideas, intuition, impressions and biases. In this study, the researcher will use personal notes as an opportunity for maintaining contact with her own internal environment by describing her personal feelings and thoughts. This study will make use of all types of field notes. After they are typed, the notes will become part of the database.

- Observational notes are the description of events experienced through watching and listening and contain as little interpretation as possible. In this study, the researcher will note the nonverbal gestures observed from the participants as an aid to understand their feelings. The home conditions will be observed during the interview visits.

Other sources of information should include the services rendered PHC nurses, health care services, social workers, other relevant professionals. These multiple data sources will help to confirm important findings to access information that the individual may not be in a position to supply and help in generating a holistic picture of health care needs for persons living with SPMI.

**7.2.1.3 DATA ANALYSIS**

Polit and Hungler (199:329) state that the purpose of data analysis is to impose some order on a large body of information so that some general conclusions can be reached and communicated in the research report. The research data needs to be processed and analyzed in some systematic fashion so that trends and patterns of relationship can be detected (Polit & Hungler, 1993: 269). Data collected from the interviews will
be transcribed verbatim and analyzed according to the steps suggested by Tesch, to identify themes and sub-themes relevant to the development of case studies (Creswell, 2003: 192). The researcher will make use of an independent coder during data analysis.

7.2.1.4. LITERATURE CONTROL

Literature control is the discussion of findings in the light of literature. Justification of the results of the study will be one by means of literature control. Literature control will be done on the themes that emerged from data collection to confirm the findings and to highlight new insights gained from the research. Guidelines to help in the formulation of recommendations will be developed, with input from the literature.

7.2.1.5. PILOT STUDY

A pilot study is frequently defined as a smaller version of a proposed study conducted to refine the methodology (Burns and Grove, 1997:52). The function of the pilot study is to obtain information for improving the project or for assessing the feasibility (Polit and Hungler, 1993:40). The pilot study will be executed in the same manner as the main study.

7.2.1.6. MEASURES TO ENSURE TRUSTWORTHINESS

The researcher will use a model proposed by Guba to ensure trustworthiness of the study, without sacrificing its relevance. According to Krefting (1991:214) these measures are:

- **Credibility**

Credibility refers to the confidence in the truth of data (Polit and Hungler, 1995:362). This can be done by utilizing multiple references to draw conclusions about the truth such as, data gathering in the interviews, field notes and literature control (De Vos, 2002:349). The researcher will triangulate the findings by the use of multiple data
gathering methods, interview techniques, peer review, member checking and the authority of researcher as strategies to establish credibility (Krefting, 1991:7-12).

- **Transferability**

This refers to the external validity of data, that is, to demonstrate applicability of one set of findings to another context as the researcher cannot generalize. The researcher will therefore have to provide an adequate database to allow transferability judgments to be made by others (De Vos, 2002:351). The researcher will use comparison of sampling data and dense description strategies.

- **Dependability**

This refers to the stability of data over time and over conditions (Polit and Hungler, 1995:362). The researcher should account to changing conditions in the phenomenon chosen for the study as well as for changes in the setting. Triangulation and dense description of research method strategies will be used by the researcher.

- **Confirmability**

Confirmability refers to the objectivity of the data (De Vos, 2002: 352). The researcher should decide whether another could confirm the findings. The researcher will use reflectivity and triangulation to confirm findings.

**7.2.2. PHASE TWO**

Construction of relationship statements allows better understanding of the study because the defined major concepts will be simplified by connecting related concepts together by means of statements. Relationship statements describe, explain or predict the nature of the interactions between the concepts of the theory (Chinn and Kramer, 1991:98). The concepts that will be identified and defined in Phase 1 will be arranged according to their relationship through interrelationship statements. The researcher and the independent coder will group similar concepts together (Chinn and Kramer, 1991:86).
8. ETHICAL CONSIDERATIONS

The researcher understands and will recognize that the research population is a vulnerable Person living with SPMI, should not be stressed. The researcher intends to observe and adhere to the basic principles of ethical conduct in research. The following ethical aspects relate specifically to this study.

The right to privacy, confidentiality and anonymity

The right to privacy is the individual’s right to decide when, to whom and to what extent to reveal his or her attitudes, beliefs and behavior (De Vos, 2002:67-68). Confidentiality refers to agreements between persons that limit the access of others to private information (De Vos, 2002:67-68). Anonymity means that the researcher cannot link the participants with the information reported (De vos, 2002:67-68). This study will ensure that these rights are protected by using pseudonyms rather than names of the participants during the interviews. Cassettes and transcriptions will be destroyed once the study is completed. Findings will be communicated in such a way that data cannot be linked to a specific patient. Each participant will be interviewed alone and no family members will be present to ensure privacy.

Informed consent

Informed consent entails informing the participants about the purpose of the study and the main features of the design, as well as possible risks and benefits from participation in the research study. It further involves obtaining voluntary participation of the participants, while allowing the participants the right to withdraw from the research at any time. This counteracts potential undue influences and coercion (Kvale, 1996: 112). Voluntary consent means the participant has decided to take part in the research study on his own volition. Autonomous participants, who are capable of understanding the benefits and risks of a proposed study, are competent to give consent (Burs & Grove, 1997:212). In this study, participants will be informed of the purpose of the research, methods and procedures, recording of data, nature of participation and possible advantages and benefits. They will be informed that they may withdraw from the study should they uncomfortable (see Annexure C).
**Deception of participants**

Deception of participants is the deliberate misinterpretation of facts in order to make another person believe what is not true and violates the respect to which a person is entitled. It involves withholding information or offering incorrect information in order to ensure participation of the participants when they would otherwise possibly have refused it. However, participants have a right to withdraw at any stage of the study (De Vos, 2002: 67). In this study, the researcher will not inflict any form of deception to participants. If this happens inadvertently, it will be rectified immediately after or during debriefing interview.

**Action and competence of the researchers**

Researchers are ethically obliged to ensure that they are competent and equitably skilled to undertake the proposed investigation (De Vos, 2002: 69). The researcher will work according to the research protocol under the guidance and mentorship of an experienced supervisor.

**Publication of findings**

Participants will be informed about the findings in an objective manner without violating confidentiality (De Vos, 2002: 72). The findings of the study will be published in written form so that the public will have an access to information. The report will be as clear as possible and contain all the information necessary for readers to understand what the researcher has written and will carry the quotes from the interviews.

**Right to protection from discomfort and harm**

Participants are more likely to suffer emotional harm during this study although physical harm cannot be ruled out completely (De Vos, 2002:64). The researcher asks participants to recall negative behavior of the past that be the beginning of the renewed personal harassment or embarrassment). Should the participant experience emotional discomfort, a counselor will be provided for professional intervention as necessary. However, if the participant wishes to withdraw from the research study, due to any emotional discomfort, his or her wish will be granted.
**Debriefing**

The researcher will invite the participants for a debriefing session after the study. This provides the participants with an opportunity to work through the experience and its aftermath, to minimize possible harm that arose in spite of all precautions taken against such harm. The researcher will rectify any misperceptions that might have arisen in the minds of the participants after completion of the research. Termination is handled with sensitivity.

**Permission to conduct study**

The researcher will approach the Department of Health of the Eastern Cape and Managers of the PHC services for permission to conduct the study (see Annexure D).

**9. CHAPTER DIVISION**

The research study report will be presented as follows:

Chapter one: Overview of the study

Chapter two: Research design and methods

Chapter three: Discussion of results and literature of phase 1

Chapter four: Placing the concepts in relationship

Chapter five: Identification and Description of strategies

Chapter six: Conclusion, guidelines and recommendations

**10. STUDY SCHEDULE**

Writing research proposal and approval by the FRTI - May 2006

Pilot study - April 2008

Fieldwork and data analysis - April-May 2008
11. BUDGET

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Editing</td>
<td>R2000</td>
</tr>
<tr>
<td>Independent coding</td>
<td>-R2000</td>
</tr>
<tr>
<td>Photocopying</td>
<td>-R1000</td>
</tr>
<tr>
<td>Printing &amp; binding</td>
<td>-R2000</td>
</tr>
<tr>
<td>Stationary</td>
<td>-R1000</td>
</tr>
<tr>
<td>Transport</td>
<td>-R3000</td>
</tr>
<tr>
<td>Typing</td>
<td>-R1500</td>
</tr>
<tr>
<td>Library costs</td>
<td>-R2000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>R11900</strong></td>
</tr>
</tbody>
</table>

12. CONCLUSION

This chapter introduced the topic “strategies for community-based health care of persons living with SPMI and their families”. The problem statement highlights the difficulties faced by the communities. This study aims to explore and describe how health care needs of persons living with SPMI in the community by the community-based health care services are met.