

Exploring nursing presence as an approach to prevent relapse of discharged mental health care users

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DECLARATION

I, Roselyn Patricia Motaung, student number 24766828 declare that the mini-dissertation with the title: *Exploring nursing presence as an approach to prevent relapse of discharged mental healthcare users*, is my own work and that all the sources that are used have been indicated and acknowledged by means of complete reference.

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Roselyn Patricia Motaung

.....
Date: November 2017

DEDICATION

This mini-dissertation is dedicated to my two boys, Junior and Kakanyo Motaung, for their relentless support, encouragement, and love. I also dedicate this mini-dissertation to my late mother Angela, who gave me the opportunity to explore my potential without any limits. Lastly, I would like to dedicate this mini-dissertation to my lovely aunt Nokhaya for empowering me with all the relevant interpersonal skills and for encouraging me to pursue my studies. Thank you for taking up the role of my mother, you are indeed a blessing.

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ABSTRACT

The aim of this study was to explore and describe primary healthcare nurses' (PHC nurses) perceptions of the factors that influence nursing presence as an approach to prevent the relapse of a discharged mental healthcare user. Relapse of mental healthcare users is one of the major contributing factors to the high burden of mental illness in South Africa. One of the standard components of a strategy to prevent relapse is good compliance to treatment by a mental healthcare user (MHCU) after being discharge from the psychiatric institution at an identified down-referral primary healthcare facility. The challenges that professional nurses in primary healthcare experience with respect to follow-up treatment include a high workload, lack of adequate time to cater for people with mental disorders, and a lack of support and supervision to undertake their tasks with confidence.

Nursing presence should be considered an approach used by PHC nurses to build a trust relationship with the mental healthcare user to detect any signs and symptoms of relapse at an early stage so that they can mobilize appropriate resources and can design nursing interventions unique to the specific MHCU. However, no studies could be found specifically on nursing presence to limit the relapse of a discharged MHCU, and little is known about PHC nurses' perceptions of nursing presence with regard to limiting relapse of a discharged MHCU.

Purpose

The purpose of the study was to explore and describe the perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs.

Design and method

The research project followed a qualitative descriptive design. The population consisted of professional nurses from various PHC clinics in a district rendering mental healthcare services to discharged MHCUs. Participants were selected by means of purposive sampling with the assistance of a mediator in the person of the provincial mental healthcare coordinator. Four semi-structured focus group interviews were conducted to collect data. The sample size was determined by data saturation. Data were captured on a digital audio recorder and transcribed verbatim. The researcher and co-coder analysed the data independently and six main themes were identified after the researcher and the co-coder reached consensus.

Results and conclusions

The main themes correlated with the attributes of nursing presence as defined by Finfgeld-Connet (2006:711). The sub-themes describe the participants' specific views on these attributes as they relate to preventing relapse of a MHCU. The conclusions that were reached are also applicable to the attributes of nursing presence namely: attentiveness and sensitivity, holism, intimacy, vulnerability, uniqueness, and limiting relapse.

This study reveals that PHC nurses are willing to provide holistic care and to practice nursing presence to prevent relapse in discharged MHCUs, but so many challenges limit their efforts to do so. These challenges include a lack of resources, lack of training and running multiple programmes. This leads to burnout and eventually a 'don't care' attitude as a defence mechanism. It is also important to note that despite these challenges, some PHC nurses are really eager to learn more about mental health. They are willing to participate in any training on the topic of mental health despite workplace adversities and their perceived lack of support from their employer.

Recommendations were formulated for nursing education, nursing research and nursing practices, focusing on supporting and empowering PHC nurses with respect to nursing presence to prevent the relapse of a discharged MHCU.

Key words: relapse, relapse prevention, primary healthcare, nursing presence, primary healthcare nurses.

OPSOMMING

Die doelwit van hierdie studie was om primêre gesondheidsorgverpleegkundiges (PGS verpleegkundiges) se persepsies van die faktore wat verpleegteenwoordigheid as 'n benadering om terugval onder ontslaande geestesgesondheidsorggebruikers (GGSG) te voorkom, beïnvloed. Die terugval van GGSG is een van die hoof bydraende faktore tot die hoë las van geestesgesondheid in Suid-Afrika. Een van die standaard komponente van 'n strategie om terugval te voorkom is die GGSG se goeie nakoming van behandeling na ontslag uit 'n psigiatriese inrigting by die relevante primêre gesondheidsorgsentrum. Die uitdagings wat PGS verpleegkundiges ondervind met betrekking tot opvolgbehandeling sluit in 'n hoë werkslading, 'n gebrek aan tyd om aandag te gee aan mense met geestesongesteldhede, en 'n gebrek aan ondersteuning en toesig om hierdie take met selfvertroue te onderneem.

Verpleegteenwoordigheid moet gesien word as 'n benadering wat PGS verpleegkundiges gebruik om 'n vertrouensverhouding met 'n GGSG te bou ten einde enige tekens of simptome van 'n terugval vroeg waar te neem sodat hulle die toepaslike ondersteuning kan mobiliseer en verpleegintervensies kan ontwerp wat uniek is tot die betrokke GGSG. Geen studies kon opgespoor word oor spesifiek verpleegteenwoordigheid om terugval onder GGSG te beperk nie en min is bekend oor PGS verpleegkundiges se persepsies van verpleegteenwoordigheid met betrekking tot die beperking van terugval onder GGSG.

Doel

Die doel van die studie was om PGS verpleegkundiges se persepsie van verpleegteenwoordigheid as 'n benadering om terugval onder ontslaande GGSG te beperk te ondersoek.

Ontwerp en metode

Die navorsingsprojek het 'n kwalitatiewe beskrywende ontwerp gevolg. Die populasie het bestaan uit professionele verpleegkundiges van verskeie PGS klinieke in 'n distrik wat geestesgesondheidsorgdienste lewer aan ontslaande GGSG. Deelnemers is uitgesoek deur middel van doelgerigte steekproefneming met die hulp van 'n medeerder in die persoon van die provinsiale geestesgesondheidskoördineerder. Vier semigestruktureerde groepsbesprekings is gehou ten einde data in te samel. Die steekproefgrootte is bepaal deur dataversadiging. Die onderhoude is per klankopname vasgevang en verbatim getranskribeer. Die navorser en 'n medekodeerder het die data onafhanklik van mekaar geanaliseer en ses temas is geïdentifiseer na die navorser en medekodeerder konsensus bereik het.

Resultate en gevolgtrekkinge

Die hoofemas korreleer met die kenmerke van verpleegteenwoordigheid soos uiteengesit deur Finfgeld-Connet (2006:711). Die subtemas beskryf die deelnemers se spesifieke sienings rakende hierdie eienskappe soos dit betrekking het op terugval onder GGSG. Die gevolgtrekkinge is ook toepaslik op verpleegteenwoordigheid: sorgsaamheid en sensitiwiteit, holisme, intimiteit, weerloosheid, uniekheid, en beperking van terugval.

Die studie toon dat PGS verpleegkundiges gewillig is om holistiese sorg te bied en om verpleegteenwoordigheid te gebruik om terugval te voorkom by ontslaande GGSG, maar soveel struikelblokke ry hulle pogings in die wiede. Hierdie struikelblokke sluit in 'n gebrek aan hulpbronne, 'n gebrek aan opleiding en veelvoudige programme wat aangebied word. Dit lei tot uitbranding en uiteindelik 'n 'kan nie omgee nie' houding as 'n verdedigingsmeganisme. Dit is ook belangrik om te noem dat ongeag hierdie uitdagings, is sommige PGS verpleegkundiges werklik ywerig om meer van geestesgesondheid te leer. Hulle is bereid om deel te neem aan enige opleiding oor die onderwerp ten spyte van uitdagings by die werk en die gebrek aan ondersteuning van hulle werkgewer wat hulle aanvoel.

Aanbevelings is geformuleer vir verpleegopleiding, verpleegnavorsing en verpleegpraktyke met die klem op die ondersteuning en bemagtiging van PGS verpleegkundiges met betrekking tot verpleegteenwoordigheid om die terugval van 'n ontslaande GGSG te voorkom.

Sleutelwoorde:terugval, terugvalvoorkoming, primêre gesondheidsorg, verpleegteenwoordigheid, primêre gesondheidsorgverpleegkundiges

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LIST OF ABBREVIATIONS

AIDS:	Acquired immunodeficiency syndrome
APNA:	American Psychiatric Nurses Association
DoH:	Department of Health
FSDoH:	Free State Department of Health
HIV:	Human immunodeficiency syndrome
HREC:	Health Research Ethics Committee
ICAM:	Interactive learning, Communication and Management
IMCI:	Integrated Management of Childhood Illnesses
INSINQ:	Quality in Nursing and Midwifery (INSINQ) is a research focus area within the Faculty of Health Sciences of the North -West University
MHCA:	Mental Healthcare Act
MHCU:	Mental HealthCare User
NGO'S:	Non-Governmental Organisations
NMHPF:	National Mental Health Policy Framework
PHC:	Primary Healthcare
SA:	South Africa
SAFMH:	South African Federation for Mental Health
SANC:	South African Nursing Council

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction

Chapter 1 gives an overview of this research and provides some background to the research problem. This is followed by the discussion of the research problem and the research question. The purpose of the study is mentioned, followed by a discussion of the paradigmatic perspective. The researcher then provides an overview of the research design and research method that were used in this study. The measures to ensure rigour and the ethical considerations are described shortly, with a more detailed discussion in Chapter 2. The chapter is concluded with an outline of the research report and a summary of the chapter.

1.2 Background and rationale for the study

Relapse is one of the major contributing factors to the high burden of mental illness and mental healthcare in South Africa (Nagel *et al.*, 2008:1). According to Sariah *et al.* (2014:1) relapse is a major challenge for mental health service providers globally. One of the standard components in the prevention of relapse strategies is good compliance to treatment by a mental health care user (MHCU) after discharge from the psychiatric institution at an identified down-referral primary healthcare (PHC) clinic. The key therapeutic goal is to reduce the risk of relapse (Nagel *et al.*, 2008:4; Chan *et al.*, 2011:324).

Previously, designated professional nurses received a discharge summary and managed the follow-up of MHCU at clinics (Nagel *et al.*, 2008:4), but due to the integration of mental health into the PHC system, all professional nurses are responsible for receiving a discharged MHCU at the identified down-referral PHC clinic from the psychiatric institution for follow-up treatment (Uys & Middleton, 2014:72). This poses a challenge, as not all professional nurses are qualified and/or experienced in psychiatric nursing and the danger is that such a nurse may misdiagnose a relapse in mental illness because of lack of knowledge (Mwape *et al.*, 2010:21). Further challenges in follow-up treatment by professional nurses in primary healthcare (PHC nurse) include a high workload, lack of adequate time to cater for people with mental disorders, and a lack of support and supervision to confidently undertake their tasks (Mkhize & Kometsi, 2008:107, Saraceno *et al.*, 2007:370). The continued high rates of relapse and re-admissions of mentally ill patients after being discharged from psychiatric institutions despite some interventions, can be attributed to factors such as the lack of a nursing presence at primary healthcare level. This creates a need for measures such as a nursing presence at primary healthcare level to be studied and put in place to equip PHC nurses to prevent repeated cycles of relapses and re-admissions of MHCUs.

According to Marais and Petersen (2015:12), South Africa's new policy framework supporting the integration of mental health into primary healthcare is not sufficient to ensure transformation of the healthcare system towards integrated primary mental healthcare. An earlier study by Nagel *et al.* (2008:3) revealed that we do not yet know how to reorient mental health services and successfully integrate relapse prevention principles into the day-to-day PHC services. The Re-engineering PHC Programme in South Africa (Re-engineering PHC in SA, 2010) might be seen as a strategy that contributes to relapse prevention in general, as it prescribes that PHC outreach teams should visit patients, including MHCUs, supported by specialized mental health teams (Padarath & English, 2011:204). However, the Re-engineering PHC Programme in South Africa (Re-engineering PHC in SA, 2010) does not specifically provide practical guidance for relapse prevention in a discharged MHCU. Still, the Mental Healthcare Act (17 of 2002) does stipulate in Chapter 1 that an MHCU must be assessed, treated and cared for at a PHC clinic to ensure continuity of care after being discharged from a psychiatric institution. Similar to the Mental Healthcare Act, the Free State Department of Health (FSDoH 2010:4) indicated in its Free State Provincial Mental Healthcare Policy of 2010 which outlines in its objectives the importance of a fully functional mental healthcare service and points at the level of PHC for continuity of care after discharge to prevent relapses. In addition, the World Health Organization (WHO, 2010a:23) outlines in its Mental Health Action Plan for 2013–2030 that PHC in particular is the foundation for high quality mental healthcare. Similarly, mental health services are included in the plans for re-engineering PHC, which places renewed emphasis on population based health and outcomes (Padarath & English, 2011:203-204).

It seems that it is a lack of psychiatric knowledge and skills, and frequent demonstration of negative attitudes towards psychiatric patients that make a successful transformation from institutional and specialist-oriented psychiatric services to PHC services difficult (Marais & Petersen, 2015:14). Proper staffing, namely the appropriate number of PHC nurses with the appropriate skills mix, will promote collaborative approaches and improve attitudes to ensure an adequate PHC service to prevent relapse (Mkhize & Kometsi, 2008:107).

This situation is confirmed by several examples. The spokesperson of the South African Depression and Anxiety Group, Casey Amore (as quoted in Lund *et al.*, 2010:393) makes the claim that: "We all know how difficult it is for patients with psychiatric illnesses to get the appropriate help." An anonymous PHC nurse states in her speech: "As a nurse I don't feel equipped to treat patients with mental health problems. I found myself struggling to care for mentally ill patients despite my best efforts and despite my previous experience, thus making me frustrated and I get tired. They are indeed difficult patients; too often we are faced with aggression or refusal of treatment. As nurses we urgently need to be listening to the stories of people who suffered poor mental health, and such listening could be part of our training, both initial and

ongoing” (Anonymous Healthcare Professionals Network, 2014:1-3). Further literature confirms that nurses at the PHC level seem to focus on the clinical examination of the body and do not concentrate on the mental health of an MHCU (Marais & Peterson, 2015:14). Nurses tend to miss warning signs of relapse by for instance not linking somatic complaints with mental illness (Mkhize & Kometsi, 2008:107).

Within this context, nursing presence as an approach to prevent relapse should be considered. Nursing presence involves being there for the MHCU psychologically and physically by giving them proper attention and being emotionally accessible and available (Berg & Hallberg, 2000:323-333). Nursing presence in the context of providing mental healthcare is thus the clinical competence of using oneself therapeutically on behalf of the discharged MHCU (Caldwell *et al.*, 2005:855). Some of the characteristics for a nurse who is implementing nursing presence include relational skills and moral maturity, something that is much needed among PHC nurses who have to manage discharged MHCUs (Smith, 2001:299-322). Such a relational skills set includes the nurse’s ability to recognize a MHCU’s therapeutic communication needs, to use the right words and gestures, and the capacity to be available as needed through behaviours such as attentiveness, active listening, quiet availability and touch (Tavernier, 2006:152-156). In professional literature it is noted that in nursing presence is the way we communicate our care, our concern and our honouring of others by the way we move, speak and deliver service (Caldwell *et al.*, 2005:855). Furthermore, McMahon and Christopher, (2011:78) emphasize that the willingness of a nurse to engage with a patient is not dependent on time available to spend with the patient.

Nursing presence can be critically important in limiting relapse, because in many mental healthcare settings, one of the characteristics of a discharged MHCU is that the MHCU relies on the advice of healthcare professionals, especially nurses, to decide whether or not to continue with medication post-discharge (Chan *et al.*, 2011:325). According to Sariah *et al.* (2014:240), relationships have been seen to play an important role in the development of trust. When a MHCU receives good services, they develop trust, which fosters a sense of belonging and a good therapeutic relationship. This characteristic of a discharged MHCU points towards the need for presence during the encounter with the nurse and stresses the importance of trust and rapport (Finfgeld-Connet, 2008:111-119). Individuals with mental illness often experience periods of despair related to psychiatric symptoms or psychosocial consequences of their mental illness, so the presence of someone such as a PHC nurse can provide hope and empathy towards the MHCU, which will help them through these difficult times (Sariah *et al.*, 2014:240). Therefore, nursing presence may be a crucial factor in influencing the MHCU’s compliance with treatment (Chan *et al.*, 2011:325).

It thus seems that in order to be fully effective and efficient, PHC for mental health must be complemented by PHC nurses with the kind of nursing presence to which the MHCUs can turn for support and understanding (WHO, 2010:3). This study explores nursing presence as an approach that includes attributes such as risk-taking, being willing to be emotionally vulnerable, knowing yourself and the MHCU, and overcoming the distance between self as a PHC nurse and the MHCU, thus potentially preventing the relapse of a discharged MHCU (Caldwell *et al.*, 2005:855).

1.3 Problem statement

The researcher is a professional nurse working in an acute inpatient setting at a psychiatric institution. This setting involves the most acute mental healthcare (reducing psychotic symptoms and enhancing health with immediate treatment and care) and is reserved for acutely ill MHCUs who are at imminent risk for harming themselves or others or who are unable to care for their basic needs because of their level of impairment (American Psychiatric Nurses Association (APNA, 2012:35). The treatment is typically short-term, focusing on crisis stabilization. The MHCU's discharge and down-referral to PHC is coordinated from this unit for continuity of care after stabilizing the MHCU. Relapses and re-admissions shortly after discharge from the psychiatric institution have become common and costly.

Vulnerability to relapse and re-admission poses a central challenge in the overall management of people suffering from a mental illness, as at some point in time, relapse is inevitable and unavoidable. One of the key therapeutic goals is consequently to reduce the risk of relapse (Chan *et al.*, 2011:324). It is essential that PHC nurses develop more training and educational programmes with respect to mental health to improve the recognition, diagnosis and treatment of mental disorders (Kapungwe *et al.*, 2010:192-203.) Studies have shown that relapse and re-admissions of discharged MHCUs has become a global problem. According to Heslin and Weiss (2012:2), studies in the USA show that close to one fifth of all users discharged from hospitals are re-admitted within 30 days after discharge. According to Smith *et al.* (2014:51-55) limited empirical data exist in terms of specific relapse and re-admission rates within South Africa. However, a study done by Kazadi *et al.* (2008:52-56) in South Africa shows that as much as 61% of MHCUs diagnosed with schizophrenia in Johannesburg relapse at least once, with the majority having two or more relapses. The South African Federation for Mental Health (SAFMH, 2014:2). in the Free State reported a 30% relapse rate in the Free State alone A specific psychiatric institution in the Free State admitted 874 MHCUs in the period between April 2014 and April 2015, of which as many as 275 were re-admitted two to four weeks after discharge from the hospital (FSDoH, 2014). According to the World Health Organization, the re-admission rates are supposed to be between 3% and 5%, this guideline was instituted by WHO (2008) as a control

measure for the high rates of re-admissions, but the relapse and re-admission rate at the specific psychiatric complex referred to above is at risk to be more than the acceptable 3to5% rate as it already stands on 3.2%.

It thus seems important that strategies should be put in place in the PHC setting to prevent relapse of discharged MHCUs (Abera *et al.*, 2014:28). Nursing presence should be considered as an approach used by PHC nurses to build a trust relationship with mental healthcare users, to listen intently, to care confidently, to detect signs and symptoms of relapse at an early stage, to mobilize appropriate resources and to involve MHCUs optimally, to design nursing interventions unique to the specific MHCU, and to effect mutually defined change (Caldwell *et al.*, 2005:861-862), thereby preventing relapse. Nursing presence requires of the PHC nurse the ability to rise above time restrictions and to make a concerted effort to engage with the MHCU, supporting the premise that nursing presence is largely controlled by the nurse's perceptions and authentic intention to "be with" the mental healthcare user (McMahon & Christopher, 2011:78-79). Studies relating to this topic found that building a therapeutic relationship with MHCUs have tremendous potential to prevent relapse (Sariah *et al.*, 2014:41). However, no studies could be found specifically on nursing presence to prevent relapse of discharged MHCUs. It therefore seems worthwhile to explore the use of nursing presence in limiting the relapse of MHCUs as little is known about PHC nurses' perceptions of nursing presence with regard to limiting relapse of MHCU.

1.4 Research question

Based on the background of the study and the research problem, the following question can be formulated:

- What are the perceptions of PHC nurses on nursing presence as an approach to relapse prevention with discharged MHCUs?

1.5 Purpose of the study

The purpose of the study is to explore and describe the perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs. Reaching this goal would enable the formulation of recommendations regarding nursing presence to prevent relapse of discharged MHCUs.

1.6 Paradigmatic perspective

A paradigm is a worldview, a general perspective on the complexities of the world (Polit & Beck, 2012:11).A researcher's paradigmatic perspective is made up of the assumptions that he or she has internalized, which might have an influence on the research (Burns & Grove, 2009:712). A

researcher should therefore declares any assumptions as good practice in research. The paradigm used by the researcher implies a pattern, structure and a framework of scientific and academic ideas, values and assumptions, and it guides how questions are asked and which rules determine the interpretation of the answer obtained (Botma *et al.*, 2010:40, Ponterotto, 2005:128). The researcher was guided by the meta-theoretical, theoretical and methodological assumptions discussed below.

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions refer to the researcher's beliefs as applicable to this research (Botma *et al.*, 2010:40). The researcher's ontological assumptions, epistemological assumptions (see 1.6.1.1 and 1.6.1.2) and methodological assumptions (see 1.6.3) are integrated in the paradigmatic perspective set out in this section (Botma *et al.*, 2010:40-41).

1.6.1.1 Ontology

Ontology is defined as a branch of philosophy dealing with the nature of reality and being (Botma *et al.*, 2010:40; Polit & Beck, 2012:11). The researcher believes that what people feel, think and refer to is important and must be taken seriously because people are different and experience reality differently. The ontology of this research includes exploring the reality and the meaning of the phenomenon, namely the perceptions of PHC nurses regarding nursing presence to prevent relapse in discharged MHCUs.

1.6.1.2 Epistemology

Epistemology is a branch of philosophy that deals with the nature of knowledge and is concerned with the relationship between the research participant, "the knower," and the researcher, "the would-be knower" (Botma *et al.*, 2010:40, Ponterotto, 2005: 130). The researcher believes that it is possible to understand the experience of participants from interacting with them and listening to them. Epistemological views are objective, rational, neutral and separate from the society, so they do not have personal value. The epistemology of this research includes exploring and describing the perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs. During the process the researcher remained open to the perceptions of the participants by using "bracketing." Both closed and open-ended questions were asked in an interactive process of talking, listening and writing notes, which is an interactive mode of accurate data collection (Botma *et al.*, 2010:45). Through this inductive process, the researcher integrated information that helped illuminate the phenomenon under study (Polit & Beck, 2012:15).

1.6.2 Theoretical assumptions

The theoretical assumptions of this research include the central theoretical argument and the conceptual definitions of key concepts applicable to this research.

1.6.2.1 Central theoretical statement

Exploring and describing the perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs led to the formulation of recommendations for nursing practice, nursing education and further research. These recommendations provide a foundation for designing effective nursing presence interventions to prevent the relapse of discharged MHCUs. This study can potentially contribute to improving the standards of mental healthcare for discharged MHCUs at down-referral PHC clinics.

1.6.2.2 Definition of concepts

The following definitions are pertinent to the study:

1.6.2.2.1 Perceptions

Forming perceptions means an active process of creating meaning by selecting, organizing and interpreting people, objects and other phenomena (Wood, 2016:75). The Concise Oxford English Dictionary explains perceptions as the ability to refer sensory information to an external object, giving meaning to what a person experiences in life (Allen, 1990:883). For the purpose of this study, perceptions of PHC nurses, in other words, the meaning they create or the meaning they attach to nursing presence to prevent relapse of MHCUs through their experience of this phenomenon were explored and described.

1.6.2.2.2 Nursing presence

Nursing presence is the relational skill of facilitating authentic spontaneous encounters between the patient and nurse to improve the well-being of the patient. Skills such as therapeutic silence, gentle eye contact, physical proximity, and stillness of the spirit are used to practice nursing presence (Rowe & Kellam, 2013:135; McMahon & Christopher, 2011:71). Nursing presence can be seen as a quality of being rather than doing (McCollum & Gerhardt, 2010:348), and is described by Caldwell *et al.* (2005:854) as “the clinical competence of using oneself therapeutically on behalf of seriously and persistently mentally ill clients.”

1.6.2.2.3 Relapse

Relapse has been defined as a worsening of psychopathological symptoms or re-hospitalization in the year after the hospital discharge of the MHCU (Schennach *et al.*, 2012:87-90). In this research, relapse refers to the deterioration of a discharged MHCU who responded well to treatment while in hospital, but who suffers a relapse while discharged and on follow-up treatment at a down-referral PHC clinic.

1.6.2.2.4 Preventing relapse

“Preventing relapse” is the term used to describe a way of identifying triggers and early warning signs and developing appropriate response plans for reducing the likelihood and severity of relapse following the cessation or reduction of problematic behaviours (Rickwood, 2005:7, Relapse Prevention Guide, 2012:2). Identifying early warning signs as quickly as possible means an individual can take positive action and seek help early to minimize or possibly prevent the impact of a relapse on their quality of life. Preventing relapse is an essential part of the recovery process after being discharged from a mental institution. It involves maximizing wellness for people with mental illness by reducing the likelihood and impact of relapse (Relapse Prevention Guide, 2012:2). The perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs were explored and described.

1.6.2.2.5 Primary healthcare (PHC) to discharged MHCUs

According to the South African National Mental Health Policy Framework and Strategic Plan 2013–2030 (SA, NMHPF 2013-2020:8), primary healthcare is essential healthcare made accessible at a cost a country and community can afford with methods that are practical, scientifically sound and socially acceptable. This approach aims to reduce exclusion and social disparities in health; it is people-centred, intersectoral, collaborative and promotes the participation of all stakeholders. In this research, the focus was on the presence of PHC nurses in a specific district in the Free State. This district offers follow-up services to discharge MHCUs as a continuity of care, which is an effective strategy in the management of long-term psychiatric conditions of such an MHCU (Burns & Grove, 2009:632-639).

1.6.2.2.6 Primary healthcare nurse (PHC nurse)

A PHC nurse is a professional nurse with or without an additional qualification in primary healthcare nursing and who is registered with the South African Nursing Council (SANC, 2005:1) as a professional nurse. The Nursing Act (33 of 2005) indicates that such a professional nurse provides direct care to patients with all types of illnesses and ailments, offering the first level of nursing care to patients. A registered nurse is competent to render appropriate and skilled primary

care services independently as first line of care (SANC, 2005:1). For the purpose of the study, PHC nurses are professional nurses who may have or who may not have an additional qualification in primary healthcare nursing and who render PHC to MHCUs who have been down-referred from a psychiatric institution to the PHC clinic for follow-up treatment and care.

1.6.2.2.7 Mental health care user (MHCU)

A MHCU is a person receiving care, treatment, and rehabilitation services or using a health service at a health establishment aimed at enhancing his or her mental health status (South Africa, 2002). This study is concerned with the discharged MHCU at primary healthcare level, specifically with regard to limiting relapse.

1.6.3 Methodological assumptions

Methodology refers to the process and procedures followed to do the research. It specifies how the researcher studied or investigated what she believed must be known and provides the researcher with methods to follow when obtaining knowledge (Botma *et al*, 2010:41; Ponterotto, 2005:132).

There are three major dimensions or approaches in science that a researcher can follow or choose to identify a research problem, namely positivism, Interpretivism and critical theory (Botma *et al.*, 2010:42-43). The researcher applied methodology in line with Interpretivism, which is an approach to social science that emphasizes the role of people and how they interact with the phenomenon under investigation (Algatawna *et al.*, 2009). The ontological view taken by the researcher is that people's experiences are real and should indeed be taken seriously. This aligns with interpretivism. In addition, the epistemological position taken by interpretivism relates to the nature of knowledge and the relationship between the research participant, namely "the knower," and the researcher, "the would-be knower" (Botma *et al.*, 2010:40). This naturalistic inquiry thus led the researcher to a qualitative research design and method (Lincoln & Guba, 1985; Polit & Beck, 2012:15). It was expected that this approach would lead to the formulation of recommendations for nursing practice, nursing education and further research in respect to nursing presence and limiting relapse of discharged MHCUs.

1.7 Research methodology

The research methodology, namely the research design and method, are briefly discussed here. A detailed discussion is provided in Chapter 2.

1.7.1 Research design

A research design is the overall plan for obtaining answers to the research questions (Polit & Beck, 2012:58). The study followed a qualitative descriptive inquiry design as described by Botma *et al.* (2010:194). This design was deemed applicable to exploring and describing the perceptions of PHC nurses regarding nursing presence to prevent relapse of discharged MHCUs.

1.7.2 Research method

Research methods are the techniques researchers use to structure a study and to gather and analyse information relevant to the research question (Polit & Beck, 2012:12). In an early version of their work, Polit and Beck (2008:765) describe this research method as a way in which a study is conducted. It includes a description of the population, sampling, sample size, data collection plan and data analysis. An overview of these aspects as they relate to this research is provided below, followed by a detailed discussion in Chapter 2.

1.7.2.1 Population

A population is the entire group of all individuals that is of interest to the researcher (Brink *et al.*, 2012:131). According to Polit and Beck (2012:59), a population is all or objects with common, defining characteristics. In this research, the population included PHC nurses (N=72) working at 12 down-referral PHC clinics in one district of the Free State province.

1.7.2.2 Sampling

Sampling involved scientifically selecting a group of PHC nurses to participate in the research (Burns & Grove, 2009:343). Purposive sampling was used to identify and select participants. The inclusion criteria required professional nurses employed in government PHC clinics in a specific district who were involved in the management and care of MHCUs at the down-referral PHC facility. Participants had to have more than 6 months of exposure in the PHC setting and had to be able to communicate in English and willing to be audio-recorded.

1.7.2.3 Sample size

The sample size is determined by the depth of information that was needed (Burns & Grove, 2009:361). In this study, data saturation determined the sample size. Saturation of data was seen as occurring when additional sampling provides no new information, but only redundancy of previously collected data (Burns & Grove, 2009:361).

1.7.2.4 Data collection

The data collection method for this study involved semi-structured focus group interviews. The researcher utilized semi-structured focus group interviews with a minimum of six to eight participants to gather information on the perceptions of PHC nurses on nursing presence to prevent relapse among MHCUs. Semi-structured focus group interviews involve a collaborative activity between the researcher and the participants to discuss a phenomenon and gain understanding by listening and learning (Botma *et al.*, 2010:210). Such interviews are used to obtain qualitative data about participants' beliefs and perceptions on a particular subject, as in this case. According to Gill *et al.* (2008:291-295), this is the most appropriate method for generating information on collective views and the meaning behind those views, as was needed in this case. The data collection plan is discussed in detail in Chapter 2, referring to the role of the researcher, recruitment of potential participants, obtaining informed consent, the physical environment and data collection method.

Field notes were also used as part of data collection (see Appendix H). Field notes are the written account of the things the researcher heard, saw and felt in the process of the focus group interview. It is much broader, more analytical and more interpretive than merely a listing of occurrences (Botma *et al.*, 2010:217). Methodological notes, theoretical notes and personal notes were taken after each interview.

1.7.2.5 Data analysis

Qualitative analysis is a systematic, sequential, verifiable, continuous process of comparison (Botma *et al.*, 2010:221). The process of data analysis involved making sense of text data, moving deeper into understanding the data and interpreting its larger meaning (Botma *et al.*, 2010:220). The transcriptions of the interviews were read carefully, followed by the detailed notes gathered during the focus group interviews. The researcher requested an experienced qualitative researcher to conduct independent co-coding and to verify the themes and coding. Transcripts of the semi-structured focus group interviews and field notes were provided to the co-coder and the steps for data analysis were outlined. A consensus discussion was held to reach consensus on the codes, themes and sub-themes that emerged from the data. A detailed discussion on data analysis follows in Chapter 2.

1.8 Measures to ensure trustworthiness

Trustworthiness is the corresponding term used in qualitative research as a measure of the quality of the research to gain knowledge and understanding of the true nature, essence, meanings, attributes and characteristics of a particular phenomenon under study (Leininger, 1985:68).

Lincoln and Guba (1985) posit that the trustworthiness of a research study is an important evaluation of its worth. Rigour in this study was ensured through the perceived credibility, transferability, dependability and conformability as suggested by Lincoln and Guba (1985). These concepts are discussed in detail in Chapter 2.

1.9 Ethical considerations

Ethical considerations should be overt in every phase and aspect of research, from conceptualization, planning and implementation, writing the report and disseminating the results. Proper ethics were observed throughout this study and the researcher ensured that the research is conducted in an ethical manner by applying the ethical principles prescribed by the Department of Health (DoH) of the Republic of South Africa (2015:14-17). The three broad principles of ethical conduct in research guided the researcher, namely respect for persons, beneficence and justice (Polit & Beck, 2010:152). Ethical clearance was obtained from the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, North-West University (see Appendix B) and permission to conduct the research was granted by the Free State Department of Health (FSDoH) (see Appendix C). The PHC clinic district manager indicated in her response that the permission given by the FSDoH was sufficient, meaning that there was no need for her to grant further permission (see Appendix C with the note attached). The ethics aspects are discussed in detail in Chapter 2.

1.10 Chapter outline

Chapter 2: Application of the qualitative research process

Chapter 3: Findings and literature integration

Chapter 4: Conclusions, limitations and recommendations

CHAPTER 2: APPLICATION OF THE QUALITATIVE RESEARCH PROCESS

2.1 Introduction

Chapter 1 provided an overview of this study. This chapter describes in detail the methodology, including the research design, the methods applied to identify the population, sampling, sample size, data collection and analysis, and the measures taken to ensure that the results comply with the principles of ethics and trustworthiness.

2.2 Research design and method

The researcher used methodological studies to investigate ways of obtaining high quality data and rigorous research was conducted to ensure that the purpose of the study is attained. The researcher ensured that the research process are valid and reliable and that ethical considerations are maintained and discussed below in detail.

2.2.1 Research design

According to Burns and Grove (2009:218), a research design guides the researcher in the planning and implementation of a study in such a way that it is most likely to achieve the intended goal. Botma *et al.* (2010:6) emphasize the importance of being knowledgeable about the research design and adhering to its guidelines.

This research followed a qualitative descriptive inquiry design as described by Botma *et al.* (2010:194) and aimed at presenting a comprehensive summary of a phenomenon. Since nursing presence is a new field of research in South Africa and limited research is available regarding nursing presence and the perceptions of PHC nurses on this concept as it relates to limiting relapse of a discharged MHCU, there was a need for a comprehensive description of this phenomenon. As such, this type of design was the most appropriate choice.

Furthermore, this design is based on principles of naturalistic inquiry, namely understanding the unique, dynamic, holistic nature of human beings in an inductive manner (Burns & Grove 2009:51). New insights, ideas and possibilities were gained on the phenomenon by means of this design, and this relatively unknown territory could be explored deeply (Mouton & Marais, 1996:45-103, Polit & Beck, 2012:18). This design furthermore allowed the researcher to remain open to the perceptions of the participants through the use of “bracketing” (Polit & Beck, 2010:590). This

means that the researcher suspended her own perceptions and remained open to the viewpoints of the participants during data collection and data analysis.

A qualitative descriptive inquiry was deemed appropriate to explore and describe PHC nurses' perceptions on nursing presence to prevent relapse of a discharged MHCU. This design is contextual as the phenomenon was explored and described in the context of PHC nurses' working environment of providing PHC care to discharged MHCUs. In this context, the researcher explored multiple realities as viewed by professional nurses at the PHC clinics regarding nursing presence and limiting relapse of discharged MHCUs.

2.2.2 Research method

The research method is the way in which a study is conducted in phases, with specific referral to the description of the population, sampling and sample size, data collection and data analysis (Polit & Beck, 2008:765).

2.2.2.1 Population

A population is defined as the entire aggregation of cases in which a researcher is interested (Polit & Beck, 2012:273). In this research, the population was all the professional nurses at PHC clinics who have a diploma or degree in nursing, who are recognized by the South African Nursing Council (SANC) as professional nurses and who are currently employed in the Department of Health (DoH) in the government sector and responsible for assessment, treatment and care of MHCUs. The district where the research took place included 12 down-referral PHC clinics, and each clinic is allocated at least six professional nurses every day. On a weekly basis, these professional nurses have to attend to four to ten MHCUs newly down-referred from specialized psychiatric institutions and/or clinics, in addition to their existing patient load. The total number of nurses who constituted the population was 72 (N=72).

2.2.2.2 Sampling

Purposive sampling was used to identify participants. This type of sampling entails conscious selection by the researcher of certain participants for inclusion in the study (Burns & Grove, 2009:344). Denzin and Lincoln (1994:229) and Brink *et al.* (2006:133) suggest that the logic and power behind purposeful sampling is that participants should be information rich and such a technique is used by the researcher to choose particular individuals because they show some features that are of importance in a particular study or they are knowledgeable about the topic.

This sampling method was applicable for the study because the prospective participants were professional nurses working in PHC clinics who are knowledgeable about the topic as they have

to attend to discharged MHCUs on a daily basis. In this study, the researcher selected participants according to sampling criteria with the help of a mediator. The criteria were as follows:

Inclusion criteria:

- Professional nurses employed in government PHC clinics in a specific district, registered with the SANC.
- Professional nurses who are involved in the management and care of MHCUs at the down-referral PHC clinics.
- Professional nurses with more than 6 months of exposure to the PHC setting.
- Both male and female professional nurses were included.
- Professional nurses willing to be audio-recorded during a semi-structured focus group interview.
- Professional nurses willing to sign a consent form to participate in the study.

Exclusion criteria:

The sample selection excluded the following:

- All auxiliary nurses and enrolled nurses, due to the fact that the professional responsibility of follow-up and monitoring of discharged MHCUs at a PHC clinic is outside of their scope of practice.
- Professional nurses with less than 6 months of exposure in a PHC setting.

2.2.2.3 Sample size

According to Polit and Beck (2012:521), there are no fixed rules for sample size in qualitative studies, but the sample size should be based on informational needs, hence a guiding principle in sampling is data saturation. This requires sampling to a point where no new information is obtained and redundancy is achieved (Polit & Beck, 2010:275; De Vos *et al.*, 2005:306). The researcher sampled until repetition of data was achieved. Data saturation was achieved after four semi-structured focus group interviews had been conducted with 5-6 participants per group. The four semi-structured focus group interviews included a trial run (first interview).

2.2.2.4 Data collection plan

A detailed description of data collection is provided stepwise under the following headings: the role of the researcher, recruitment of potential participants, obtaining informed consent, the setting and data collection method.

2.2.2.4.1 The role of the researcher

The researcher submitted the research proposal to the Quality in Nursing and Midwifery research focus area (INSINQ) Research Committee for quality control purposes. This committee approved the proposal (see Appendix A). The proposal was then submitted to the HREC of the Faculty of Health Science, North-West University for ethics clearance of the research and permission was granted (NWU-00041-16-A1) (see Appendix B). After obtaining ethics approval from the HREC, the researcher submitted a request to gatekeepers to obtain permission to conduct the research, namely the FSDoH, and permission was granted (See Appendix C). The PHC district manager indicated in her response that the permission that was granted by the FSDoH was sufficient, meaning that there was no need for her to grant further permission (see Appendix C with the note attached). As soon as the permission was granted, the involvement of a mediator was requested by the researcher (Appendix E) and informed consent forms were given to the mediator to inform potential research participants about the research. This step is discussed below.

2.2.2.4.2 The recruitment of potential participants

According to Pilot and Beck (2012:286), recruiting people to participate in a study involves two major tasks, namely identifying eligible candidates and persuading them to participate. In this study, the research participants were recruited with the help of a mediator. The researcher identified and deliberated with the provincial mental health coordinator to be the mediator between the researcher and research participants. The mediator is a professional nurse who fulfils a leadership role in mental healthcare and who coordinates all mental health programmes in the district. She has a good trust relationship with the researcher and the professional nurses working at the down-referral PHC clinics. One of her roles as a mental healthcare coordinator is to visit the clinics on a monthly basis to ensure that the implemented mental healthcare programmes are running smoothly and to address complaints and shortcomings affecting the mental health programme.

The researcher explained the purpose of the study and what would be expected from the mediator. The researcher informed her that if she was satisfied with the information and willing to act as a mediator, she would be required to sign a confidentiality agreement (see Appendix E). The role of the mediator was to approach the PHC nurses at their monthly district meeting to

inform them of the research and to identify and purposively select eligible participants according to the inclusion and exclusion criteria. She also had arrange meetings with them, invite them to participate and had to obtain informed consent (see Appendix D) if they were willing and agreed to participate. The researcher made contact and maintained constant contact with the potential participants to keep them updated about the dates of the focus group interviews.

2.2.2.4.3 Obtaining informed consent

Informed consent implies not only the imparting information, but also the comprehension of that information by the participant (Burns & Grove, 2009:203). Therefore, informed consent is an extremely important procedure for safeguarding and protecting participants (Polit& Beck, 2012:157). The researcher ensured that the participants were approached through the mediator during meetings, that they received adequate and comprehensive research information about the study, that they comprehended the information and that they had the opportunity and power to choose whether or not they will participate in the research freely (Polit& Beck, 2012:157). Potential participants who agreed to participate in this study were given consent forms (see Appendix D) through the mediator. Essential information was presented verbally to the potential participants by the mediator and the written consent form includes information regarding the study, purpose, specific expectations of potential participants regarding participation in the study, the voluntary nature of participation, specific expectations and potential costs and benefits (Polit& Beck, 2012:158).

2.2.2.4.4 The setting

The researcher ensured that the semi-structured focus group interviews were held in a private and comfortable setting, free from interruption. For this study the district office's boardroom was booked as it is private, convenient, well ventilated, clean and adequately lit to create a conducive environment. To ensure privacy, a "Do not disturb" sign was put on the door to inform others that a focus group interview session was in progress. In line with Yalom (2005:73), the researcher preferred to have no central obstruction, e.g. a table, so as to be able to see the entire body of each member to observe nonverbal or postural responses more readily. The chairs in this context were easy to move, so that members could control the degree of closeness to each other and to the group. The room allowed for a comfortable seating arrangement and group members and seating was arranged in a circle format to maintain eye contact with all participants. Participants were requested to put their cell phones on silent, but were allowed to answer work-related calls.

2.2.2.4.5 Data collection method

The data collection method involved semi-structured focus group interviews and field notes. Semi-structured focus group interviews were utilized to gather information on the perceptions of PHC nurses on nursing presence to prevent relapse of discharged MHCUs. Semi-structured focus group interviews involve collaborative activity between the researcher and the study participants to discuss and gain understanding of a phenomenon by listening and learning from them (Botma *et al.*, 2010:210). Semi-structured focus group interviews are used to obtain qualitative data about participants' beliefs and perceptions of a particular subject, as in this case. According to Gill *et al.* (2008:291-295), this is the most appropriate method for generating information on collective views and the meaning behind those views, as was needed in this case. Semi-structured focus group interviews are a vehicle for understanding the members within the group and reflecting upon their interaction as they sit together to discuss issues. They can listen to each other and in the process they trigger each other's thoughts to provide rich data. The researcher used the four dimensions of group dynamics, namely communication and interaction patterns, cohesion, social integration and group culture as an advantage for accessing rich information (Gill *et al.*, 2008:291-295). The researcher planned to conduct semi-structured focus group interviews with 6 to 10 participants per group (Burns & Grove, 2009:513). The interviews were expected to last between 60 and 90 minutes.

The group was assured by the researcher that all information collected from them will be treated as highly confidential and that the researcher will not disclose any information about them without their consent. Participants were made aware that full anonymity and full confidentiality would not be possible, as the researcher cannot control what is shared by the participants outside the group. The group was made aware that what members share in the group is their responsibility and that each member interacts individually and voluntarily. The group was facilitated to formulate ground rules for themselves regarding maintaining the confidentiality of the group.

According to Botma *et al.* (2010:212), the researcher must have an understanding of and be familiar with group processes before entering the focus group. The researcher had experience in facilitating group processes as she had practised role-play of group interviews while studying for her Diploma in Human immunodeficiency syndrome (HIV/AIDS) in 2010. The researcher also passed a clinical module in advanced psychiatric nursing in 2014. In this module, the researcher conducted individual, family and group therapy. The researcher also completed a module on research methodology during 2015 in which focus group interviews were practiced. The researcher recognizes that, although similar communication skills are used in therapy and research, the purpose of and approach to research differs from therapy. Therefore, before commencing with data collection in this study, she conducted a role-play with non-participants to

practise the application of the semi-structured focus group interview in this research and obtained feedback from her supervisor on her research interview skills. The first semi-structured interview with actual participants was seen as a trial run to evaluate the clarity of the interview questions (Motelle, 2003:22).

The interviews were conducted in a semi-structured format according to an interview schedule with clear open-ended questions (Botma *et al.*, 2010:209). According to Botma *et al.* (2010:209), an interview schedule, also known as a topic guide, is a set of predetermined open-ended questions that guides and does not dictate the interview. The questions should be limited to three to six in number. The interview schedule was developed by ensuring that six formulating open-ended questions relevant to the research were asked (some questions were rephrased leading to eight questions in total) to ensure that rich and comprehensive information is generated. Also, the interview schedule was developed by formulating the questions to be in line with the research purpose. Questions were also carefully structured to prevent the participants from any emotionally harmful exposure in answering questions. The researcher drafted the initial interview schedule and presented it to the research supervisor for feedback. The interview schedule was also presented to the INSINQ Research Committee and HREC for their comments as part of the research proposal.

The following made up the interview schedule:

- Introduction and confirmation of informed consent and confirmation that participation is voluntary and that a participant may withdraw at any stage.
- Clarification of uncertainties and opportunity for questions. The concept nursing presence was explained as follows: Nursing presence is a way to offer caring in a healing way of “being” and relating and experiencing a connection between the MHCU and the healthcare provider (Hessel, 2009:276-281). Presence lies within us, around us and above us as nurses and is thus a skill to facilitate authentic spontaneous encounters between the patients and nurse to facilitate the well-being of the patient (Rowe &Kellam, 2013:135).
- Formulation of ground rules.
- Facilitation of research interview, guided by the following questions based on the attributes of nursing presence as defined by Finfgeld-Connet (2006:711) (See Table 2-1).

Table 2-1: Attributes of nursing presence and related interview questions

Attributes	Questions asked
Sensitivity	What are your perceptions of attentiveness and sensitivity towards the MHCU?
Holism	What are your perceptions of holistically focusing on the needs of the MHCU? What is your view on being available and open in a holistic manner towards the MHCU?
Intimacy	What are your perceptions of engaged availability, in other words interpersonal connectedness with the MHCU?
Vulnerability (mutual)	What is your view on mutual trust and sharing between the professional nurse and the MHCU?
Uniqueness	What are your perceptions of adapting to the uniqueness of circumstances of the mental healthcare? What are your perceptions of adapting to the uniqueness of the MHCU's relapse?
Limiting relapse	How do you think these factors can contribute to limiting relapse of the MHCU?

The researcher used communication and facilitation skills such as clarifying, paraphrasing, probes, continuous reflection and summary during the semi-structured focus group interviews to probe participants to give more information about the issue under study and to ensure the free flow of the interview (De Vos *et al.*, 2005:306; Okun & Kantrowitz, 2008:75-78). Communication techniques were applied as follows:

- Clarifying – the researcher asked the participants clarifying questions to clarify their statements by repeating what they said in order to understand the basic nature of the participants' statements.
- Paraphrasing – the researcher used verbal statements to test whether the researcher understood what the participants attempted to communicate.
- Probes – probes were used to assist the participant to express their experiences and needs openly by posing open-ended questions and encouraging participants to give more information to substantiate their point of view.
- Continuous reflection was ensured by repeating the participants' statement using the exact words to communicate the participants' understanding, concerns and perspectives, thus

allowing other participants to hear and follow the discussion to enhance commitment, participation and ownership of the process.

- Summarizing – the researcher used this technique by synthesizing and highlighting the key ideas expressed to ensure all group members, including the researcher, understood what was communicated during the discussion.

2.2.2.4.6 Field notes

The researcher used field notes during the course of data collection to describe and explain what she heard, saw, felt, experienced and thought, in a broader, more analytic and more interpretive manner than a mere listing of occurrences (Botma *et al.*, 2010:217). These field notes were taken for use as part of the data and/or for verification of the results. Three kinds of field notes were taken, namely descriptive notes, reflective notes and demographic notes (Creswell, 2009:181). For descriptive notes, the researcher objectively described the events and physical settings as they occurred during the semi-structured focus group interviews. For reflective notes, the researcher wrote her own personal thoughts and experiences and the progress in the field such as speculation, feelings, problems, ideas and impressions (Botma *et al.*, 2010:218). The demographic notes contained information such as the time, place and date where the semi-structured focus group interviews were held, as well as demographic notes about the participants such as gender, age and working experience in order to facilitate an orderly description of data analysis (Botma *et al.*, 2010:219). See Appendix H as an example of the field notes.

2.2.2.4.7 Recording of data

A digital audio recorder was used to record the semi-structured focus group interviews for comprehensive record keeping. Before the digital audio recorder was used in the focus group interview to record any conversations, the researcher first obtained permission from the participants. The digital audio recorder was placed in a place where it did not distract participants. Soon after the focus group interview was over the researcher listened to the audio-recorded interview to check for audibility and completeness and to allow for self-evaluation of the researcher's own interviewing style and any need for follow-up (Botma *et al.*, 2010:214).

2.2.2.4.8 Transcribing data

The researcher transcribed the data verbatim from the audio recorder as verbatim transcription is a critical point in preparing for data analysis. The researcher ensured that transcriptions were accurate and that it reflected the totality of the interview by repeatedly listening to the audio recordings and ensuring a true portrayal of the data (Botma *et al.*, 2010:214). In the transcripts,

the researcher left enough space in both left and right margins to allow her to make notes during analysis. Additional data in the transcription such as silence, sigh, laugh and crying can enrich the depth and the context of the transcription and were also noted (Botma *et al.*, 2010:215).

2.2.2.4.9 Storage of data

According to Creswell (2013:175), there are certain principles to be followed for data storage. This includes the following:

- Any identifying information was removed from the transcripts and participants are referred to using code names, e.g. "Participant 1."
- The recordings were destroyed after transcription. Electronic copies of the transcripts are stored on a password-protected computer.
- These copies will be destroyed after a period of 7 years by deleting the copies from the computer.
- Hard copies of the transcripts will be stored in the INSINQ Research Focus Area office in a locked cupboard for a period of 7 years, after which they will be destroyed through shredding.

2.2.2.5 Data analysis

The process of data analysis involves making sense of the text, understanding the data, representing the data, and an interpretation of the larger meaning of the data (Botma *et al.*, 2010:220). The process of data analysis involved the preparation of data for analysis, conducting the analysis by moving deeper and deeper into the data to understand it, interpreting the data and making it less complex and easily understandable (Creswell, 2009:183). Data were processed by means of thematic analysis. The steps of thematic analysis were followed as outlined by Tesch (as quoted by Creswell, 2009:186).

The researcher read through all the transcripts repeatedly to obtain and conceptualize the meaning and to identify ideas that match the topic. The process adhered to the steps as described by Creswell (2009:184):

In step one the researcher organized and prepared data for analysis, which involved transcribing interviews, typing up field notes, sorting the data into different types depending on the source of information, and thereafter breaking it into parts for understanding (Botma *et al.*, 2010:224). This means that the researcher had to be fully devoted to obtaining the details and had to spend an

extensive amount of time reading the data before breaking it down to gain an understanding of the interview.

In the second step, the researcher again read through all the data to obtain a general sense of the information and to reflect on its overall meaning. The researcher then started writing notes in the margins (Creswell, 2009:186).

In the third step, the researcher coded the data. Coding involves the process of noting significant text data, sentences, words, paragraphs and phrases and assigning codes to these text fragments (Creswell, 2009:186). The codes were used as a framework to identify significant data in further transcripts. After analysing all the transcripts, the codes were clustered into topics. Topics were organized into columns and similarities were clustered further. Themes and sub-themes were formed from the clusters.

The final step in data analysis involved making meaning of the data (Creswell, 2009:186). This involved the whole process of data analysis starting from organizing and preparing the data for analysis, coding the data, and identifying and formation of themes from the coding process. It also involved bringing the themes and sub-themes in relation with the purpose of the research, and comparing the themes and sub-themes with existing literature (Creswell, 2009:186).

The researcher was involved in the analysis together with an independent co-coder (see Appendix F), and a consensus discussion was held to finalize themes and sub-themes that emerged from the data.

2.3 Measures to ensure trustworthiness

Burns and Grove (2009:54) define the term rigour in qualitative research as striving for excellence, openness, relevance, thoroughness in collecting data and scrupulous adherence to details and strict accuracy. The participants in this study were asked to be honest, open and truthful about all the information they provided. This perspective traditionally stimulates the development of trustworthiness in qualitative research.

In order to ensure trustworthiness, Lincoln and Guba (1985:290-294) outline four epistemological standards, strategies and criteria by which the quality or worth of a qualitative study can be evaluated, namely, truth value, applicability, consistency and neutrality (Polit & Beck, 2012:589-585; Brink *et al.*, 2012:126; Botma *et al.*, 2010:234; Krefting, 1991:215-222).

The applications of these four criteria are discussed below in Table 2-2.

Table 2-2: Strategies to ensure trustworthiness

Criteria	Strategies	Application
<p>Truth value</p> <p>This criterion is concerned with whether the findings of the study are a true reflection of the perceptions of the participants. It involved ensuring the credibility of the findings and interpretations by presenting the perceptions of the participants as adequately as possible. (Botma <i>et al.</i>,2010:233)</p>	<p>Credibility</p> <p>The researcher used prolonged engagement, field notes, and peer debriefing and comprehensive description of the research to achieve credibility.</p>	<p>With regard to prolonged engagement, the researcher engaged with research participants and the data for a prolonged time. This included the process of recruitment and invitation to participate. Although the researcher involved a mediator in this process, she was on standby and potential participants could meet her and ask clarifying questions. The researcher’s engagement with participants continued during data collection, during which time she built rapport and engaged with participants to facilitate in-depth discussions. Prolonged engagement furthermore entailed spending enough time in the data collection setting and with participants to be able to distinguish patterns in and the essence of the data.</p> <p>Furthermore, the researcher used field notes to reflect on her own developing views and to enable her to continue identifying and bracketing her own views.</p> <p>Peer debriefing enabled the researcher to reflect on new insights and to expose herself to critical questions. During data collection, the researcher had regular meetings with the research supervisor for this purpose, as well as a consensus meeting with the independent co-coder during the process of data analysis.</p> <p>Finally, the researcher ensured that the research report exhibits coherence, consistency and logic, and that the whole and the complexities of the phenomenon under study are evident from the discussion of the results, conclusions and recommendations.</p>
<p>Consistency</p> <p>Consistency is concerned with being consistent within and during the application of the research process.</p> <p>The strategy of ensuring dependability was used (Botma <i>et al.</i>, 2010:233).</p>	<p>Dependability</p> <p>To ensure dependability, the researcher established an audit trail and exposed the research report to external, expert examination.</p>	<p>To establish an audit trail, the researcher ensured a dense description of the research process. This enables an external researcher to examine the processes used in data collection, analysis and drawing of conclusions.</p> <p>In the field notes, the researcher described the changes that occurred in the setting, the interview schedule and within her during the research and how these changes affected the way she approached the study. In addition, the research report is submitted for external, expert examination. The examination of the dependability of the research process forms part of this process.</p>

Criteria	Strategies	Application
<p>Neutrality</p> <p>Neutrality refers to the way in which the research is carried out to eliminate the influence of prejudices, interests and individual views on the data and the interpretation of the data (Rossouw, 2003:177). The strategy of conformability was used to ensure that the data is neutral and free from judgment, potential bias or distortion.</p>	<p>Conformability</p> <p>Conformability was practiced through bracketing, reflexivity and ensuring an audit trail.</p>	<p>Bracketing was implemented by identifying and setting aside any preconceived beliefs and opinions the researcher might have had about the phenomenon under investigation (Polit & Beck, 2010:590). The researcher therefore clearly describes the problem statement, the research purpose and her paradigmatic perspective in Chapter 1, and also kept field notes, engaged in peer debriefing and involved an independent co-coder during data analysis.</p> <p>The researcher used the same strategies to practice reflexivity to reveal her assumptions at the onset of the research and her reflections during the research.</p> <p>Lastly, the dense description of the research enabled an audit trail of the data generated, the process of data analysis, the results and literature control, conclusions and recommendations. Thus, apart from evaluating the research process, as mentioned earlier, external, expert examiners will also scrutinize the research report for evidence that the data support the results and conclusions, and that the results, conclusions and recommendations are consistent with data generated in the research.</p>
<p>Applicability</p> <p>Applicability refers to the degree to which the same research findings can be generated from different contexts and groups (Rossouw, 2003:176). Applicability was ensured through transferability. Guba & Lincoln (2005:195-215) state that transferability is more the responsibility of the person wanting to transfer the research to another situation or population than the researcher of the original study.</p>	<p>Transferability</p> <p>The strategies of dense description and appropriate sampling ensured transferability.</p>	<p>The researcher provided a dense description of the research design and method, the context and the results to allow readers to make decisions regarding transferability.</p> <p>Purposive sampling was used and the researcher used an experienced mediator in the research field to assist in the selection of the participants who are representative of the phenomenon under study. In this research, a requesting letter was written to the district mental health coordinator to assist in selecting participants from the different PHC clinics who met the inclusion criteria (See Appendix E).</p>

2.4 Ethics considerations

The researcher ensured that the research was conducted in an ethical manner by applying the ethics principles prescribed by the Department of Health (SA DoH, 2015:14-17). The three broad principles that guides ethical conduct in research is respect for persons, beneficence and justice (Polit& Beck, 2010:152). The application of these principles in this research is discussed in short below.

2.4.1 Relevance and value

This research is relevant and valuable and makes a contribution in the form of recommendations for nursing education, nursing practice and research regarding nursing presence and the prevention of relapse.

2.4.2 Scientific integrity

Ethics approval was obtained from the HREC of the Faculty of Health Sciences, North-West University (Reference number NWU-00041-16-A1). Permission to conduct the study was obtained from the FSDoH. The PHC clinic district manager indicated in her response that permission given by the FSDoH was sufficient, meaning that there was no need for her to grant further permission (see Appendix C with the note attached from the PHC district manager). To conduct research ethically, the researcher:

- carried out the research in a methodologically strict and skilled way;
- the researcher used all resources with utmost respect and integrity;
- all those who contributed guidance or assistance are acknowledged fairly in order to prevent plagiarism; and
- all results are communicated accurately, meaning that no results are forged, falsified or fabricated in any form of communication, whether verbally or in writing.

Furthermore, scientific integrity was upheld by following the most appropriate research design and method for this study, as discussed in the “Research design and method” section.

2.4.3 Role-player engagement

Participants were engaged by inviting them to participate via a mediator. They were fully informed on the nature and purpose of the study and on what is expected of them. The use of semi-structured focus group interview as data collection method also contributed to role-player

engagement, as participants were asked to share their expertise on the topic of nursing presence and limiting relapse.

2.4.4 Favourable risk-benefit ratio

There is no direct benefit to participants, but the indirect benefit is that their participation will contribute to the formulation of recommendations on such relapse prevention. The burden and benefits of the research is balanced by acknowledging that participants spent some time to participate, while also acknowledging that participants contributed to the body of knowledge in nursing with their participation. Potential participants may feel vulnerable due the stigma associated with mental illness when delivering services to the mentally ill population. To counteract this possible ethics risk, the researcher recruited participants with the assistance of the mediator.

In order for the researcher to protect the well-being of the participants during data collection and to ensure a favourable risk-benefit ratio, the principle of beneficence was applied (Botma *et al.*, 2010:13) by taking precautions to safeguard the participants' needs, be it physical, emotional, spiritual, economic, social or legal (Brink *et al.*, 2012:35). A psychologist from the researcher's workplace was on standby in case of any physical or emotional distress during the focus group interviews. The researcher continuously monitored the participants for any sign of emotional discomfort and/or fatigue by providing short breaks in between the discussions.

This was a medium risk study, and the benefits outweighed the risks.

2.4.5 Fair selection of participants

The researcher selected participants for reasons directly related to the research and not because participants were easily accessible, as discussed under "Sampling" and recruitment. In short, a mediator was involved to recruit participants. The mediator, who is the district mental health coordinator, had good, trusting and professional relationships with professional nurses at the PHC clinics and information about the research process was disseminated from the researcher to the mediator.

The researcher also ensured that no form of deception was inflicted on the participants by explaining the topic and the process of data collection to them thoroughly (Brink *et al.*, 2006:33; Burns & Grove, 2009:190).

2.4.6 Informed consent

Potential participants can only exercise the right to self-determination and act autonomously if well informed about the research project and procedures. An internal memo and informed consent letter were thus compiled to explain the content of the proposed research in a language that the participants could understand (see Appendix D). Written, voluntary informed consent was obtained from the participants during the recruitment stage and it was also done as an ongoing process. They were assured of their freedom from harm as the researcher gave an explanation of the aims and methods of the study so that they could choose if they want to participate in the study or not. The contact numbers of the researcher and the ethics committee were made available to participants in the informed consent letter.

2.4.7 Respect, confidentiality, anonymity and privacy

With regard to respect, all communication (written and verbal) used understandable language and the data were collected by a skilled researcher who adhered to the research protocol and informed consent letter provided to participants. The researcher recruited PHC nurses through the mediator to participate in the study and all agreements made with the participants, such as punctuality and terminating the session at agreed time, were honoured.

With regard to anonymity, participants' names were not mentioned during the discussions, even though anonymity is rarely possible with a focus group because of the presence of other participants. Nonetheless, the researcher did everything in her power to ensure partial anonymity and confidentiality by informing participants that the digital audio recordings would be destroyed after verbatim transcriptions of the interviews and the issues raised during the interview sessions will not be communicated with participants' colleagues. Participants were asked to formulate ground rules during the semi-structured focus group interviews with regard to upholding confidentiality among themselves. This aspect is described in more detail under "Data collection." No names or even place of employment are revealed during data presentation to avoid the possibility of linking participants to responses (Green & Thorogood, 2009:71; Burns & Grove, 2009:197).

A digital audio recorder was used to record the semi-structured focus group interviews for comprehensive record keeping. Before the audio recorder was used in the focus group interview to record any conversations, the researcher first obtained permission from the participants and the researcher did not collect data without their permission. As such, the researcher respected the participants' right to privacy. The participants' right to privacy was furthermore protected by conducting the semi-structured focus group interview in a private room. The researcher also

explained to the participants their right to withdraw from the study at any time without being penalized (Polit& Beck, 2008:177).

The following measures were put in place to limit access to the data:

- Any identifying information in the transcripts were removed and participants are referred to using code names, e.g. "Participant 1."
- The recordings were destroyed after transcription. Electronic copies of the transcripts are stored on a password-protected computer. These copies will be destroyed after a period of seven years by deleting the copies from the computer.
- Hard copies of the transcripts will be stored in the INSINQ office in a locked cupboard for a period of seven years, after which it will be destroyed through shredding.

2.4.8 Researcher competence and expertise

As a psychiatric nurse who is trained and skilled in group therapy, the researcher used her skills and clinical judgement to manage all focus group interviews. This aspect is discussed in more detail under "Data collection." Both the researcher and the supervisor have undergone training on ethics in research. In addition, a co-coder experienced in qualitative research with a Master's degree was identified.

2.4.9 Dissemination of results

The results of the study will be made available to all participants verbally and in writing during monthly district meetings. This will be done shortly after examination of the mini-dissertation. A scientific publication is also planned.

2.4.10 Remuneration

The participants received refreshments during the focus group interviews. No remuneration was offered because the focus group interviews were conducted during office hours at the participants' workplace, with no cost to the participants for transport. Permission to conduct the focus group interviews during office hours at the participants' workplace was obtained from their management before the onset of data collection.

2.4.11 Monitoring of the research

The implementation of the research was monitored during monthly meetings between the researcher and supervisor. The researcher provided a report on the implementation of the

research and compliance with the proposal in the introductory section of the results chapter in the mini-dissertation, and added appendices to the mini-dissertation as proof that the research process was followed as planned (a part of a transcript (anonymised), field notes (anonymised), proof of HREC approval and proof of permission from authorities). If any amendments were needed, an application for amendment would have been submitted to the HREC for approval. No amendments were needed.

The progress of the research was monitored during regular meetings between the researcher and the supervisor during which the researcher's progress were compared to the timeline outlined in the proposal. In addition, six-monthly reports by the supervisor were submitted to the INSINQ research director, faculty research committee and ethics committee.

Serious adverse events would have been reported immediately to the INSINQ research director and HREC. In such a case, the research would have been suspended until a decision had been reached on how to manage the adverse event. No serious adverse events occurred.

2.5 Summary

This chapter presented the research design and method, including the data collection methods, measures for ensuring trustworthiness and ethical considerations. Chapter 3 presents the findings and literature integration.

CHAPTER 3: FINDINGS AND LITERATURE INTEGRATION

3.1 Introduction

Chapter 2 described the research process and the measures that were taken to ensure rigour and ethical considerations. This chapter presents the findings regarding the PHC nurses' perceptions on nursing presence as an approach to prevent relapse of MHCUs. These findings are supported by quotations from the focus group interviews conducted with PHC nurses from PHC clinics. These findings were compared with all the relevant literature regarding the perceptions and views of PHC nurses in managing a discharged MHCU at primary healthcare level.

3.2 Reflection on data collection and analysis

The initial plan was to conduct the semi-structured focus group interviews in the district boardroom, but this had to be changed to the different PHC clinics on the advice of the local area managers and operational managers. The reason for the change in venue was that meetings at the district level only take place once a month if they were not postponed. The interviews would then only have involved the managers of the different clinics, which would have delayed the process of data collection. Consensus was reached between the researcher and the relevant clinic managers to allow the researcher to conduct focus group interviews in the clinics on Fridays because PHC nurses booked fewer patients on Fridays since Fridays are used for academic purposes, such as in-service trainings and team building exercises from 08h00–10h00. This meant that this was the only time available for the researcher to see the PHC nurses. The area managers and operational managers also humbly requested the researcher not to move the participants from their work area to avoid staff shortages as they already have a great staff shortage. They instead provided the researcher with a suitable room to conduct the focus group interviews. Clinics in close proximity were grouped together and participants assembled at one specific clinic where the majority of PHC nurses volunteered to participate.

The researcher identified participants with the help of the mediator and informed consent were obtained from all participants. During the interview, the researcher communicated in English, but gave the research participants an opportunity to respond in a language of their own choice. Most of the participants responded in English, Afrikaans, Sesotho and Setswana. An audio recorder was used to record all the focus group interviews for the purpose of data analysis and all recordings were translated in English and transcribed verbatim as indicated in Chapter 2.

The change of venue for the focus group interviews to the selected PHC clinics contributed both positively and negatively. Positively, the PHC nurses felt comfortable and at ease at their work

place. Negatively, some participants had to leave the groups to attend to emergencies; nevertheless, rich data were obtained. Four semi-structured focus group interviews (see Appendix G for an example) were conducted for data collection. This included a trial run. The first focus group was conducted on 12 October 2016, the second on the 28 October 2016, the third on 4 November 2016 and the fourth focus group was conducted on 13 November 2016. The reason for the short intervals in between conducting the focus groups was that the different clinics were busy planning their year-end functions and personnel were going on vacation.

The field notes (Appendix H) were categorized as descriptive, reflective and demographic notes. The data was analysed independently as described by Creswell (2013:184) and a consensus meeting was held between the researcher and the co-coder to compare findings. The findings could be categorized according to the interview schedule and consensus was reached on the research findings and the main themes and sub-themes that had emerged (See Table 3-2).

3.3 Findings and literature integration

The research findings are discussed by providing an overview of the main themes and sub-themes, followed by a discussion of each theme and a literature integration.

Table 3-1 outlines the questions that were asked during the focus group interviews based on the attributes of nursing presence as described by Finfgeld-Connet (2006:711). The main and sub-themes could be categorized according to these attributes and questions.

Table 3-1: Attributes of nursing presence and related interview questions

Sensitivity	What are your perceptions on attentiveness and sensitivity towards the MHCU?
Holism	What are your perceptions on holistically focusing on the needs of the MHCU? What is your view on being available and open in a holistic manner towards the MHCU?
Intimacy	What are your perceptions on engaged availability, in other words interpersonal connectedness, with the MHCU?
Vulnerability (mutual)	What is your view on mutual trust and sharing between the professional nurse and the MHCU?
Uniqueness	What are your perceptions on adapting to the uniqueness of circumstances of the mental healthcare? What are your perceptions on adapting to the uniqueness of the MHCU's relapse?
Limiting relapse	How do you think these factors can contribute to limiting relapse of the MHCU?

The above-mentioned questions and probing questions from the researcher brought about lively and lengthy discussions, debate and arguments. Six main themes emerged from the six questions, with related sub-themes (see Table 3-2.) The themes and sub-themes are discussed in detail and supported with direct quotations from the participants. Quotes from the focus group interview are marked as for example fg2, indicating the focus group number. The researcher searched and explored the relevant literature and as such integrated it with the research findings. Different languages were used during the focus group interview and words spoken in Afrikaans, Sesotho and Setswana were translated into English in the transcripts.

The findings of this qualitative inquiry describe the interpersonal interaction between the professional nurse working in PHC and the discharged mental healthcare user. Findings also describe participants' views on nursing presence and preventing relapse in discharged MHCUs.

3.3.1 Themes and sub-themes

The themes and sub-themes are discussed below, aided by a literature integration.

Table 3-2: Themes and sub-themes: exploring nursing presence as an approach to prevent relapse of discharged MHCUs

Themes	Sub-themes
Sensitivity	<ul style="list-style-type: none"> • MHCUs present with: <ul style="list-style-type: none"> ○ Fear of nurses' negative attitude ○ Fear of stigmatization • Attentiveness and sensitivity needs time • Nurses have to build a trust relationship with MHCUs – proper nursing uniform improves trust • Nurses have to rotate attending to MHCUs • MHCUs should be prioritized
Holism	<ul style="list-style-type: none"> • Holism is affected by: <ul style="list-style-type: none"> ○ Shortage of staff ○ Lack of information and confidence ○ Overcrowding at PHC facilities ○ Lack of resources – lack of psychiatric nursing skills and shortage of psychiatric medication ○ Stigmatization of MHCUs by PHC nurses
Intimacy	<ul style="list-style-type: none"> • Nurses are empathetic and firm • Intimacy is linked to humanity
Vulnerability	<ul style="list-style-type: none"> • A need for conducive environment
Uniqueness	<ul style="list-style-type: none"> • Uniqueness is determined by knowledge and skills • Nurses should have empathy and understanding for MHCUs
Limiting relapse	<ul style="list-style-type: none"> • Positive attitude among nurses • PHC nurses should have a spirit of <i>ubuntu</i> • Proper referral system • Need for half-way houses • Family support/Need for family support • Adequate nursing personnel • Continuous education for PHC nurses • Collaboration among families, PHC nurses and psychiatric institutions

3.3.1.1 Theme 1: Sensitivity

With regard to sensitivity, which in this case refers to professional attitudes, is a crucial influencing factor that affect the MHCUs' perceptions of psychotic relapse and pharmacological treatment (Chan *et al.*, 2011:325). Six sub-themes could be identified, namely fear of nurses' negative attitude, fear of stigmatization, attentiveness and sensitivity needs time, trusting relationship

between the nurse and patient, rotation of nurses taking care of MHCUs, and MHCUs should be prioritized.

3.3.1.1.1 Sub-theme 1.1: Fear of nurses' negative attitude

Participants mentioned that they are aware that MHCUs present with fear of nurses' negative attitude towards them. This sensitivity towards the probable experience of the patient gives birth to a further awareness that MHCUs requires meaningful time with the nurse. If nurses should fail patients in this regard, MHCUs might not return to the clinic. The following reports quoted from the focus groups supports the above sub-theme:

“Ja, mhhhh when a patient come to us I think he is also afraid and stressed of will this person really understand, will this people really be able to support me or listen to me or will they really understand my problem or they could come with the attitude of nobody cares and they don't give me what I need and I don't trust them, I think is all original fear of being misunderstood or humiliation for feeling stigmatised or whatever.” (fg1: pg4)

“In the end because of your attitude, your time schedules, your....., approach towards him, it's so important for us to have time for our patients.” (fg1: pg6)

“Now I told you I was there 20 years back and I don't want anything to do with psychiatry, but if the opportunity appears..., yes to me as a PHC nurse I'm being paid to do PHC and when the patient come here with somaticized psych things, hi it's not my business.” (fg1: pg15)

“They will become scared because we don't give that full time or show them that we are having time for them, so we fail them and they don't want to come back hey...laughing”.(fg1: pg5)

Literature supports these findings. According to Sariah *et al.* (2014:10), relationships between the nurse and the MHCUs have been shown to play an important role in the development of trust. Sensitivity towards the patient requires presence, and presence requires resilience, willingness to enact presence, personal and professional maturity and a work environment that supports the enactment of presence (Finfgeld-Connet, 2008:113).Bright (2012:93) further mentions that presence requires awareness of the patient, of the moment, of self-healing and healing others and a moral concern that is satisfied by authentic engagement. A relational skills set includes the nurse's ability to recognize a MHCUs therapeutic communication needs, to use the right words and gestures and the capacity to be available as needed with behaviours such as attentiveness, active listening, quiet availability and touch (Tavernier, 2006:299-322).

Previously, a designated professional nurse was identified for the purpose of receipt of a discharged MHCUs at the clinics (Nagel *et al.*, 2008:4), but due to the integration of mental health

into the PHC system, all professional nurses at the PHC down-referral clinics are expected to receive and treat a discharged MHCU from the psychiatric institution. According to Mkhize and Kometsi (2008:7), challenges in follow-up treatment for MHCUs by PHC nurses include increased workload, lack of adequate time to cater for people with mental disorders, and lack of support and supervision to confidently undertake their tasks.

3.3.1.1.2 Sub-theme 1.2: Fear of stigmatization

It was clear from participants' responses that they use their conscious knowledge of sensitivity in their treatment of MHCUs as psychiatric stigma is sometimes perpetuated by healthcare providers. Some participants verbalized that MHCUs fear stigmatization not only by healthcare workers, but by their family and the society at large, leading to delays in help seeking.

The following reports as quoted from the focus groups support the above theme:

"I think is all original fear of being misunderstood or humiliation for feeling stigmatised or whatever." (fg1: pg4)

"I don't want to go to the clinic because there is this thing attached to it, there is this label attached to it "I'm mad and I don't want to be associated with mad people because going to the clinic I will meet other mad people, so I rather not go to the clinic because I don't want to be seen with mad people because they are also going to label me as being mad." (fg1: pg11)

"There is nobody accompanying the patient to the clinic, there is nobody supervising the taking of medication, which can also lead to relapse." (fg1: 10)

"Yes family should be more involved in the patients care because at the end of the day patient is 29 days with the family where else the patient come to us for an hour for that month." (fg3: pg40)

"The community must also be taught how to handle the psychiatric patients because they tend not to trust them in any way and they are putting more stress on the patient." (fg4: pg62)

According to Kapungwe *et al.* (2010:192-203) there is a widespread stigmatizing and discriminatory attitudes among PHC nurses towards MHCUs. This finding corroborates some studies that have explored stigma among the mental health population globally and found that health and mental health professionals may contribute to the development and reinforcement of mental illness stigma. The direct consequences of a stigmatizing attitude from PHC nurses is a delay in seeking help from service providers at the clinics, leading to poor adherence to treatment. MHCUs are reluctant to return to the clinic to follow up on their treatment regimen (Egbe *et al.*, 2014:16). This in turn makes the MHCUs unable to live and move around in their communities or

participate in outdoor activities like other members of the community. According to Sariah *et al.* (2014:8), family members may not support the MHCU because they do not want to share some of their property with the MHCU's. Families have a tendency to ignore the user's symptoms and treatment, which results in relapse.

3.3.1.1.3 Sub-theme 1.3: Attentiveness and sensitivity needs time

Participants revealed that they find it difficult to be sensitive and attentive towards MHCU's due to their workload and time constraints. Most participants verbalized that the shortage of staff and with the long queues they are facing on a daily basis make it almost impossible to even listen to a MHCU. Some participants feel that attentiveness and sensitivity depends on the unique patient, namely the clinical manifestation of the MHCU and the nature of the information obtained from the patients and their families. The following reports as quoted from the focus groups support the above theme:

“As PHC nurses with psychiatry or to deal with psychiatry it is a time consuming process and the thing for us in PHC as nurses and due to our restraints of personnel and really time is a factor when you look at the queues is not always so possible to listen to him.”(fg1: pg4)

“In the end because of your attitude, your time schedules, your....., approach towards him, it's so important for us to have time for our patients.” (fg1: pg6)

“But if we can be provided with enough staff, enough hands to attend to our patients I think our attention to them will be more.” (fg1: pg5)

“It depends on the clinical manifestation of the patient, each and every case is different on its own grounds and you will see that this patient needs more time than the other, so it depends on the information that you get from the patient or family and that will decide how much time you need to invest on the patient.” (fg4: pg56)

Literature on presence in nursing differs from these findings. McMahon and Christopher (2011:78) emphasize that the willingness of a nurse to engage with a patient is not dependant on time available to spend with the patient, but by concern and honouring of others. However, Awenva *et al.* (2010:184-191) do mention that one of the major challenges affecting the quality of mental healthcare services in PHC clinics is that PHC nurses simply do not have the necessary time to provide quality mental healthcare to MHCUs. According to Finfgeld-Connet (2006:708-714), adequate time is a prerequisite for presence. Nurses are thus continually confronted with the dilemma of allocating time to be present with clients and allocating time to the required task (Melnechenko, 2003:18-24).

3.3.1.1.4 Sub-theme 1.4: Building a trusting relationship with the MHCU and wearing proper nursing uniform improves trust

Participants verbalized that it is important to build a trusting relationship with MHCUs. Participants debated whether wearing uniform and distinguishing devices contributed to such a trust relationship or not. Those who argued that wearing a uniform does not make any difference said that the trust relationship depends on the approach of PHC nurses to the MHCU. The following reports as quoted from the focus groups support the above theme:

“We had to build a trust with a psychiatric patient even if you do wear you epaulettes if they can trust you we can go anywhere with them, you must not force them but you must listen to them and that’s my experience with psychiatric patients.” (fg4: pg58)

“And the moment he does not trust you, he will not tell you his problems or make a plan to tell you, he will go home with symptoms un... unsaid and that will be the cause of him relapsing.” (fg1: pg4)

“I mean there therapeutically you must be there, you must listen, you must understand, you must deal, you must be there in the type of a healing.” (fg1: pg4)

“Get them to trust you because I have seen many times that if there is someone new in the clinic it is very difficult for them and they will ask where is sister so and so.” (fg3: pg36)

According Finfgeld-Connet (2008:111-113), presence requires resilience, willingness to enact presence, personal and professional maturity, and a work environment that supports the enactment of presence. Consequently, trust is vital to the relationship between the healthcare provider and the healthcare user (Searle, 2009:227).

Another point on intimacy as improving the trust of the MHCU was the fact that participants acknowledged that they thought that wearing proper uniform with distinguishing devices improves the trust of a MHCU in a PHC nurse, while other participants felt that wearing uniform makes an already aggressive patient worse. The following report as quoted from the focus groups support the above theme:

“We had to build a trust with a psychiatric patient even if you do wear you epaulettes if they can trust you we can go anywhere with them, you must not force them but you must listen to them and that’s my experience with psychiatric patients.” (fg4: pg58)

Literature confirms the above statement. According to Sariah *et al.* (2014:10), therapeutic factors within a therapeutic relationship always relate to how an MHCU reacts to the interventions offered

by a nurse, and that specific reaction will be the conception of rapport between nurse and her/his patient. When an MHCU receives good service, they develop trust in the person who provides the services to her/him. According to Dreyer *et al.* (2006:169), distrust and misunderstandings occur when there is a lack of knowledge and considerations for the expectations and beliefs of patients as healthcare recipients. In a survey that was done by Miller *et al.*, (2010:178-183) many MHCUs revealed that uniform makes nurses appear more approachable, competent, more professional and easy to identify, while other MHCUs felt that attire made no difference to approachability.

3.3.1.1.5 Sub-theme 1.5: Nurses have to rotate on attending to a MHCU

Some participants felt that there is a need for rotation so that all nurses have a fair chance to work with MHCUs. Other participants felt that it is better for a certain nurse to do mental health only because they all have their own specialities and they do not want to end up doing something that they do not like. Most of the MHCUs are attached to certain professional nurses and refuse to be helped by other professional nurses.

“Maybe the issue of a patient to be assisted by a certain individual in the clinic is wrong because we need to rotate.” (fg3: pg37)

“and other professional nurses will complaint that when sister so and so is doing the mental health clinic she is taking long why, because with me I just take a few minutes, it is because when they asked the patients questions they will just say I’m fine because they don’t trust and they are not used to other professional nurses.” (fg3: pg49)

“so if understood your statement well it means the patient becomes so attached to a certain professional nurse who is rendering mental healthcare services that they actually don’t want to be seen by another nurse or they are reluctant to see other professional nurses.” (fg1: pg7)

Finfgeld-Connet (2006:712) posits that enacting presence has a positive effect on the nurses’ mental well-being through increased job satisfaction, learning and maturation, and increased self-confidence. Rotation includes line and staff functions, which are different methods of assigning authority in an organization. Nursing practice and such methods should be implemented to provide proper patient care (Booyens, 2008:127). According to Chang *et al.*, (2009:10-11) job rotation is regarded as a method of allowing employees to learn job skills from different departments. It eliminates employee fatigue caused by tedious job assignments. In a study that was done by Van Deventer *et al.* (2008:136-140), PHC nurses did not have the necessary skills and expertise to manage the mentally ill and in the same study MHCUs complained of seeing different healthcare workers every time they required follow-up treatment.

3.3.1.1.6 Sub-theme 1.6: MHCUs should be prioritized

The majority of participants felt that MHCUs should be attended to as soon as they arrive at the clinic to prevent them from becoming irritable. A few participants were of the opinion that MHCUs should and must be treated like any other client and they must also queue because the clinics use the supermarket approach. This is confirmed by the following statements:

“When a patient arrived with a referral letter like that, we should see them first and put a sticker on their files.” (fg2: pg30)

“So if we can immediately approach them, treat them and let them go because they won’t stand in the queue like a normal patient, so hence when I treat them I give them first preference, I attend to them and let them go.” (fg4: pg57)

“We need to prioritise like I said earlier fast lining them so that by the time they get irritable or whatever or they fighting anybody that already being assisted.” (fg3: pg48)

“People like that we must try to help them first because they are really in a bad space because they are depressed.” (fg3: pg23)

“But now if you can fast line them and prioritise them, you will be able to assist them nicely vulnerability can be revertible.” (fg3: pg49)

“You see now what I was saying that if there is now two psychiatric clinics and with the influx of the patients that you receive, you either have to create a queue, so we are not dealing with one passer-by of a patient, say for instances you have 20 psychiatric patients that comes on a monthly basis, those patients they will queue, so the issue of you trying to expertise they will still be subjected to queue because of the limited resources.” (fg4: pg57)

“...and with the management of this patients jwale ka ntate ane a bua ka di community healthcare workers (like what Participant 3 was saying) they should also be involved in psychiatric patients because it is like ha bana clue (they don’t have a clue) gore (like) prioritising psychiatric patients it is like..., because they say..., they argue like that this patients are living with other people so why are you treating them special because they should also queue in the line like others and for us at the clinic it is not right to allow psychiatric patients gore bafole line ba etseng ba etseng the whole day (like psychiatric patients busy queuing in the line doing this and that for the whole day).” (fg3: 49)

Literature confirms that queue management is about ensuring fairness and demonstrating to the clients at the PHC clinics that they are waiting in a planned environment, while reassuring them

they will be attended to timeously (Sokhela *et al.*, 2013:2). The “fast queue” strategy was implemented to resolve challenges in the arrangement of healthcare services so that the patients who come for a brief or routine follow-up consultation, including patients and families of patients with mental illness who come for treatment and follow-up, would not be kept unnecessarily in the PHC clinic for the whole day (Sokhela *et al.*, 2013:2).

3.3.1.2 Theme 2: Holism

The participants mentioned a number of sub-themes regarding their ability to deliver holistic care to the MHCUs in a PHC setting. Holism and holistic care in this regard refers to holistically attending to the physical, psychological and spiritual health of patients (Finfgeld-Connet, 2006:710). These sub-themes are discussed in the paragraphs following below.

3.3.1.2.1 Sub-theme 2.1: Holism is affected by shortage of staff

Participants acknowledged that shortage of staff, the increased workload and their attitude towards mental health make it impossible for them to deliver a holistic care to MHCUs at primary healthcare level. In certain clinics where specialized psychiatric services are rendered, the psychiatric nurse is able to deliver holistic care to MHCUs, although in most instances they are also pressed for time and are instructed to assist with other programmes at their clinics. This is confirmed by the following statements:

“You must remember we are in PHC and in PHC it is ‘sister my kop is seer’, (sister I’ve got a headache) sister ek hoes vir 3 weke’(sister I’ve been coughing for 3weeks), now you come with your psych needs to me and the clinic is full and the day is short and the staff..., we are 3 sisters in the clinic and per month we see two thousand and something patients, really it’s a challenge to be holistic and then the other thing is my attitude of a PHC sister towards the same psychiatry.” (fg1: pg8)

“It is not about time management, it is about staff shortage because if we could be enough staff then one person can attend to that patient accordingly, but now you have to attend to all the other patients that are waiting for you outside.” (fg3: pg42)

We don’t have time to go deeper, it is highly impossible, you treat them and let them go.” (fg3: pg1)

“It is very important to be holistically there, because if you are not holistically there you are only going to give the treatment without approaching the emotional, spiritual and whatever the patient is presenting with.” (fg2: 24)

"I think it also goes down to shortage of nurses because that must also be looked at because at the clinics there are such great numbers of patients, you only give medication, even health education you hardly give it, it is always nstate take your treatment and leave then you call' next' and it is not supposed to be like that." (fg3: pg38)

"That question means that you may not be necessarily focus on the mental status alone at that given time when you are with them assessing them. It means you are also looking for things such as the sti's, HIV and all the other things, it means you are looking into it in totality." (fg4: pg61)

"But now there is no time and there are no personnel." (fg2: pg28)

A shortage of human resource is a big challenge that results from financial constraints, also in the FSDoH. Even though the Department of Health is experiencing challenging staff shortages, therapeutic presence is essential for congruence. For presence to be enacted, the patient must experience a holistic need and be open to experiencing presence and caring (Finfgeld-Connet, 2008:113; 2006:7008). This is evidenced by physical, psychological and spiritual distress. The nurse must possess self-knowledge, a willingness to be present and professional knowledge (Finfgeld-Connet, 2006:711).

According to a study done by Mkhize and Kometsi (2008:107), PHC nurses reported that time constraints and heavy workload effect on their ability to meet the needs of MHCUs and their families. Mkhize and Kometsi (2008:107) further mention that PHC nurses tend to miss the warning signs of relapse, e.g. not giving attention to somatic complaints where there is no physiological cause. Literature confirms that nurses at the PHC level seem to focus on the clinical examination of the body and do not concentrate on the mental aspect of a MHCU (Marais & Petersen, 2015:14). Muller *et al.* (2006:478) report that it is important to manage resources in such a fashion that they support policy and the strategy of an effective operation to the process.

3.3.1.2.2 Sub-theme 2.2: Lack of information and confidence

In all the focus groups, participants stated that they find it difficult to render holistic care to MHCUs because they lack information and confidence on how to manage and handle MHCUs at PHC level. Some are really scared of these patients. The following statements confirm these findings:

"I mean the only information that we have is whilst we were students doing psychiatry, but now...., we don't know anything." (fg2: pg22)

"It is like they were told that these patients they are so dangerous and that prevents them to render a holistic care or approach to these patients because they don't want anything to do with

this patients, it is like certain people must attend to this patients like myself and participant 1, the rest don't want anything to do with this patients.” (fg3: pg44)

“But now you must also understand that without information we lack confidence and that is why we are pushing them to those that we think can handle them better, so we need some form of in service trainings (laughing).” (fg3: pg. 44)

“Yes to me as a PHC nurse I'm being paid to do PHC and when the patient come here with somaticized psych things, hi it's not my business.” (fg1: pg18)

“What you have said about psychosomatic illness there is this psychiatric patient that we all ignores when he comes to the clinic and we will say like oho ona le a motseba kaofela ke ntate Thabo o be a ntse a lla ka mahlaba (ohoo we all know this is papa Thabo who always complaints about pain).” (fg3: pg. 50)

This situation is confirmed by several examples. The spokesperson of the South African Depression and Anxiety Group, Casey Amooore (as quoted in Lund *et al.*, 2010:393), for instance reported that: “We all know how difficult it is for patients with psychiatric illnesses to get appropriate help.” According to Mkhize and Kometsi (2008:107), proper staffing and the appropriate number of PHC nurses with an appropriate skills mix will promote collaborative working relationships and improve attitudes to ensure an adequate PHC service to prevent the relapse of a MHCU at PHC level. In a study that was conducted by Marais and Petersen (2015:4), negative attitudes and lack of experience or training in mental health among PHC nurses in particular was identified as a major barrier to the integration of mental health into primary healthcare.

3.3.1.2.3 Sub-theme 2.3: Overcrowding at PHC facilities

Participants mentioned that most of their clinics are overcrowded and that they are overworked to such an extent that they even lack the spirit of *ubuntu* (humanity) towards the MHCUs at PHC level. Participants feel dissatisfied with the quality of work that they are delivering and feel that they are not acknowledged and taken care of. This is confirmed by the following statements:

“No we do try, but we also see how much time we have, if I have 20 to 30 patients waiting for me I can't sit with that patient for an hour, it's just no way and sometimes they do need more than half an hour because they are so upset and we need to calm them down.” (fg2: pg. 25)

“I think in PHC we are overworked, underpaid and not being recognised, so really, I really think we need debriefing sessions. Sometimes when you looked at the patients coming in and going

out and you heard of a patient who died then you asked yourself oh what did I missed because we do miss a lot of things, the work is too much, it is an inhuman the situation at PHC.” (fg1: pg9)

“Like I said this integration is really posing a problem and it is like we are working according to the statistics like we want to see 20 patients per day so..., it’s kind of making us insensitive towards our MHCUs, instead of picking up you know those ‘smallanyana’ (minor) issues that we can address before they become bigger problems we miss them.” (fg1: 7)

Literature confirmed the above reports. Overcrowding at the clinics as the primary point of contact with the patient has some effects on both the patient and the healthcare worker. According to Bahadori *et al.* (2017:2), clinic and outpatient visits are increasing and this has led to overcrowding, long waiting times and patients and employees dissatisfaction. PHC facilities were not prepared for the sudden influx of clients, which resulted in an increased workload, leading to long waiting times and dissatisfaction with the service (Sokhela *et al.*, 2013:1). A study conducted by Sokhela *et al.*, (2013:2) found that insufficient staffing contributed largely to dissatisfaction and burnout among healthcare workers at the PHC clinics. Mash *et al.* (2010:128) report that heavy workload in PHC clinics is a source of job stress.

3.3.1.2.4 Sub- theme 2.4: Lack of resources

Lack of resources was also one of the major challenges for participants. This includes inadequate mental health training, lack of psychiatrists, lack of skilled psychiatric nurses and lack of psychiatric medication at most of the clinics. Participants revealed that they find it difficult to manage a MHCU at PHC level without the necessary resources. Some participants complained that resources are allocated to the specialized clinics only, while other clinics are expected to deliver the same services to MHCUs as their specialized colleagues while they either have limited resources or nothing at all. The lack of resources is discussed under the following headings:

- **Inadequate mental health training**

Participants were concerned that they only have basic psychiatric knowledge from their training. They do not receive any refresher courses and they are not updated in the psychiatric field, yet they are expected to render a service to these patients. Participants also feel that they are working in isolation and that they are excluded from mental health training programmes running at the psychiatric complex. These are confirmed by the following statements:

“Remember I have done twenty years back psychiatry and was in an institution where I dealt with psychiatric patients, now I’m twenty years in PHC, what do I know now about psychiatry.” (fg1: pg9)

"I mean the only information that we have is whilst we were students doing psychiatry, but now...., we don't know anything." (fg2: pg22)

"The environment outside there is cruel to the poor psych patients and we know it, but we don't have time, we don't have resources." (fg1: pg16)

"Don't you have training there at the psychiatric complex for PHC nurses like contacting the clinics and making them aware that you are having training sessions such as Schizophrenia at the complex and you need available PHC nurses to attend just to get a better understanding." (fg2: pg32)

The situation is confirmed by a study that was done by Petersen and Lund (2011:751-757). They report that PHC nurses and doctors who are often the first contact with the healthcare system revealed insufficient training and support in the emergency management of MHCUs, especially those in an acute state of mental illness and the severely mentally ill MHCUs. One of the recommendations made in the Mental Healthcare Act(17 of 2002)for improving decentralized emergency care was to improve training and support of PHC nurses and doctors for management and referral cases as set out in the Mental Healthcare Act (17 of 2002). According to Marais and Petersen (2015:4), service providers are not sufficiently trained to deal with mental health issues and they are trained in a biomedical orientation towards acute care instead of holistic and patient-centred care.

- **Lack of psychiatrists at the down-referral clinics**

Most of the participants felt that they attend to psychiatric patients without the help of a psychiatrist. They do not even have a general doctor to prescribe or renew the prescriptions. As a result, they have to refer the patients to other clinics or hospitals where psychiatrists are available on a daily or monthly basis. This is confirmed by the following statements:

"I want to say thirdly that the patients come here with down referrals, but we have no psychiatrists on site." (fg2: pg33)

"Exactly because I feel if that patient can be followed up at the specialist block every second week or once a month whatever the need may be, then it is far better than sending the patient to the local clinic for follow up where the patient is seen once a month by the outreach team (psychiatric doctors) where else the specialist block is having doctors on a daily basis." (fg3: pg46)

Literature confirmed the above statements. According to Shierenbeck *et al.* (2013:117), a shortage of doctors is identified as a general hindrance to the enjoyment of the right to health in South Africa. However, the problem is worse for people suffering from a mental illness, which can

be indicated as a barrier to receiving proper mental healthcare services due to the lack of properly trained staff, including the great shortage of psychiatrists who can properly diagnose and treat mental disorders at PHC clinics. This was also echoed by an article written by Ambikile and Iseselo (2016:22), who state that the lack of psychiatrist is actually a global problem. There is not only a shortage of psychiatrists at PHC clinics, but even in psychiatric hospitals.

- **Lack of psychiatric nursing skills**

Participants verbalized that they do not understand psychiatry and do not know how to manage psychiatric patients because they lack the necessary psychiatric skills and only depend on the basic psychiatric knowledge that they gained during training. This is confirmed by the following statements:

“Remember I always says there is a specialist for midwifery, there is a specialist for paediatrics neh, but there is no specialist for psychiatry and they expect me as generalist must cater for the specialized areas, it is also a thing that we must be re trained into this thing, but there must be a specialist in the re-engineering process so that we can have a contact and even that same specialist can be trained to train us so that our attitudes at the end can be changed and our skills can be improved by picking up these things, we can even have role plays with that specialist you know to show us this hidden symptoms sometimes when the patients come.” (fg1: pg16)

“My problem with psychiatry is if a patient comes to the clinic and gets moderate, really I have no idea what moderate is, I just inject them and I talk to them and I listen to them, but I have no idea about psychiatry, if the patient comes to me and said sister you gave me an injection but I’m still hearing voices, I have no idea what to do. All I want to know is how to manage a psychiatric patient and it is actually unfair to the patient.” (fg4: pg61)

“Yes that is what we are asking, because we know about TB, HIV, diabetes, hypertension whatever, but I don’t know about mental health rerig (really) maybe if we can get clarity on that (smiling and looking at participant 3).” (fg3: pg42)

“But how do you assist if you don’t have a skill do deal with this patients.” (fg2: pg28)

Literature confirms the above statements. The WHO (2013:23) outlines in its Mental Health Action Plan for 2013–2030 that primary healthcare is the foundation of high quality mental healthcare. Similarly, mental health services are included in the plans for the re-engineering of PHC, which places renewed emphasis on population-based health and outcomes (Padarath & English 2011:203-204). However, factors such as the shortage of PHC personnel, their current lack of psychiatric knowledge and skills ,and their frequent demonstrations of negative attitude towards

psychiatric patients make transformation from institutional and specialist oriented psychiatric services to PHC services difficult (Marais & Petersen, 2015:14). A study that was done by Shierenbeck *et al.*(2013:116) emphasizes that incorporating mental health into PHC without having sufficiently educated staff actually creates a barrier for patients suffering from a mental illness as they won't be able to receive proper mental healthcare leading to inappropriate diagnosis or re-admission to the psychiatric inpatient facilities.

Furthermore, as mentioned earlier, Peterson and Lund (2011:3) mention that PHC nurses and doctors reported insufficient training and support in managing MHCUs, especially those suffering from a severe and acute mental illness. Therefore, one of the recommendations that were set out in the Mental Health Act (17 of 2002) includes the improved training and support of PHC nurses and doctors for the proper management and referral of MHCUs. At the 2012 Mental Health Summit, health Minister Aaron Motsoaledi proposed increasing the production and employment of other mental health professional categories and at the same time ensuring that mental health does not become the sole responsibility of mental health practitioners, but that it becomes integral to the training of all health professionals, especially to those work in primary healthcare services (SAFMH, 2014:2).

- **Shortage of psychiatric medication at PHC clinics**

Participants verbalized that they are expected to help psychiatric patients who had been referred to their clinics, but most of the clinics do not even have basic psychiatric medication, leading to the patient being sent from one clinic to another in search of medication. This, according to the participants also leads to the many relapses and re-admission of patients to the psychiatric complex. These are confirmed by the following statements from the participants:

“So they come to us in one month and the same month must go to another clinic where there is psychiatric medication because we don't have medication here.” (fg 2:pg34)

“Like at my clinic there are not much psychiatric patients maybe because I don't have their psychiatric medication so they come to this clinic (clinic where the focus group was held) well I don't have it, we don't even have Voltaren injections only pills, (laughing) don't have Rivotril at the clinic, they are at hospital level, but for now when they are down referred they don't come to the clinic, they come to the hospital.” (fg3: pg38)

“Yes and I'm chasing them away telling them that they should come to this clinic (clinic where the focus group was held) (laughing).” (fg3: pg53)

“My statement says if you can make psychiatric services available in three clinics and give them all that medication for psychiatry because I can tell you in my clinic we don’t have Modecate, Clopixon depot, we do not have all the psychiatric medication, we only have Serenace, Nuzak and Trepilline that’s all.” (gf4:pg60)

“Another thing is that we don’t have certain anti-psychotics at the clinic (specifically referring to chlorpromazine).” (fg4: pg68)

“But if they are on any other medication please don’t refer them to the clinics that do not have their medication.” (fg2: pg34)

Literature confirms the above statements. According to Petersen and Lund (2011:3) some studies suggest that psychotropic medication is not universally available at PHC clinics across the country and this poses a risk to adequate treatment compliance and increases the likelihood of defaulting and relapse, leading to the re-admissions of psychiatric patients. Sunkel and Viljoen of the South African Federation for Mental Health (SAFMH, 2017:2) confirm that psychiatric drug shortages threaten patients with relapse, loss of employment and social isolation. In a survey that was done by the SAFMH (2017:2), it revealed that most psychiatric patients have been turned away from PHC clinics without at least one of their medications. Contrary to this, the National Health Mental Health Policy Framework and Strategic Plan 2013–2020 in South Africa made the commitment that all psychotropic medicines as provided on the standard treatment guides and the essential drug list will be available at all levels of care, including primary healthcare clinics. However, this is not happening and it remains a challenge.

3.3.1.2.5 Sub-theme 2.5: Stigmatization of MHCUs by PHC nurses

This sub-theme was repeated directly or indirectly in most of the groups. Participants strongly emphasized that the healthcare professionals play a leading role in stigmatizing the MHCU. Some participants’ complaints that the very same PHC nurses who happen to be their colleagues with a basic knowledge of psychiatry are the ones that attach a stigma to psychiatric patients. Participants mentioned they have also seen this type of behaviour and attitude towards MHCUs from the medical doctors either at the clinics or at the hospitals when psychiatric patients go for follow-up on other medical conditions. They felt that mental health policy framework does not provide sufficient guidance on how stigma should be addressed. Some participants suggested that the mental healthcare coordinator should play her role in terms of prioritizing issues surrounding mental health at PHC level, including addressing the issue of stigmatization. This is confirmed by the following statements:

"I really don't think so, it is like ehmm I'm looking for this word, it is a scary thing or ha ke itse (I don't know) ikare (it is like) if you talk about psychiatric patients even professional nurses they will say no nono ijoooh I want nothing to do with those patients keep him away, ikare (it is like) they are aliens and they don't treat them as human beings." (fg3: pg43)

"So when he was taken to the doctor and the doctor just say no no this is a psych patient, just get him out of my face, so this is what is happening to the psych patients that is why I say information...". (fg3: pg.: 52) "I think is all original fear of being misunderstood or humiliation for feeling stigmatized or whatever." (fg1: pg4)

"Mental health and the coordinators they are also failing us somewhere somehow because they are like non-existent so if people can be made aware of mental health and the coordinators they are not making it a point that mental health is out there and for me as a professional nurse I have realised that the rate of mental illness is going higher and higher and with the increase rate of mental illness nothing is been done about it." (fg3: pg51)

"And it is still the same that is why I said this demarcation of resources you are actually creating a stigma. The coordinator for psychiatry should facilitate the availability of psychiatry everywhere." (fg4: pg60)

"It is like the way they treated people with HIV in the beginning." (fg3: pg43)

Literature also addresses the fact that stigma is a major barrier to healthcare and good quality of life. According to a study that was done by Egbe *et al.* (2014:23) healthcare providers are often guilty of treatment stigma to MHCUs. Due to the fact that mental healthcare has been integrated into primary healthcare services in South Africa, many healthcare providers at primary healthcare level who have not been exposed to patients with mental disorders, now have to provide services to MHCUs. Various authors describe that psychiatric stigma truly affects the well-being of MHCUs and reduces their rate of recovery (Egbe *et al.*, 2014:29). Marais and Petersen (2015:4) emphasize that negative attitudes and lack of experience and training in mental health by primary healthcare nurses in particular can lead to stigmatization, which is a major barrier to the integration of mental healthcare into primary healthcare services as most of the primary healthcare nurses believe that psychiatric patients need psychiatric hospitals. In a study that was done by Abera *et al.* (2014:4), the majority of PHC nurses expressed discomfort about the idea of being directly involved with MHCUs and felt that services for people with mental illness should be delivered in a separate facility.

3.3.1.3 Theme 3: Intimacy

Two sub-themes emerged under the theme “Intimacy,” which in this case means that presence is closely “being with” a patient (Finfgeld-Connet, 2006:710).

3.3.1.3.1 Sub-theme 3.1: Nurses are empathetic and firm

In terms of intimacy, participants feel that they have to balance having empathy and being firm. They do have empathy for their patients, but they still have to be firm and must educate them on the inappropriate behaviour. Some participants felt that they need more listening and communication skills to go deeper and to reach the emotions of the MHCUs when seeing him/her at PHC level. They felt that there is also a need for a therapeutic relationship between the nurse and the MHCU and for increasing the communication between the MHCU and the PHC personnel, even though they understand that they use the supermarket approach where they do not really have time to listen attentively to the MHCU. Other participants felt that they will reach out to the MHCU, but will never touch them even if they are depressed for fear of being physically abused. The MHCU may interpret reaching out and touch wrongly and some psychiatric patients might have their own agendas. The following statements illustrate this point:

“If I can say something, we need to be very careful there. We have empathy for the patient and not sympathy. We have empathy for the patient but still be firm enough to give education and tell what is wrong is wrong.” (fg3: pg47)

“We are also supposed to be empathetic and not sympathetic because if you are sympathetic you are creating problems now because the patient keep on running to you with problems and the patient must be able to stand up for him/herself and some of the clinics they don’t do that.” (fg2: pg26)

“I’m not saying eh you will be on the level empathetically with the patient, you will be there for him but still being objective not losing your objectivity to keep you therapeutic relationship.” (fg1: pg12)

“You know sometimes these intimacy are good but you won’t know what goes on in the mind of a psych patient.” (fg4: pg63)

“But I won’t touch the patient or give him a hug, no I won’t do that because I think that is there personal space or they might just say something else into it, but ja no only those ones.” (fg2: pg2)

“You will have to be warm, understanding and empathise and not be judgemental.” (fg4: pg. 69)

Literature reveals that the characteristics of a discharged MHCU points towards the need for presence during the encounter with the nurse and the importance of trust and rapport (Finfgeld-

Connet, 2008:111-119). A relational skills set includes the PHC nurse's ability to recognize a MHCU's therapeutic communication needs, to use the right words and gestures and the capacity to be available as needed with behaviours such as attentiveness, active listening, quiet availability and touch (Tavernier, 2006:299-322). According to Sariah *et al.* (2014:10), MHCUs often experience periods of despair due to their psychiatric symptoms or other psychosocial problems. Therefore, the presence of someone who can provide hope and empathy, such as the PHC nurse, will help the MHCU through difficult times.

3.3.1.3.2 Sub-theme 3.2: Humanity

Participants linked the attribute "intimacy" with the concept of "humanity," also called "*ubuntu*." Participants felt that both nurses and doctors lack the spirit of *ubuntu* towards MHCUs. Even the Non-Governmental Organisations (NGOs) and the primary care takers of the MHCUs lack the spirit of humanity. Some participants felt that NGOs and other half-way houses are just taking MHCUs in for the sake of money and do not really care about them. The same applies to the families of the MHCUs. Participants felt that some PHC nurses have no heart for psychiatric patients and really need the spirit of *ubuntu* (humanity) because if you have the spirit of *ubuntu* as a PHC nurse, you will be able to accommodate the MHCUs at PHC level. The following reports as quoted from the focus groups support the above theme:

"It goes back to humanity, I mean botho ba hao (your humanity) because if you are doing this not for the sake of money or just doing because you must do it, you will be having a good interaction with them (MHCUs)." (fg3: pg48)

"PHC they are taken so serious by the community neh, they will even go and knocked at your door at 22:00 am at night when they got problems (laughing), so with the spirit of Ubuntu you will accommodate them, someone will say hey sister o qadile gape (she has started again), can you assist us, so you see so I think the spirit of Ubuntu is still needed." (fg1: pg20)

"Maybe PHC sisters also need the spirit of "Ubuntu." (fg1: pg58)

A person with *ubuntu* is open and available to others. According to Mulaudzi and Peu (2013:7) the attitude of an individual determines their perception of healthcare. In a study that was done by Mulaudzi *et al.*, (2009:46), a person who embraces *ubuntu* feels and thinks about herself or himself and her/his own health behaviour in relation to others. A nurse must be able to plan services that will be able to accommodate all different individuals and their similarities, as well as their differences. Therefore, or as a result the nurse must be aware of the environment in which he/she operates to be able to intervene appropriately (Mulaudzi & Peu, 2013:7).

3.3.1.4 Theme 4: Vulnerability

Only one sub-theme emerged, namely the awareness that MHCUs are in need of a conducive healthcare environment due to their vulnerability. In terms of vulnerability as an attribute of presence, presence requires both parties to lower defences and to be willing to experience feelings such as being aware of the other person's needs and suffering (Finfgeld-Connet, 2006:711).

3.3.1.4.1 Sub- theme 4.1: Need for a conducive environment

Participants thought that the level of vulnerability in psychiatry is high just by the look of things in the clinics .As they work, they can see that HIV programmes receive a lot of funding, but “have you ever heard something about psychiatry? There is so much discrimination that makes a psychiatric patient and the system around psychiatry much more vulnerable than any other system, especially when comparing psychiatry to HIV, it is as if psychiatry is not part of health. Participants felt that the stigma attached to mental illness makes the MHCU even more vulnerable than medical patients. Participants admitted that even they themselves as PHC nurses cannot reached out to the MHCUs due to their own state of vulnerability created by their lack of knowledge, attitudes, and lack of experience in managing psychiatric patients. This contributes to an environment, which is not conducive for the MHCU. Due to the integration of mental health into PHC, participants feel that they are forced to deal with an already vulnerable psychiatric patient, meaning these patients cannot trust them because they have no interpersonal relationship with the MHCU and they as PHC nurses are forced to do something that they do not even like. Some participant shared the opinion that the psychiatric complex discharges the patient too early, thereby contributing and increasing their vulnerability, which in turn can lead to the many relapses. These are confirmed by the following statements:

“The environment should be conducive that is why we are also emphasising on the resources, gore (so that) patients should feel safe and so that we can have a trusting relationship, I don't know whether I've answered the question correctly.” (fg3: pg48)

“The environment outside there is cruel to the poor psych patients and we know it, but we don't have time, we don't have resources.” (fg1: pg16)

“Another thing is that you people are discharging the patients too early “yes they want beds (loudly), the patient must go not even 'reg' (right). It makes the poor patient even more vulnerable to whatever is happening outside, so you are contributing even more to these things.” (fg1: pg18)

“This integration has caused a lot of problems. You will even find that it exposes the clients to this vulnerability because people end up doing what they don't love.” (fg1: pg16)

The WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being (WHO, 2015:323). Vulnerable and marginalized groups, such as the mental health population, tend to bear an undue burden of health problems and are often less likely to enjoy the right to health (WHO, 2015:323). The WHO also puts strong emphasis on the violation of human rights and their right to receive proper treatment. There are shortages of hospital beds in mental institutions, which often leads to MHCUs being discharged prematurely, in turn leading to high re-admission rates and sometimes untimely death (WHO, 2015:323). According to an article that was written by Janine Bezuidenhout (2016) in response to the Life Esidimeni Healthcare Centre incident, South Africa has a history of being unkind to its vulnerable population and people with mental illnesses are often discriminated against and stigmatized, meaning they often do not have access to the healthcare they need. If they do get it, it is often not the quality of care they need. At the 2012 National Health Summit, the health Minister, Aaron Motsoaledi, also raised a concern that MHCUs are often “voiceless” because of their condition. so there is a need for this vulnerable group to be given space to voice their needs and respond appropriately by including mental health in all other health programmes (SAFMH, 2014:2). According to Kaphagawani and Useh (2013:184), a conducive environment is a one that is supportive and that fosters a good relationship.

3.3.1.5 Theme 5: Uniqueness

Two sub-themes could be identified as linked to uniqueness. Finfgeld-Connet (2006:711) description of uniqueness as an attribute of presence entails that presence takes place in a context of adaptation to unique circumstances. Nurses can be present through flexibility in various ways and on different levels.

3.3.1.5.1 Sub-theme 5.1: Uniqueness is determined by knowledge and skills

Participants felt that adapt to the uniqueness of the user is very difficult as every person is seen and treated as an individual. Most of the participants verbalized that they do not know the users and some are new to them. Other participants felt that it is important to note that if they have information, they will realize the uniqueness of the patient. A lack of information makes them ignorant to some of the psychiatric symptoms. As a result they give analgesics such as Panadol, Brufen etcetera, for certain physical complaints because they do not have information, so information is important. The following reports as quoted from the focus groups support the above theme:

“For me their uniqueness must go with understanding, if you understand psychiatry then you will accept their uniqueness.” (fg 4:pg69)

“So it is important if you have information then you will realise the uniqueness of the patient, lack of information you will just be ignorant.” (fg3: pg51)

“So now you must have enough time as participant 2 indicated so that you can be able to understand his uniqueness and to adapt to his uniqueness.” (fg1: pg19)

Literature confirms the above statements. In a study that was done by Dube and Uys (2015:10), it became evident that MHCUs do not receive the quality healthcare they deserve due to the lack of knowledge and skills among PHC nurses. Staff shortages is another barrier to providing quality mental healthcare to the MHCUs due to the overcrowding and overburdening of multiple programmes, leading to high patient workloads (Dube &Uys, 2015:10). According to Sariah *et al.* (2014:10),MHCUs from the study suggested that mental healthcare nurses and psychiatrists should dedicate some of their time to listen to their concerns, but due to the shortage of well-trained mental healthcare nurses, this kind of relationship is impossible.

3.3.1.5.2 Sub-theme 5.2: Nurses have to demonstrate empathy and understanding

Participants felt that PHC nurses should show empathy to the users and not judge them based on the condition and their behaviour. The following reports as quoted from the focus groups supports the above theme:

“You will have to be warm, understanding and empathise and not be judgemental.” (fg4: pg69)

“If I can say you must be empathetic towards what the patient wants to deal with.” (fg1: pg4)

According to Sariah *et al.* (2014:10), people with mental illness often experience periods of despair related to their psychiatric symptoms or the psychosocial consequences of having a psychiatric illness, hence the presence of someone who can provide hope and empathy towards a person’s suffering helps them through these difficult times. In the same study, MHCUs suggested that mental health nurses and psychiatrist should spend time to listen to their concerns.

3.3.1.6 Theme 6: Limiting relapse

Limiting relapse is one of the key therapeutic goals and it is a joint effort that needs a holistic approach from nurses, the psychiatric institution, families and the MHCU him/herself because in many health service settings, patients rely on the advice of healthcare professionals to decide on whether to continue their medication or not. Professional attitudes therefore play a crucial part in influencing the patient’s perception about psychotic relapse and pharmacological treatment (Chan *et al.*, 2011:325). Eight sub-themes could be identified linked to limiting relapse.

3.3.1.6.1 Sub-theme 6.1: Positive attitude among nurses

Participants acknowledged their own feelings, mentioning that they must understand, listen, feel and be sensitive towards MHCUs by displaying a positive attitude among themselves when dealing with psychiatric patients. Participants admitted that even though they are outside the field of psychiatric nursing, with the new system or the integration, they still have to be therapeutically there for MHCUs as PHC nurses by displaying a positive attitude.

The following reports as quoted from the focus groups supports the above theme:

“We are there eh we must be there for them and have that positive attitude towards them when they are visiting the clinic.” (fg1: pg4)

“Our positive attitude means, I mean there therapeutically you must be there, you must listen, you must understand, you must deal, you must be there in the type of a healing.” (fg1: pg4)

Literature confirms the above statements. According to Marais and Petersen (2015:37) the attitude that mental health is not the responsibility of primary healthcare nurses, coupled with severe workloads and other pressures, lead to poor uptake of guidelines in treating mental health. According to Mkhize and Kometsi (2008:107), proper staffing and appropriate number of PHC nurses with appropriate skills mix will promote collaborative work relationships and improve attitudes among nurses to ensure an adequate PHC service to prevent the relapse of a MHCU at PHC level. In a study that was done by Abera *et al.* (2014:3), 93.0% trained PHC nurses who had experience in clinical attachment during pre-service training had more positive attitudes towards delivering mental healthcare compared to those without pre-service training in mental health.

3.3.1.6.2 Sub-theme 6.2: Primary nurses should have the spirit of *ubuntu*

A person's attitude determines their perception of healthcare. Nurses felt that *ubuntu* plays a major role in limiting relapse, though some PHC nurses have no heart for psychiatric patients and really needs the spirit of *ubuntu* (humanity). If you have the spirit of *ubuntu* as a PHC nurse, you will be able to accommodate the MHCUs at PHC level as was discussed in sub-theme 3.2 under humanity. The following reports as quoted from the focus groups supports the above theme:

“Maybe PHC sisters also need the spirit of “Ubuntu.” (fg1: pg20)

“So with the spirit of Ubuntu you will accommodate them, someone will say hey sister o qadile gape (she has started there at home again), can you assist us, so you see so I think the spirit of Ubuntu is still needed”(laughing) (fg1: pg20)

In a study that was done by Mulaudzi *et al.*(2009:46), they found that a person who embraces *ubuntu* feels and thinks about herself or himself and her/his own health behaviour in relation to others. In a nurse, such view is about how others will benefit or how their decisions as nurses are going to affect the user. A nurse must be able to plan services that will accommodate different individuals and their similarities as well as their differences. Therefore, the nurse must be aware of the environment in which he or she operates to be able to intervene appropriately (Mulaudzi &Peu, 2013:7).

3.3.1.6.3 Sub-theme 6.3: Proper referral system

A lack of continuity of care is also seen as a challenge due to the inappropriate referral system. Participants stated that there is a poor communication line between the clinics and the psychiatric institution, which hampers the continuity of care and leads to MHCUs being sent from one clinic to another in search of follow-up medication, often resulting in relapse. Participants also stated that they have no clue how the referral system works, they do not know who to refer to and when is it really appropriate to refer a patient to the next level of services. The following reports as quoted from the focus groups supports the above theme:

“their letters must be addressed, they must (referral letter) be specific so that when they go to the reception for registrations their letter must be addressed to a specific sister or the sister in charge so that we can know really this one must be prioritised.” (fg2: pg30)

“And also the referral point, if they are now relapsing whom do we talk to.” (fg2: pg32)

“...and your referral to us, I don't send a patient to gateway (another specialised clinic) without a proper referral and say there you go, I phone them first and tell them about the patient to get an appointment date for the patient, I mean can't we start doing this with the psychiatric complex, because usually the psychiatric complex sent the patients with only one month supply of medication without a prescription, we don't have doctors and our doctor is fully book for months in advance.” (fg2: pg 32-33)

“Can we also go back to the referral system, if a patient must be referred to whom, where to and how, because now I will see the patient is having a problem but where do i refer to, so we need that proper referral system which can help us.” (fg3: pg54)

“Then we know who to speak to, just need better communication between us and the psychiatric complex.” (fg2: pg32)

“I just want to ask when you give the patients the discharged letters, how do you communicate? Do you only communicate with the patient or also with the clinic or how do you communicate?” (fg4: pg57)

“I think the biggest problem here is a lack of communication within the different structures above to the different places, there is no proper communication.” (fg4: pg69)

“Why they are doing that, we don’t know so that must first be corrected because you before you send a patient to a tertiary institution he/she should have first gone to the district hospital and then to the regional hospital before going to the tertiary hospital.” (fg4: pg70)

According to Marais and Petersen (2015:14), there is a communication breakdown between the different healthcare providers, especially between the hospital, clinics and pharmacies. There are instances where there is breakdown in communication between the clinic and the hospitals that is down-referring MHCUs, leading to patients being sent from one facility to another. This results in relapse, as was stated by one of the participants. Marais and Petersen (2015:14) further state that a lack of continuity is a challenge because of poor communication between the critical departments, such as the poor follow-up or tracking of patients for adherence of those admitted to an institution and then down-referred to the clinics for their monthly follow-up medication. This results in patients more often relapsing. In a study that was done by Dube and Uys (2015:8), PHC nurses complained that continuity of care is a challenge because they do not receive feedback when a user has been referred to the psychiatric hospital, the whole up and down-referral system is a broken chain. In my own experience, this is indeed a true reflection of the current situation in the mental health up and down-referral system.

3.3.1.6.4 Sub-theme 6.4: Need for half-way houses

Half-way houses keep mental health patients out of hospital and assist with the recovery process. This takes the pressure of psychiatric wards and allows patients a meaningful recovery. Participants mentioned that there is a need for half-way houses while other participants feel that the half-way houses are not treating MHCUs well and that they are just after their money. There is no proper supervision and MHCUs deteriorate physically at the hands of caretakers at the half-way houses, as was mentioned by one participant. The following reports as quoted from the focus groups support the above theme:

“That is why I was saying there must halfway houses that can assist with the recovering of those discharged patients.” (fg4: pg66)

“Mhhhh and we don’t have halfway houses.” (fg4: pg66)

“Ja (yes) I think there is an overall problem with people who are in charge of these halfway houses because the prime function is to care for these people (MHCU) but if you look at them it is not like that.” (fg3: 47)

“Besides their mental illnesses they will be having other problems like their feet will be swollen, others having Ascites, gore it will be terrible conditions that they are sitting with them, so if these people (halfway houses/ NGO’s) can also be involved in decision makings and be involved in everything o the patient you know.” (fg3: pg47)

“It is like they are more after money than taking care of them (MHCU’s), they don’t give the patients their treatment and they will always be very dirty and very sick.” (fg3: pg47)

“Even if you asked them at the halfway house who is giving the patients their medication, apparently there is no trained staff, at times there is nobody to issue the patient’s medication.” (fg3: 48)

According to Marais and Petersen (2015:11), the move to deinstitutionalization and introduction of community-based services has been slow and services are largely concentrated at institutional level. The gap in the provision of community-based residential care and psychosocial rehabilitation programmes to facilitate recovery and reintegration into the community, many patients relapse and have to be re-admitted to the hospital. In cases where residential facilities exist, a lack of structured psychosocial programmes at these facilities is a problem. At the 2012 National Health Summit, the Minister of health, Mr Aaron Motsoaledi, called for a move away from a “hospicentric” approach to the treatment of mental illness and the up-scaling of community-based mental health resources to reverse the trend of institutionalized care (SAFMH, 2014:2). Contrary to what the Minister of Health said at the National Health Summit in 2012 about deinstitutionalization and the up-scaling of community-based mental health resources, sadly many MHCUs have lost their lives and others were admitted to different general hospitals for treatment of physical ailments during the Life Esidimeni Healthcare Centre process of deinstitutionalization. According to the National Mental Health Policy Framework and Strategic Plan 2013–2020, the Provincial Departments of Health will license and regulate the provision of community-based mental health services by NGOs and for-profit organizations, such as community residential care, day care services, and half-way houses. This is in keeping with Section 43 of the regulations of the Mental Healthcare Act. NGOs will also play an active role in the provision of health education and information on mental health and substance abuse and targeting vulnerable groups such as women, children, the elderly and those with disabilities.

3.3.1.6.5 Sub-theme 6.5: Family support / need for family support

Poor family support in individuals with mental illness is a common problem and ignorance about symptoms and treatment often result in relapse. People with mental illness need critical support from their family members to assist them during their recovery process. Participants verbalized that most of the time users are alone at the clinics with no family member to accompany them, making it very difficult for healthcare workers to educate family members on the basic needs of the MHCU. The following reports from the focus groups support the above theme:

“We must tell him just to bring a family member so that whatever we explained to the patient at least there is a second ear because they tend to forget.” (fg1: pg5)

“Because family support is very important for the patient.” (fg1: pg5).

“There is nobody accompanying the patient to the clinic, there is nobody supervising the taking of medication, which can also lead to relapse.” (fg1: pg10)

“Yes family should be more involved in the patients care because at the end of the day patient is 29 days with the family where else the patient come to us for an hour for that month.” (fg3: pg40)

Literature confirms the above statements. According to Sariah *et al.* (2014:9), the family environment is a contributing factor to the relapse or rehabilitation of a MHCU, therefore the role that the family plays is a very important factor in affecting the mental well-being and outcome of the user. The kind of support that the family provides to the users, such as giving and supervising medication and accompanying users to the mental health facilities regularly promote adherence and assist in the recovery process of MHCUs(Sariah *et al.* 2014:9). In a study that was done by Monyaluo *et al.* (2014:4), families reported that they want nurses to teach and educate them about the signs and symptoms of relapse and aggressive behaviour and how to seek assistance and in the same context this statement was supported by Du Plessis E. (2014), who say that family needs support from healthcare professionals in mental health education. The WHO (2001:3) indicates that with regular partnership with families through regular contact, health staff are able to learn from families what knowledge, attitudes and skills are needed to enable them to work together effectively. Families in turn benefit from learning a process of problem solving in order to manage their relative’s mental illness most effectively.

3.3.1.6.6 Sub-theme 6.6: Adequate nursing personnel

The participants felt that the provision of adequate nursing personnel was an important point and it was repeated by all four groups as a burning issue. The incorporation of mental healthcare into primary healthcare without the adequate nursing personnel and other resources has created a

barrier for MHCUs to getting appropriate mental healthcare at PHC clinics. It also leads to early discharge of MHCUs from psychiatric institutions. Participants pointed out to the lack of resources such as inadequate staff, lack of facilities as facilities cannot cater for the growing population of South Africa. They regard this a departmental issue that needs intervention. In such instances they have to do what is practically necessary and they have to protect the rights of patients. The following reports as quoted from the focus groups supports the above theme:

“But if we can be provided with enough staff, enough hands to attend to our patients i think our attention to them will be more.” (fg1: pg5)

“it is about staff shortage because if we could be enough staff then one person can attend to that patient accordingly, but now you have to attend to all the other patients that are waiting for you outside.” (fg3: pg42)

“As long as the resources are not responding to the demand, it goes a long way because it is a departmental intervention. As I said the population has grown, how many people of Lesotho is staying in South Africa now?” (fg4: 70)

“...and now let me tell you psych has changed, the corporation has increased but the resources has not expanded and there is more substances available now as it used to be before, a lot of substance induced psychosis, so the system has not expanded to accommodate the changes in the community and everything so if I see you look a bit better then obviously I'm going to accommodate the more psychotic one, and then within 2-3 weeks you will be back, so it sticks to the availability of resources.” (fg4: pg66)

Literature confirms the above statements. According to a study that was done by Marais and Petersen (2015:13), there is a shortage of human resources, services continue to expand and expand, but the staff structure remains the same over the years. This leads to burnout, work overload and people leaving the services. Muller *et al.* (2009:478) report that it is important to manage resources in such a fashion that they support policy and the strategy of an effective operation to the process. Mkhize and Kometsi (2008:107) mention early in their study that proper staffing and the appropriate number of PHC nurses with an appropriate skills mix will promote collaborative working relationships and improve attitudes to ensure an adequate PHC service to prevent the relapse of a MHCU at PHC level. A study conducted by Sokhela *et al.* (2013:2) reported that insufficient staffing contributed largely to dissatisfaction and burnout of healthcare workers at the PHC clinics.

3.3.1.6.7 Sub-theme 6.7: Continuous education of PHC nurses

Lack of training and knowledge on mental health among PHC nurses is a contributing factor to poor management of psychiatric patients. Participants feel that for them to understand mental health issues and to manage mental health disorders they need continuous education and in-service training just like the other programmes that are presented and followed at the clinics. The following reports as quoted from the focus groups support the above theme:

“...don't you have training there at the psychiatric complex for PHC nurses like contacting the clinics and making them aware that you are having training sessions such as Schizophrenia at the complex and you need available PHC nurses to attend just to get a better understanding.”(fg2: pg32)

“Why is this mental health not been followed up and also in PHC someone must be trained not only in one specific clinic, someone must be trained, yes we only have the basic training, but there must be a focal person who is evaluating how the program is doing and the data and the trainings.” (fg2: pg33)

“So we need some form of in service trainings.” (fg3: pg44)

According to Marais and Petersen (2015:37), providing staff with training and support must be seen as one way to combat the integration of mental health into primary healthcare as well as dealing with the high staff turnover. Training therefore has to be continuous and consistent. These trainings must be followed up to ensure that nurses are following the guidelines in identifying mental health issues. Providing staff with training was further emphasized by Bezuidenhout (2016:3) in her opinion on the Life Esidimeni incident, namely that all healthcare professionals of different levels should be trained on how to manage mental healthcare disorders. Managers should ensure that mental healthcare and its treatment is an essential part of healthcare delivery. She further mentioned that mental healthcare management should not be a specialized field, but it should be introduced to the broader curriculum for students and covered as a routine care management for healthcare workers. Furthermore, one of the recommendations made in the Mental Healthcare Act(17 of 2002)to improving decentralized emergency care was to improve the training and support of PHC nurses and doctors for management and referral cases as set out in the Mental Healthcare Act (SA, 2002).Dube and Uys (2015:9) further mention in their study that training and capacity building of PHC nurses must be an ongoing process because new nurses who have not been trained in mental health are continuously being allocated to PHC clinics.

3.3.1.6.8 Sub-theme 6.8: Collaboration among families, PHC nurses and psychiatric institutions

People who have been diagnosed with a mental illness are no different from other people and want the same basic things out of life, no matter what others may think about them, because behind the label and diagnosis are real people. The National Mental Health Policy Framework and Strategic Plan 2013–2020 emphasizes that the Department of Health will also engage with consumer and family associations in policy development and implementation, as well as the planning and monitoring of services. The following reports as quoted from the focus groups support the above theme:

“first don’t discharge the patient too soon, secondly do home based care, the re-engineering process to be there and effectively, do home visits, educate the PHC, enhance resources, holistic approach.” (fg1: pg20)

“...even from your institution, I don’t know is it because of shortage from your side, but I have never ever seen a professional nurse accompanying the patients to our clinics (HIV clinic) for their follow up visits, it is always the assistant nurses and in most cases we need a report from a professional nurse because the nursing assistants sometimes can’t give a proper report.” (fg3: pg52)

“...the care at home yes you know when there is team rounds they bring their families with or by another concerned community member or the police, so when they bring the patient you try to educate them, but I’m telling you this thing of patients relapsing immediately after discharge (coughing) it is our own making as the department of health because we do not want to expand and utilise the resources as we should.” (fg4: pg66)

“Ja (yes) it is true what she said (referring to the researcher) in the past as she said we used to have the G2/49 which was the form to discharge a patient, I was also working at the outpatients department then, so we used to phone the clinics and notify them about the patient and their medication, so if the patient defaulted the community psychiatric nurse used to go out to go and see this defaulter hence the hospitals those days were never overcrowded.” (fg4: pg58)

According to the WHO (2001), people diagnosed with mental illness are entitled to be heard in the discussion on mental health policy and practice that involves professionals, family members, legislators and opinion leaders. The WHO also puts strong emphasis on the violation of human rights and the right to receive proper treatment. There are shortages of hospital beds in mental institutions, which often leads to MHCUs being discharged prematurely. This can lead to high re-admission rates and sometimes untimely death (WHO, 2015:323). Collaborative work infers that

conditions that support recovery, such as the provision of hope, facilitating a meaningful life, fostering self-determination and developing supportive relationships are key care drivers (Onken *et al.*, 2007). This means that service users will be encouraged to take the recovery journey, be actively supported in making personal choices and acknowledged as decision makers in their ability to solve personal problems (Kartalova-O'Doherty Tedstone-O'Doherty, 2010; McCloughen *et al.*, 2011). Collaborative work also means that the mental health environment is a respectful system that allows for the knowledge and expertise of both parties to inform the care planning process. According to Robertson *et al.* (2012:419), essential collaboration between the health, welfare, education, justice and other sectors has been lacking. Involvement of service users and their families in the service system has not occurred because there is still an emphasis on curative services, while rehabilitation has been neglected and prevention and promotion remain insufficient.

3.4 Summary

The research findings on exploring nursing presence as an approach to prevent relapse of discharged MHCUs were discussed in this chapter. The researcher integrated the data analysed with the existing literature and supported the findings with direct quotations from the transcripts. The themes and sub-themes that were identified from the focus groups interviews were discussed. Chapter 4 concludes the study report by discussing the limitations, conclusions and recommendations.

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 Introduction

Chapter 3 presented the findings and literature integration. This final chapter of the research study discusses the limitations, conclusions and recommendations. The conclusions provide evidence that the purpose of the study, namely to explore and describe PHC nurses' perceptions on nursing presence as an approach to prevent relapse of discharged MHCUs, was reached. Recommendations are made for nursing practice, nursing research, as well as nursing education.

4.2 Limitations of the research

Although the study provides a rich discussion on exploring PHC nurses' perceptions on nursing presence as an approach to prevent relapse of discharged MHCUs, there are some limitations of the study that should be noted.

The following limitations were identified:

- The semi-structured focus group interviews that were planned to take place in the district boardroom could not take place because the weekly district academic meetings were no longer held at the district boardroom. Each clinic had their own weekly academic and team building meetings at their own facilities. The researcher and area managers, as well as the operational managers from the different clinics, agreed that the interviews should be conducted at different clinics, grouping nearby clinics together over a period of two months. That made it extremely difficult for the researcher to gather the participants at one facility, and it was also very time consuming.
- The planned focus group interviews unfortunately also clashed with the Expanded Programme on Immunization campaign and some of the participants were allocated for the campaign, thus limiting the number of potential participants. At the same time, it was also diabetic month and some potential participants had to attend some of the events. This study involved one part of a district with 12 down-referral clinics in a specific context and smaller clinics that are understaffed, with only two professional nurses on duty, meaning those staff members could not participate as much as they wanted to.
- The study focused on only one district. It is one of the biggest districts in the Free State province, but the psychiatric institution discharges MHCUs to their different districts, therefore

the generalizability of the findings and applicability of the recommendations based on the findings is limited to one district only.

- Other mental healthcare workers such as medical doctors, psychiatrists, operational managers, auxiliary nurses and mental health coordinators were not interviewed while they are important role players in primary mental healthcare services.
- Also, the MHCUs themselves would have been important actors in relating their experience of receiving a nursing presence at the PHC clinics and fully understanding the barriers to mental healthcare and nursing presence.

4.3 Conclusions

The conclusions are based on the research findings as discussed in Chapter 3 and on the relevant literature.

4.3.1 Conclusion 1: Overall conclusion

Although research regarding nursing presence exists in the literature, very little research has been done specifically on exploring PHC nurses' perceptions on nursing presence as an approach to prevent relapse of a discharged MHCU. This study reveals that PHC nurses are willing to provide holistic care and practice nursing presence to prevent relapse in discharged MHCUs, but so many challenges keep them from doing so. These challenges include a lack of resources, lack of training and running multiple programmes, leading to burnout and eventually a "don't care" attitude as a defence mechanism. It is also important to note that despite these challenges, some are really eager to learn more about mental health and are willing to participate in any event regarding mental health despite workplace adversities and their perceived lack of support from their employer.

4.3.2 Specific conclusions

4.3.2.1 Conclusion 2: Conclusion regarding the perception of PHC nurses of attentiveness and sensitivity towards the MHCU

With respect to the PHC nurses perceptions regarding their attentiveness and sensitivity towards the MHCU, they felt that MHCUs face emotional challenges and uncertainties when visiting the clinics because of the mistrust between the MHCU and the nurse. PHC nurses felt that there is no barometer in place to measure sensitivity and it all depends on the clinical manifestation of the user. They use primary and secondary information provided by the user and collateral information

from family members to determine how much time to spend with each user, as each case is different.

Participants were of the opinion that the MHCUs' fear of stigmatization and nurses' negative attitudes are contributing factors to the many relapses. Nurses feel that even though it is time consuming to listen to a MHCU and in spite of their huge workload and being short staffed, they still have to spend more time with them to make them feel comfortable to develop trust between them. They feel that the MHCUs require special treatment and have to be prioritized. Based on these statements, it can be inferred that sensitivity and attentiveness towards the MHCU may play a positive role in limiting relapse and could increase if more staff can be allocated to the different down-referral clinics.

4.3.2.2 Conclusion 3: Conclusion regarding the perception of PHC nurses of holistically focusing on the needs of the MHCU

According to the participating PHC nurses, it is very important for the MHCU to be cared for holistically. This means that they should not merely give treatment or attend to the MHCUs' physical needs without approaching their psychological, spiritual and whatever other needs the MHCU is presenting with at the clinic. PHC nurses mentioned that as much as they would like to deliver holistic care to the MHCUs, a number of factors influence their ability to deliver holistic care to the MHCU in a PHC setting.

They view shortage of staff, increased workload and their attitude towards mental health as factors that make it impossible for them to deliver holistic care to MHCUs at primary healthcare level. Furthermore, they also viewed lack of resources and lack of psychiatric skills as hampering their ability to render holistic care to MHCUs. Therefore, it is the duty of the Department of Health to address the lack of resources at PHC clinics to prevent the many relapses that we are facing in the province at large. PHC nurses can also support each other as a team and by doing so will increase comfort and they will display a more positive attitude towards the MHCU. Developing a therapeutic relationship among themselves is seen as supportive and goal-oriented. It will therefore increase the level of sufficient holistic care towards the MHCU, which will limit the relapse of a MHCU.

4.3.2.3 Conclusion 4: Conclusion regarding the perception of PHC nurses of engaged availability or interpersonal connectedness with the mental healthcare user in limiting the relapse of a MHCU

PHC nurses emphasized the importance of a therapeutic relationship between themselves and the MHCU to increase their level of communication. Most of all they feel they must have listening

skills to be available to the MHCU, but again insufficient time compromise the quality of care they want to deliver to the MHCU. It is important to note that it is emphasized by authors such as McMahon and Christopher (2011:78) that the willingness of a nurse to engage with a patient is not dependent on time available to spend with the patient.

The response from participants on their therapeutic commitment indicated their understanding as PHC nurses and their attitude towards the MHCUs' behaviour and mannerisms, as well as their empathetic understanding of the MHCU. In conclusion, nurses felt that it is good to have an intimate therapeutic relationship with the user, but they felt that they have to be more cautious of getting too close to the MHCU as they experience the MHCUs as unpredictable and acknowledged that they need training on how to manage a psychiatric patient.

4.3.2.4 Conclusion 5: Conclusion regarding the view of PHC nurses of vulnerability and mutual trust sharing between the professional nurse and the MHCU

With regard to their view on vulnerability, PHC nurses feel that due to the integration of mental health into PHC they are forced to deal with an already vulnerable psychiatric patient. An effective interpersonal relation with the MHCUs including warmth, mutual trust and empathy are important characteristics for the PHC nurse to build a supportive relationship with the MHCU. They acknowledge that these patients sometimes find it difficult to trust them because they (MHCUs) are used to only one psychiatric nurse. They also feel that the stigma attached to mental illness and early discharge from the psychiatric complex to the clinics makes the MHCU even more vulnerable than the patients with more general medical conditions. PHC nurses feel even themselves as PHC nurses find it very difficult to reach out to the MHCUs due to their lack of knowledge, their attitude towards the MHCUs and their lack of experience in managing psychiatric patients. This contributes to a lack of mutual trust and an environment that is not conducive for the MHCU, which in turn can lead to the many relapses. They call for training, addressing stigma and a multidisciplinary team approach.

4.3.2.5 Conclusion 6: Conclusion regarding the perception of PHC nurse of adapting to the unique circumstances of the MHCU

Despite their lack of psychiatric nursing knowledge and skills, PHC nurses were of the opinion that they have to treat every MHCU as an individual, demonstrate empathy and understanding and not judge them based on their condition and behaviour. Such an approach may make a significant difference in limiting relapse in MHCUs.

4.3.2.6 Conclusion 7: Conclusion regarding the factors that can contribute to limiting the relapse of a MHCU

MHCUs rely on the advice of healthcare professionals on whether to continue with their medication or not. Limiting relapse is one of the key therapeutic factors and it is also a joint effort that needs a holistic approach from PHC nurses, the psychiatric institution and the families of MHCUs. According to PHC nurses, one of the key factors in limiting relapse is for them to display a positive attitude among themselves when dealing with psychiatric patients, meaning that they must acknowledge their own feelings and understand, feel, listen and be sensitive to MHCUs. Even though they are not in the psychiatric field and lack the necessary knowledge and skills, the integration of mental health into primary healthcare leads nurses to feel they must be therapeutically available for MHCUs. PHC nurses felt they have to display a positive attitude among themselves. Some felt that some of them have no heart for psychiatric patients and need the spirit of *ubuntu*, which will enable them to accommodate the MHCU at PHC clinics.

From their point of view, PHC nurses see the lack of continuity of care as a challenge. This is caused by an inappropriate referral system and the poor communication line between the psychiatric complex and the down-referral clinics, leading to MHCUs being sent from pillar to post in search of medication, which is a big contributory factor to the many relapses. Another point of view of the PHC nurses pointed to the need for half-way houses that could assist with the recovery process after being discharged from the psychiatric complex. However, some nurses were of the opinion that the half-way houses actually contributes to the many relapses as MHCUs are not being taken care of properly. Family support came out as a strong factor in preventing the many relapses. PHC nurses experienced a challenge with families who refuse to accompany MHCUs to the clinics for follow-up treatment. This make it difficult for them as nurses to discuss with the family on the mental health problems and concerns of the user.

PHC nurses point out the lack of resources such as inadequate staff, lack of facilities, as facilities cannot cater for the growing population of South Africa. They view this is a departmental issue that needs intervention. They have to do what is practically necessary and have to protect the rights of patients. PHC nurses feel that for them to understand mental health issues and to manage mental health disorders, they need continuous education and in-service training just like the other programmes offered and followed up at the clinics. PHC nurses also emphasized the need for collaborative work and better communication between the PHC clinics and the psychiatric institution as they feel that the psychiatric complex personnel work in isolation.

4.4 Recommendations for nursing education, nursing research and nursing practice

Based on the research findings and the conclusions, the following recommendations for nursing education, nursing research and nursing practice can be formulated.

4.4.1 Recommendations for nursing education

- Nursing education should aim to include the recommendations of this study in the basic nursing curriculum offered at universities and nursing colleges. This is in line with the South African Nursing Council Act 33 of 2005 (SANC Nursing Act no. 33 of 2005)(SANC, 2005)which stipulates that the objectives of nursing education is to prepare student nurses to function independently and competently in rendering comprehensive nursing care and to assume responsibility and accountability for such practice.
- Student nurses allocated to psychiatry should be placed in both in-patient settings and primary healthcare settings. This would allow them to gain more insight into the importance of continuation of mental healthcare services and it will facilitate the transfer of theory into clinical practice.
- Professional nurses, especially those who are dealing with the mental health programmes at the PHC clinics, should create a conducive environment and a positive atmosphere. They should create interesting learning programmes that will attract young nurses to the psychiatric nursing field.
- There should be continuous education, ongoing training and support of PHC nurses as almost all participants at the different clinics emphasized that they should be encouraged to allow all primary healthcare nurses to practice their skills as psychiatric nurses.
- Although nursing presence is a challenging and perhaps a difficult concept to understand, an introductory programme on nursing presence must be incorporated into the undergraduate programme to ensure that students understand and develop presence skills that are consistent with the goals and policies, not only in mental health, but across the nursing profession. This will teach the students the importance of nurse presence interventions.
- In agreement with Bright (2012:520), as part of their practical placement nursing students should be accompanied by their lecturers for the purpose of reflecting with the students on their experience of providing nursing care to MHCUs, on practicing nursing presence and on how nursing presence may prevent relapse in MHCUs.

- Nurse educators should teach nurses presence by fostering this attitude during the process of nursing education.

4.4.2 Recommendations for nursing research

Further research is needed on supporting PHC nurses to cope with the challenges they are facing in order to prevent the many relapses of MHCUs post-discharge. Based on the research findings and the literature, it is perceptible that further research is needed to explore nursing presence as an approach to prevent relapse of a discharged MHCU at PHC clinics. This research was conducted in only one district of the province, while the psychiatric complex discharges MHCUs to their nearest clinics in all five districts of the province. Therefore, it is strongly recommended that the study be conducted on a larger scale, meaning that all other districts must be included to improve the access and quality of care for MHCUs across the province to limit the relapse of a discharged MHCU at PHC clinics. In addition, further studies should be conducted, especially on the use of a quantitative study to assess the level of nursing presence at PHC clinics in reducing the relapse of a MHCU. It could be a useful tool in monitoring nursing presence and trends of relapse.

Other mental healthcare workers such as medical doctors, psychiatrists, operational managers, auxiliary nurses and mental health coordinators were not interviewed while they are important role players in primary mental healthcare services.

The MHCUs themselves would have been also important actors in relating their experience of receiving a nursing presence at the PHC clinics and fully understanding the barriers to mental healthcare and nursing presence.

4.4.3 Recommendations for nursing practice

The practice of nursing presence should be increased in order to improve the quality of care delivered to MHCUs at PHC clinics. Mental healthcare coordinators have to ensure that PHC nurses receive continuous and ongoing training in nursing presence and in managing MHCUs at their level and support them. The psychiatric complex should arrange ICAM (interactive learning, communication and management) teachings for PHC nurses to keep them informed and updated on mental health issues. Furthermore, the PHC nurses should play a major role in implementing the recommendations as they are the people who are directly involved with the MHCUs post-discharge from the psychiatric complex. The specific recommendations are discussed below.

4.4.3.1 Recommendations regarding nursing presence as an approach to prevent the relapse of a discharged MHCU

The recommendations were developed from the results, conclusions and relevant literature and are presented in Table 4-1.

Table 4-1: Recommendations regarding nursing presence as an approach to limit the relapse of a discharged MHCU (T = theme; S = sub-theme; C = Conclusion)

	Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
PHC nurses should be attentive and sensitive towards the MHCU	<ul style="list-style-type: none"> PHC nurses must be educated in mental health. Coordinators at both district and provincial level should put mental health educational programmes in place such as ICAM teaching to educate PHC nurses on the importance of interpersonal skills and to provide basic training on building a trusting relationship with the MHCU 	T1; S3, C2
	<ul style="list-style-type: none"> Delivering mental healthcare at PHC level should not be done in isolation. There should be effective rotation of PHC professional nurses to and from different programmes so that they can all get enough exposure to the mental health sector to improve their mental health skills. In the process they will gain more experience 	T1; S4, C2
	<ul style="list-style-type: none"> Medical officers at PHC level should also get more exposure to mental health because some level 1 medication only needs a prescription from a medical officer instead of referring the user to a specialized psychiatric clinic 	T1; S3, C2
	<ul style="list-style-type: none"> PHC nurses have to build rapport and facilitate a nurse patient relationship by fostering trust and privacy between the MHCU and the nurse 	T1; S2, C2

Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
<ul style="list-style-type: none"> • The issue of availability of time also has to be addressed by the district manager, area managers and operational managers. In most of the clinics, the participants complained that they are overburdened with work as they are expected to deliver multi healthcare programmes and are expected to see a certain number of clients per day to reach a target set by the department. This may deprive clients of quality nursing presence and care. Government cannot ignore the need to increase the number of PHC nurses if they need to take on more MHCUs at PHC clinics 	T1;S2, C2
<ul style="list-style-type: none"> • Adequate supervision by specialists such as psychiatrists, psychologist and advanced psychiatric nurses and debriefing sessions should be provided to PHC nurses to prevent burnout 	T1; S1, C2
<ul style="list-style-type: none"> • There is a lack of training and insight among PHC nurses to detect and treat mental illness and because of this, PHC nurses have developed a negative attitude towards MHCUs and in the process attached a stigma to this vulnerable population. This issue should be addressed by imparting skills. Training should also address the overall reluctance of PHC nurses to work with people with mental illness. This calls for interventions directed at PHC nurses, mental health professionals, as well as other healthcare providers whose services are vital to the recovery of people with mental illness and the prevention of relapse 	T1;S4, C2

Recommendations		Related findings(Theme no/sub-theme no/ conclusion no)
	<ul style="list-style-type: none"> The fast queue strategy should be strengthened so that patients who report for routine follow-up consultation, including the treatment and follow-up of patients with mental illnesses are not kept unnecessarily in the PHC clinic for the whole day 	T1;S5, C2
PHC nurses should be enabled to deliver holistic care to the MHCUs in a PHC setting	<ul style="list-style-type: none"> Attention should be paid to human resource management issues in the PHC clinics. The focus on resource allocation implies that staffing levels are reduced as a cost cutting measure, while there is an influx of clients to the primary healthcare level, increasing tension between resource allocation and patient advocacy 	T2; S1, C3
	<ul style="list-style-type: none"> An advanced psychiatric nurse should be positioned in a primary healthcare setting to act as a consultant to primary healthcare nurses about mental health conditions and medication 	T2; S4 (c), C4
	<ul style="list-style-type: none"> The psychiatric outreach programme should be addressed. Teamwork and collaboration competency encourage effective interprofessional teams, fostering open communication, mutual respect and shared decisions to achieve quality mental health. Therefore it is of utmost importance that the mental health multidisciplinary team should extend their outreach programme to all PHC clinics, especially the clinics where there is no psychiatric registrars available for renewal of prescriptions and the adjustment of follow-up medications 	T2; S4 (b), C4

	Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
	<ul style="list-style-type: none"> • The National Mental Health Policy Framework and Strategic Plan 2013–2020 (WHO 2013:23)in South Africa made the commitment that all psychotropic medicines as provided on the standard treatment guides and the essential drug list will be available at all levels of care, including primary healthcare clinics • In order for this to happen, there must be proper communication between the psychiatric hospital, the pharmacy at the institution and the down-referring clinics where the MHCUs receive their medication so that all levels of prescribed drugs should be delivered in time before the next follow-up date of the MHCU 	T2; S4(d), C4
PHC nurses should demonstrate engaged availability with the MHCU	<ul style="list-style-type: none"> • PHC nurses must have a good interpersonal relationship with the MHCU.They should balance having empathy and being firm when educating them about their inappropriate behaviors. This in turn will help the MHCU to distinguish between right and wrong, thus making them dependable service users 	T3;S1(a), C4
	<ul style="list-style-type: none"> • PHC nurses should demonstrate empathy and understanding and not judge MHCUs based on their condition and behavior 	T3;S2, C4
	<ul style="list-style-type: none"> • PHC nurses must be open and available and try by all means to accommodate all different individuals from different cultures, religions and their similarities serving them from the top to the 	T3;S2, C4

Recommendations		Related findings(Theme no/sub-theme no/ conclusion no)
	bottom line of the organization in order not to jeopardize the interest of the MHCU. This will show true <i>ubuntu</i>	
PHC nurses should ensure a therapeutic environment at the PHC setting	<ul style="list-style-type: none"> Mentally ill people are a very vulnerable population and easily marginalized. Therefore, many of their behaviors are not inherent, but are the understandable results of an alienating environment and loss of autonomy. PHC nurses should try by all means to make the environment therapeutic for the MHCU, which will in turn improve the mutual trust and respect between the user and the nurse by using basic strategies for engagement. Therapeutic communication and listening could be part of creating a therapeutic milieu and such a therapeutic environment will be beneficial for good compliance and improved nurse patient relationships 	T4;S1, C5
PHC nurses should be flexible and adapt to the uniqueness of the MHCU	<ul style="list-style-type: none"> PHC nurses have be present and flexible in various ways on different levels of caring for the mentally ill patient. They have to show warmth and affection with great compassion and respect. They should meet the spiritual needs of MHCU and, most of all, respect their illness. This will help the nurse to adapt to the unique circumstances of the MHCU and to create a plan of care for the best interest of the MHCU 	T5; S1, C6
	<ul style="list-style-type: none"> PHC nurses should dedicate some of their time to listen to the concerns of the MHCU 	T5;S2, C6
Factors contributing to the relapse of a	<ul style="list-style-type: none"> The district manager, area managers, operational managers in collaboration with the provincial and district mental health coordinators, the Department of Health and the psychiatric complex 	T6, C7

	Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
MHCU should be addressed	<p>should consider addressing the following factors to assist in improving nursing presence of PHC nurses and in limiting the relapse of MHCUs:</p>	
	<p>Encourage positive attitudes among PHC nurses</p> <ul style="list-style-type: none"> • Adequate supervision of PHC nurses should be addressed. Mental health workers from the psychiatric complex should be available at all times to PHC nurses to give guidance and advice on the management of mentally ill patients • Combined team building exercises (psychiatric complex and PHC clinics) at least once a month can bring out a positive attitude among nurses in caring for the mentally ill at PHC level as this will also help with liaison and exchanged of information 	T6;S1, C7
	<p>Encourage Ubuntu among PHC nurses</p> <ul style="list-style-type: none"> • PHC nurses have to be approachable when dealing with MHCUs at their level to avoid negative interaction between themselves and the user. This will go a long way in assisting the users with good compliance 	T6;S2, C7

Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
<p data-bbox="454 395 1126 427">Addressing the need for an effective referral system</p> <ul data-bbox="501 483 1760 1233" style="list-style-type: none"> <li data-bbox="501 483 1760 667">• The absence of a proper referral system and the communication breakdown between PHC clinics, secondary and tertiary care can severely undermine the effectiveness of mental healthcare delivery at PHC level. The Alma Ata Declaration (WHO, 2001:59) called for a PHC system complete with referral systems, supervision and support <li data-bbox="501 687 1760 767">• Discharge planning should be systematic and thorough. This should give a clear picture of the MHCU's clinical picture and to the circumstances to which the user will return <li data-bbox="501 788 1760 868">• PHC services at the down-referral clinic for follow-up should be proactive and occur within two weeks or a month after discharge, depending on the stability of the MHCU <li data-bbox="501 888 1760 1233">• Perhaps there should be a return to the old referral system where the outpatients department clerk at the psychiatric complex and a professional nurse do all the referrals and bookings at the clinics and ensure that MHCU's have a follow-up date at the local clinic. They make sure their medication is available and in turn the professional nurse at the local clinic is aware of or expecting the user on that specific date. Should it happened that the user does not turn up for his/her scheduled appointment, the PHC nurse should make use of the roving nurse to trace the patient and communicate with the psychiatric complex about the missing patient in transit 	<p data-bbox="1783 379 1921 411">T6;S3, C7</p>

Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
<p>Addressing the need for half-way houses</p> <ul style="list-style-type: none"> • The provision and implementation of community-based residential care such as half-way houses for discharged MHCUs should be speed up so that the implementation of psychosocial rehabilitation programmes that facilitate recovery and the reintegration of discharged MHCUs back into the community will assist in limiting the relapse and re-admissions to the psychiatric institution 	T6;S4, C7
<p>Addressing the need for family support</p> <ul style="list-style-type: none"> • The psychiatric complex multidisciplinary team should involve the families throughout the care continuum of the users, especially in their educational plans during team rounds on a regular basis so that family can have a good understanding of managing their loved ones when discharged • This must include family counselling sessions, which can help them with management techniques about the user's mental disorder and the management thereof, at the same time emphasizing the importance of accompanying the user to the local clinic for follow-up treatment • The existing family support groups should be strengthened and PHC nurses should assist the MHCU and the family in coping with the illness and treatment prescribed 	T6;S5, C7

Recommendations		Related findings(Theme no/sub-theme no/ conclusion no)
	<ul style="list-style-type: none"> • PHC nurses should continue to educate family members after discharge of a MHCU to help them understand what the MHCUs are actually going through so that families can motivate them instead of rejecting them • Home visits should be re-introduced so that PHC nurses can have a full understanding of the family function 	
	<p>Addressing the need for adequate nursing personnel</p> <ul style="list-style-type: none"> • Now that mental health has been integrated into PHC and is treated as chronic care leading to an influx of MHCUs to the PHC clinics, the issue of a shortage of staff should be urgently addressed by the department to drive this programme. The nurse patient ratio should be re-visited • When we have more skilled professionals, the department will benefit in the long run by minimizing the challenges caused by unskilled people 	T6;S6, C7
	<p>Continuous education for PHC</p> <ul style="list-style-type: none"> • Short courses in mental healthcare should be introduced for PHC nurses at university level just like other short courses such as Integrated Management of childhood Illnesses (IMCI), reproductive health, etc. 	T6;S7, C7

	Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)
	<ul style="list-style-type: none"> • The provincial coordinator, district coordinator or the psychiatric complex training committee must assist in conducting mental health training programmes for all PHC nurses for basic screening, detection, treatment and the referral of complicated cases to the relevant institutions. This must be done on a regular basis, either bi-weekly or monthly • Training and capacity building of PHC nurses must be an ongoing process because new nurses who have not been trained in mental health are continually being allocated to PHC clinics • PHC nurses should be trained holistically, incorporating training in psychosocial care and health promotion, over and above providing proper mental health and nursing care 	
	<p>Collaboration among families, PHC nurses and psychiatric institutions</p> <ul style="list-style-type: none"> • Better communication strategies must be put in place between the PHC services and the psychiatric complex, such as the district manager and area managers attending the psychiatric hospital board meetings and vice versa and giving feedback on their different facilities • PHC facilities should be part of the mental health events taking place in mental health months on the calendar such as mental health awareness campaigns, media campaigns and interventions to strengthen the collaborative relationship between the different parties. This will also reduce the stigma attached to mental illness at PHC level 	T6; S8, C7

Recommendations	Related findings(Theme no/sub-theme no/ conclusion no)	
	<ul style="list-style-type: none"> • Information and monitoring systems on the integration process must be in place and the clinic committee can be used as the liaison officers from health to other divisions/ departments such as social departments, education, etc. and regular feedback must be given • Collaborative work with traditional healers, families, PHC nurses and the psychiatric institution should be strengthened as most of the service users and families have their own cultural beliefs and tradition that they used for healing purposes. 	

4.5 Conclusion

In conclusion, it can be stated that the goal of exploring PHC nurses' perceptions on nursing presence as an approach to prevent the relapse of discharged MHCUs at the 12 down-referral clinics in one selected area of the district has been reached. This has resulted in the formulation of recommendations to support the PHC nurses in coping with challenges that serve as barriers to delivering proper mental healthcare and practicing nursing presence to the service users.

The recommendations based on the results and conclusions can guide and empower PHC nurses, nurse educators, area and operational managers and the mental health sector at large in supporting the PHC nurses in managing MHCUs at primary healthcare level. Ongoing training and support are needed for PHC nurses with collaboration between the psychiatric complex, families and PHC facilities. The integrated data monitoring system for mental health has to be strengthened. The implementation, evaluation and monitoring of the recommendations that were formulated in the study would help remove the barriers that prevent MHCUs from receiving holistic care and nursing presence at primary healthcare level. These recommendations should be implemented.

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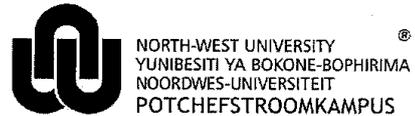
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APPENDIX A: APPROVAL BY INSINQ RESEARCH COMMITTEE



Privaatsak X05, Noordbrug
Suid-Afrika 2522

Tel: 018 299-1882
Faks: 018 299-2999
Web: <http://www.nwu.ac.za>

14 March 2016

Proposal Review: RP MOTAUNG 24766828

The nursing presence of primary health care nurses to prevent the relapse of discharged mental health care users

Proposal Review decision	
Accepted as is	
Accepted with minor revisions	X
Proposal not accepted and needs to be resubmitted	
Other (specify): The student is invited to a meeting with the panel, to discuss the feedback on the proposal.	

Prof Siedine Coetzee
Acting Director: INSINQ
North-West University, Potchefstroom Campus

Members of the Committee:

- | | |
|-------------------|------------------------|
| 1. Dr A du Preez | 2. Dr R van Waltsleven |
| 3. Dr W Lubbe | 4. Mr S Sojane _____ |
| 5. Dr R Pretorius | 6. Dr R Muller |

APPENDIX B: ETHICS CLEARANCE



Private Bag X6001, Potchefstroom,

South Africa, 2520

Tel: (018) 299-4900 Faks: (018) 299-4910

Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel: +27 18 299 4849

Email : Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by **Health Research Ethics Committee (HREC)** on **03/11/2016** after being reviewed at the meeting held on **08/06/2016**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Exploring nursing presence as an approach to prevent relapse of discharged mental health care users.														
Study Leader/Supervisor: Prof E du Plessis Student: RP Motaung														
Ethics number:														
N	W	U	-	0	0	0	4	1	-	1	6	-	A	1
Number		Year		Status									Institution Study	
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation														
Application Type: Single study Commencement date: 2016-11-03 Risk:														
Medium														
Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.														

Special conditions of the approval (if applicable):

x Translation of the informed consent document to the languages applicable to the study participants should be submitted to the HREC (if applicable).

x Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the HREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

x *The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:*

- *annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study*
- *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*

x *Annually a number of studies may be randomly selected for an external audit.*

x *The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*

x *The date of approval indicates the first date that the study may be started.*

x *In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:*

- *request access to any information or data at any time during the course or after completion of the study;*
- *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
- *withdraw or postpone approval if:*
 - *any unethical principles or practices of the study are revealed or suspected,*
 - *it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,*
 - *the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,*
 - *new institutional rules, national legislation or international conventions deem it necessary.*

x *HREC can be contacted for further information or any report templates via Ethics-HRECAppl@nwu.ac.za or 018 299 1206.*

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the IRERC or HREC for any further enquiries or requests for assistance.

Yours sincerely

Prof LA Du Plessis

Digitally signed by Prof LA Du Plessis

Date: 2016.11.08

08:00:55 +02'00 '

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

APPENDIX C: APPROVAL FROM THE FREE STATE DEPARTMENT OF HEALTH



health

Department of
Health
FREE STATE PROVINCE

21 September 2016

Prof F Du Plessis
C/O Ms. RP Motaung
North-West University

Dear Mrs. RP Motaung

Subject: Exploring nursing presence as an approach to prevent relapse of discharged mental health care users

- Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participants must be obtained
- Serious adverse events to be reported and/or termination of the study.
- Ascertain that your data collection exercise neither interferes with the day to day running of the facilities nor the performance of duties by the respondents or health care workers.
- Please discuss with the district manager the transportation of the professional nurse to the district office and indicate how you will mitigate the risk associated with the transportation.
- Confidentiality of information will be ensured and no names will be used.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of North-West and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the University of North West and to Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to ethicsunit@fs.health.gov.za or subclass@fs.health.gov.za before you commence with the study**
- No financial liability will be placed on the Free State Department of Health
- Please discuss your study with the institution managers/CICOs on commencement for logistical arrangements.
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- You are encouraged to present your study findings/results at the Free State Provincial health research day
- Future research will only be granted permission if correct procedures are followed see <http://olud.hst.org.za>

Trust you find the above in order.

Kind Regards

Dr D Motau

HEAD: HEALTH

Date: 20/9/16

Head : Health

PO Box 227, Ekurhuleni, 9300

4th Floor, Executive Suite, Egothen House, on Midland and Harvey Road, Roobolalein

Tel: (061) 400 1527 Fax: (051) 400 1568 e-mail: general@fs.health.gov.za / hr@fs.health.gov.za / hr@fs.health.gov.za

www.fs.gov.za

The letter signed
by HOD is sufficient.
Districts do not give
out permission letters.

Thank you,
Respectfully,
2016/10/27.

APPENDIX D: INFORMED CONSENT DOCUMENTATION FOR PARTICIPANTS



HREC Stamp

INFORMATION LEAFLET AND CONSENT FORM FOR PROFESSIONAL NURSES

TITLE OF THE RESEARCH PROJECT: 'Exploring nursing presence as an approach to prevent relapse of discharged Mental Health Care Users'

REFERENCE NUMBER: NWU-00041-16-A1

RESEARCHER: ROSELYN MOTAUNG

I am a M. Cur (Psychiatric nursing) student and a professional nurse.

ADDRESS:

INSINQ Research focus area

North-West University

Potchefstroom Campus

Private Bag X6001

2520

CONTACT NUMBER: 0824316127

You are being invited to take part in a research project doing research study on '**Exploring nursing presence as an approach to prevent relapse of discharged Mental Health CareUsers**' that forms part of my studies as a requirement for a Magister Curationis (Psychiatric Nursing Science) degree.

Nursing presence means a way to offer caring in a healing way of 'being' and relating to and experiencing a connection between both the MHCU and the healthcare provider (Hessel, 2009:276-281). Presence is thus a skill to facilitate authentic, spontaneous encounters between the patient and nurse to facilitate the well-being of the patient (Rowe & Kellam, 2013:135). Relapse prevention is about maximizing wellness for people with mental illness by reducing the likelihood and impact of relapse (Relapse Prevention Guide, 2012:2). The perceptions of PHC nurses on nursing presence as an approach to prevent relapse in MHCUs will be explored and described.

Please take some time to read the information presented here, which will explain the details of this project. Please ask me any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00041-16-A1) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- This study will be conducted in a safe, comfortable room at the district office boardroom where you hold your monthly meetings and will involve semi-structured focus group interviews. This means that six to ten PHC nurses will be interviewed as a group.
- The purpose of this research is to discuss the views of professional nurses working in primary healthcare on nursing presence as an approach to prevent relapse of discharged MHCU.

Why have you been invited to participate?

You have been invited to participate because you are a PHC nurse who provides continuity of care after discharge of a MHCU from a hospital setting.

You have also complied with the following inclusion criteria:

- Professional nurses employed in government PHC clinics in a specific district, registered with the South African Nursing Council (SANC)
- Professional nurses who are involved in the management and care of MHCU's at the down-referral PHC clinics
- Professional nurses with more than 6 months of exposure in the PHC setting.
- Both male and female professional nurses will be included
- Professional nurses willing to be audio-recorded during a semi-structured focus group interview
- Professional nurses willing to sign a consent form to participate in the study.

You will be excluded if you are:

- An auxiliary nurse or an enrolled nurse
- A professional nurse with less than 6 months of exposure in a PHC setting.

What will your responsibilities be?

You will be expected to share your views and perceptions on nursing presence in relapse prevention of discharged mental healthcare users being treated at your clinic. This will happen in a once-off focus group interview that will last for about one hour. The group will consist of 6-10 participants.

Will you benefit from taking part in this research?

You will not directly benefit, but the indirect benefit will be the benefits to the larger community, namely that the information which will be obtained will help to formulate recommendations on using nursing presence as an approach to prevent relapse of MHCU's. These recommendations will be made available to you and to the relevant policy makers.

Are there risks involved in your taking part in this research?

- The risk in this study is that you might experience emotional discomfort and/or fatigue due to your participation in the focus group interview. I will do my best to ensure that the room is comfortable, comfort breaks will be allowed as needed and refreshments will be served.
- A further risk is that you might feel emotionally burdened to talk about your experiences of working with patients suffering from a mental illness because of the nature of their illness. There will be a psychologist on standby that will provide debriefing if needed.
- Another risk is that only partial confidentiality can be ensured, in other words, the researcher can't ensure that participants will share what happened in the semi-structured focus group interview with people outside the group of participants. To counter this risk, participants will be asked to share information responsibly and to set the ground rules that information discussed during group interviews should not be discussed anywhere outside the group.
- The benefits outweigh the risks involved.

What will happen in the unlikely event of some form of discomfort occurring as a direct result of your taking part in this research study?

Should you have the need for further discussions due to emotional upset; an opportunity will be arranged for you to meet with the psychologist on standby that will provide debriefing.

Who will have access to the data?

- Anonymity is rarely possible with a focus group because of the presence of other participants, but nonetheless the researcher will do everything in her power to ensure confidentiality by processing data anonymously. The following measures will put in place that will limit access to the data:
- The recordings will be destroyed after transcription. Electronic copies of the transcripts will be stored on a password protected computer. These copies will be destroyed after a period of 7 years, by deleting the copies from the computer. Hard copies of the transcripts will be stored in the INSINQ office in a locked cupboard, for a period of 7 years, after which it will be destroyed through shredding.
- A digital audio recorder will be used to record the semi-structured focus group interviews, for comprehensive record keeping. Before the digital audio-recorder will be used in the focus group interview to record any conversations, the researcher will first obtain permission from

the participants and the researcher will not collect data without your permission. As such the researcher will respect the participants' right to privacy. The researcher will maintain confidentiality meaning that no names or even place of employment will be revealed during data presentation to avoid the possibility of linking participants to responses. The data will only be accessible to the researcher (who will also transcribe the interviews), her supervisor and the co-coder. Findings will be anonymous as no names will be disclosed during report writing. The results of the study will be made available to all participants verbally and in writing through meetings with participants, shortly after the examination of the study. The researcher will also submit the report to the Free State Department of Health, the Mangaung Metro Clinic Manager as well as the North-West University.

Will you be paid to take part in this study and are there any costs involved?

No monetary rewards will be given but refreshments will be provided during the focus group interviews. There will not be any costs involved for you, if you do decide to take part. The focus group interviews will be held at your workplace (District boardroom) during office hours, shortly after a monthly district meeting. Permission to conduct these interviews will be obtained from Management.

Is there anything else that you should know or do?

You can contact: ROSELYN MOTAUNG at 082..... if you have any further queries or encounter any problems.

You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled: **Exploring nursing presence as an approach to prevent relapse of discharged Mental Health Care Users** and I consent that the focus group interview may be audio- recorded

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) On (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use an interpreter.

Signed at (*place*) On (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by researcher

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did not use an interpreter.

Signed at (*place*) On (*date*) 20....

.....
Signature of participant

.....
Signature of witness

APPENDIX E: LETTER TO AND CONFIDENTIALITY AGREEMENT WITH MEDIATOR



CONFIDENTIALITY FORM FOR RESEARCH MEDIATOR

TITLE OF THE RESEARCH PROJECT: Exploring nursing presence as an approach to prevent relapse of discharged mental health care users (MHCUs)

REFERENCE NUMBER: 24766828

RESERACHER: ROSELYN MOTAUNG

ADDRESS: 18040 ETHEL MATANG STREET

BLOEMANDA PHASE 2

BLOEMFONTEIN

9323

CONTACT NUMBER: 0824316127

Dear Madam

I am **ROSELYN MOTAUNG** from the North-West University (Potchefstroom campus). I am doing research study on " **Exploring nursing presence as an approach to prevent relapse of discharged mental health care users (MHCUs)** " as a requirement for the Magister Curationis (Psychiatric Nursing Science) degree.

Because of your experience as the Provincial Mental Health coordinator, I would like to invite you to be the mediator of my research project. I would like you to identify possible participants and invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between myself and them.

To follow is information about the study and what will be expected of you should you accept this invitation, so that you can make an informed decision.

Please ask me any questions about any part of this project and your involvement that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to be involved. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU 00041-16-A1)) and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

1.1 What is this research study all about?

- *This study will be conducted at the district's office boardroom where you held your monthly meetings which I believe is a safe, comfortable room and will involve semi-structured focus group interviews. This means that six to eight PHC nurses will be interviewed as a group.*
- *The objectives of this research are to:*
 - To explore and describe the perceptions of PHC nurses with regard to relapse prevention of discharged MHCUs.
 - To explore and describe the perceptions of PHC nurses on nursing presence in relapse prevention of a discharged MHCU

1.2 Why have you been invited to act as mediator?

- You have been invited to act as mediator because you are currently filling a leadership role in mental health and coordinating all mental health programs in the province.
- You have a good and trusting relationship with the professional nurses and district mental health coordinators working at the down referral PHC clinics who are potential participants.

This approach will ensure that potential participants may feel free to ask questions about the research, and may feel free to decide whether they want to participate or not.

➤ **The following are the inclusion criteria according to which you will be requested to identify and recruit potential participants:**

- Professional nurses employed in the government PHC clinics, registered with the South African Nursing Council (SANC) with more than 6 months of exposure in the PHC setting.
- Professional nurses willing to be audio-taped during a semi-structured focus group interview.
- Professional nurses willing to sign a consent form to participate in the study.
- Professional nurses that are directly and indirectly involved in the management and care of MHCU's at the down-referral PHC clinics

➤ **The exclusion criteria includes :**

- Professional nurses with less than 6 months of exposure in a PHC setting.
- All auxiliary nurses and enrolled nurses

1.3 What will your responsibilities be?

- You will be expected to identify possible participants according to inclusion and exclusion criteria and have meetings with potential participants during which you explain the research to them, invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between myself and them.

1.4 Will they benefit from taking part in this research?

- The direct benefits for you as a participant will be to get the opportunity to share your views and perceptions on relapse prevention of a discharged MHCU. In a focus group interview, you may learn how other PHC nurses feels about being "present" as a nurse for a discharged MHCU.
- The indirect benefit will be the benefits to the larger community, and the cost on the health care system will be reduces as the information which will be obtained will help policy makers to take measures that will curb the many relapses and re-admissions of MHCU's after being discharged from the Psychiatric complex.
- The workload for inpatient personnel especially the admission wards will be reduced due to implementation of renewed policies and guidelines that will guide PHC nurses on their nursing presence in relapse prevention of a discharged MHCU.
- No monetary favours will be given in exchange for information obtained

1.5 Are there risks involved in your taking part in this research?

- The risk in this study is that you might experience physical discomfort due to your participation in the focus group interview. I will do my best to ensure that the room is comfortable, comfort breaks will be allowed as needed and refreshments will be served.
- A further risk is that you might feel physically and emotionally burdened to talk about your experiences of working with patients suffering from a mental illness because of the nature of their illness. There will be a psychologist on standby that will provide debriefing if needed.
- The benefits outweigh the risks involved.

1.6 What will happen in the unlikely event of some form of discomfort occurring as a direct result of taking part in this research study?

- > Should you have the need for further discussions due to emotional upset; an opportunity will be arranged for you to meet with the psychologist on standby that will provide debriefing.

1.7 Who will have access to the data?

Anonymity is rarely possible with a focus group because of the presence of other participants, but nonetheless the researcher will do everything in her power to ensure confidentiality by processing data anonymously. The following measures will put in place that will limit access to the data:

- Participants will be provided with a code name and the same code names will be used when discussing data
- The main list of participants' names and matching code with all the data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected.
- Set the ground rules that information discussed during group interviews should not be discussed anywhere outside the group.
- Group members should also be held accountable for maintaining the confidentiality of the group, and group rules to this effect will thus be formulated by the participants
- Data will be kept safe for a period of five years.

An audiotape recorder will be used to record the semi-structured focus group interviews, for comprehensive record keeping. Before the audio-recorder will be used in the focus group interview to record any conversations, the researcher will first obtain permission from the participants and the researcher will not collect data without your permission. As such the researcher will respect the participants' right to privacy. The researcher will maintain confidentiality meaning that no names or even place of employment will be revealed during data presentation to avoid the possibility of linking participants to responses. The data will only be accessible to the researcher (who will also transcribe), her supervisor and the co-coder. Findings will be anonymous as no names will be

disclosed during report writing. The results of the study will be made available to all participants verbally and in writing through meetings with participants. The researcher will also submit the report to the Free State Department of Health, the Mangaung Metro Clinic Manager as well as the North-West University.

1.8. Will you be paid to act as mediator in this study and are there any costs involved?

No monetary favours will be given in exchange for acting as a mediator in the study. There will also be no cost involved for you should you agree to act as a mediator.

1.9. Is there anything else that you should know or do?

- You can contact: ROSELYN MOTAUNG at 0824316127 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

If you have any questions regarding participation in the study, you are welcome to ask me (ROSELYN MOTAUNG) or my supervisor (Dr EMMERENTIA Du PLESSIS) any questions before you decide to give consent. You are also welcome to contact me at 0824316127 or my supervisor at 018 299 1876.

Declaration by mediator

By signing below, I Nomsa Berlina Leshotho agree to be the mediator in a research study entitled: **The nursing presence of primary health care nurses to prevent the relapse of a discharged mental health care user (MHCU)**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.

- I undertake to keep all information relating to participants and this research confidential.

Signed at (place) Bloemfontein..... on (date) ...26 September 2016...



Signature of mediator



Signature of witness

1.7.1 Declaration by person obtaining consent

I (name) ...Roselyn Motaung..... declare that:

- I explained the information in this document to: Ms NB Leshotho
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did/did not use an interpreter.

Signed at (place).... Bloemfontein..... On (date) ...26 September2016...

.....

Signature of researcher

.....

Signature of witness

APPENDIX F: LETTER TO AND CONFIDENTIALITY AGREEMENT WITH CO-CODER



HREC Stamp

REQUEST TO BE CO-CODER OF MY RESEARCH PROJECT

TITLE OF THE RESEARCH PROJECT: Exploring nursing presence as an approach to prevent relapse of discharged mental health care user

REFERENCE NUMBER: 24766828

RESEARCHER: ROSELYN MOTAUNG

ADDRESS: 18040 ETHEL MATANG STREET

BLOEMANDA PHASE 2

BLOEMFONTEIN

9323

CONTACT NUMBER: 0824316127

Dear Sir/Madam

I am **ROSELYN MOTAUNG** from the North-West University (Potchefstroom campus). I am doing research study on **“ Exploring nursing presence as an approach to prevent relapse of discharged mental health care user”** as a requirement for the Magister Curationis (Psychiatric Nursing Science) degree. I would like to invite you to act as

independent co-coder in this study. To follow is information about the study so that you can make an informed decision.

1. PURPOSE OF THE STUDY

The purpose of this study is to:

- To explore and describe the perceptions of PHC nurses with regard to relapse prevention of discharged MHCUs.
- To explore and describe the perceptions of PHC nurses on nursing presence in relapse prevention of a discharged MHCU

Audio-recorded data of semi-structured focus group interviews will be transcribed. You will be expected to analyze the data according to the process of content analysis. You will be expected to follow the following steps during data analysis, namely:

- Ideas and topics must be listed to match the content.
- Organise topics together into columns and cluster similarities together.
- Spend extensive time reading and thinking about the data.
- Code the data. The process of coding involves identifying small topics of information in the text, and then assigning a label to the code. The first level of coding should be descriptive, using participants' phrases as the label for the code.
- Repeat this process with all transcriptions.
- Form themes from the codes, and then organise the themes into larger units of abstraction to make sense of the data.
- Analyse the data together with the researcher.

When you are finished with co-coding, you will be expected to arrange with the researcher for a meeting to reach consensus on the codes, themes, and subthemes that emerged from the data. The research will be conducted under the supervision of experts in Psychiatric Nursing Science and Nursing Research at the School of Nursing Science at North West University.

If you have any questions regarding participation in the study, you are welcome to ask me (**ROSELYN MOTAUNG**) or my supervisor (**Prof Emmerentia Du Plessis**) any questions before you decide to give consent. You are also welcome to contact me at 0824316127 or my supervisor at 018 299 1876.

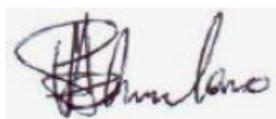
Declaration by the co-coder

By signing below, I Leepile Alfred Sehularo agree to be the co-coder in a research study entitled: **The nursing presence of primary health care nurses to prevent the relapse of a discharged mental health care user (MHCU**

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I undertake to keep all information relating to this research confidential.

Signed at (*place*) North-West University (Mafikeng Campus) on (*date*) 25 February 2017



.....
Signature of co-coder

.....
Signature of witness

Signed at (*place*) On (*date*) 20...

.....
Signature of researcher

.....
Signature of witness

APPENDIX G: TRANSCRIPT OF ONE OF THE FOCUS GROUP INTERVIEWS

The focus group interview was conducted at the Psychiatric Complex PHC Programmes Unit in the Mangaung Metro District. Six participants volunteered to participate in the study, but one participant promised to join later as he was busy with an emergency, but he unfortunately never turned up. The researcher introduced herself to the participants and explained the purpose of the study. The confidentiality and anonymity of information was explained to the participants, as well as the use of an audio recorder.

Facilitator: Good afternoon everybody and welcome to this focus group session. Thank you for being on time. We are here as a group today to discuss with you... I am Roselyn Motaung, I'm a researcher and I'm also a professional nurse, working in the Acute Wards and we are currently experiencing a big problem with relapses and re-admissions shortly after a MHCU has been discharged from the institution and down referred to her/his nearest down referral clinic. I'm currently doing a study based on exploring nursing presence of the PHC nurse as an approach to prevent relapse of discharged mental healthcare users. I am here to discuss with you your feelings, your emotions, experiences and your perceptions as PHC nurses when you receive a discharged MHCU at your clinic as an approach to prevent the many relapses.

Do you understand?

Group: (Yes)

Facilitator: My...ehmm lecturer is Prof Emmerentia Du Plessis, she is the one who is guiding and supervising my studies and she is currently at the NWU Potchefstroom campus. So eh your inputs and the information that you are giving is of utmost importance to me so that I can see and make recommendations on how best we can assist each other in order to prevent the many relapses that we are experiencing currently. You will see that a consent form was placed on each chair as each participant must sign a consent form. The study is voluntarily and you will be excused and you will not be punished if you don't want to participate. If you are happy with the content of the consent form you can sign.

Is it ok with everybody?

Group: Yes it is ok.

Facilitator: Is there any an uncertainty or questions or clarity that you would like to ask, maybe based on the topic that we are going to discuss or anything that you need clarity on?

Participant 1: Ok, now that you said we are going to discuss the topic based on the research are we going to be paid for our participation?

Group: Laughing

Facilitator: Laughing, no there will be no monetary value, but eh you will be provided with refreshments for participating in this conversation

Participant 1: Ok, thank you

Facilitator: Any other uncertainties?

Group: Everything is fine (participants still paging through the consent forms)

Facilitator: In that case, can we formulate ground rules. Can we all please put our phones on silence, but if you are expecting an important call or any work related calls, you can excuse yourself and go and answer your phone. Any other the ground rules that you want to add?

Group: silence... (Only the sound of paper, some participants still paging through the consent form)

Facilitator: the session will last for about 45- 60minutes, but we might finish earlier depending on the information given. So when coming to confidentiality whatever we are discussing inside here will remain with us inside here, and the video clip eh, we are being audio taped, are you aware that you are being audio taped?

Group: yes we are aware of the audio recording

Facilitator: I cannot guarantee total confidentiality and anonymity outside because we are a group and what we share inside here will remain with us here, but what you share outside the group I cannot be held responsible for discussions outside the group. The audio recording will also be seen by my supervisor. So thank you for your attendance and if you have all signed the consent forms, can I have them back?

(Noise of paper for ± 3minutes, participants still signing and facilitator showing them where to sign)

Facilitator: Thank you all for signing the consent forms, so now that we have all signed can we start?

Group: Yes

Facilitator: In the mean time during discussing please don't mind me, I will be taking notes. Remember there is no right or wrong answer, whatever information you are giving to me is right, it will help me in formulating recommendations in assisting relapse prevention. Before we continue are we all clear on the topic?

Participant 2: can you repeat the topic?

Facilitator: Ok (topic slowly repeated) ya utlwahala? (Is it understandable?)

Group: Yes

Facilitator: What are your perceptions on attentiveness and your sensitivity towards MHCUs when you receive the MHCUs at your clinic?

Participant 3: Very important, because ja mhhhh when a patient come to us I think he is also afraid and stressed of will this person really understand , will this people really be able to support me or listen to me or will they really understand my problem or they could come with the attitude of nobody cares and they don't give me what I need and I don't trust them, so There's a lot of factors playing a role when a patient comes to the clinic, I think is all original fear of being misunderstood or humiliation for feeling stigmatised or whatever. There is so many things that can play a role, so our sincerity, our interest, our earnestness, really our willingness to listen to bridge that fear or barrier between me and him, I think is very important that we should spent time enough time with our patients in order for them to be comfortable and for them to develop trust in us and also our intentions in being there for them

Facilitator: nodding her head, ok

Participant 2: ok , I think attentiveness needs time , to take time off to spend and to listen to the patient what he/she is saying and as we know as PHC nurses with psychiatry or to deal with psychiatry it is a time consuming process and the thing for us in PHC as nurses and due to our restraints of personnel and really time is a factor when you look at the queues is not always so possible to listen to him, but what they understand is to listen and feel for them and be sensitive toward, I think also there we as PHC nurses is long out of this field of psychiatry as we think, but with the new system or this integration we are there eh we must be there for them and have that positive attitude towards them when they are visiting the clinic .

Facilitator: ok ehmm what do you eh, can you elaborate more when you say the positive attitude of nurses

Participant 2: our positive attitude means, I mean there therapeutically you must be there, you must listen, you must understand, you must deal, you must be there in the type of a healing,, I don't know what to say, type of a healing approach towards the patient you know even if I can say you must be empathetic towards what the patient wants to deal with.

Facilitator: Mhhhh, ok

Participant 1: and what I would like to say is my perception towards our attentiveness is that we are not paying full attention to that patient and the patient who was admitted is the one that needs our attention so that he can feel secured with us, not thinking or being afraid to come to the clinic or to come to us, so but lunch we don't have it because of the population that we are attending to per day, so to my understanding maybe it can contribute to that, but if we can be provided with enough staff, enough hands to attend to our patients I think our attention to them will be more and also to try and be caring and show because they must feel that we are caring for them and that we are not rejecting them it will prevent the relapses

Facilitator: Mhhhh, I heard you saying so that they may not be scared, do you think the patients when they are discharged many of them relapse because they are scared to go the clinic or can you perhaps explain to us more about that one

Participant 1: yes, you know when they go to the clinic for the first time and meeting us as PHC nurses because they are used to see the nurse for the whole day and be able to communicate at any given time, but seeing now the new environment where they are supposed to be cared for so they will become scared because we don't give that full time or show them that we are having time for them, so we fail them and they don't want to come back hey...laughing

Group: laughing...

Facilitator: laughing, ok any other additions?

Participant 4: Ja , I also believe that being sensitive to the user and being attentive will sort of relaxed him and also make him welcome, remember he is from another setting.... he is from a ward where there is a program where things are done routinely and now he will definitely have questions as to how this setting now operates . Is it the service where I came from or how is it exactly going to happen or how are things going to happen like in the hospital they are giving me tablets , what is going to happen here cause I'm not going to sleep at the clinic definitely, so what is going to happen, he will definitely have questions and I believe as a PHC nurse I have to be ready to answer to those questions and be in position also to give honest answers to the MHCU, that is why the other thing that one must consider is to ehmm.. maybe if he comes for the first time alone we can encourage him, but for the second time we must tell him just to bring a family

member so that whatever we explained to the patient at least there is a second ear because they tend to forget so at least if there is a second ear he can be reminded what the sister at the clinic said you must do because family support is very important for the patient soeh it is important to listen because when you listen there are things that you are going to learn from the user himself , it is not that because you are a professional there is nothing that you can learn from this person, maybe there are things that you have been doing , but haven't doing it correctly, there is one or two things that you are going to learn, maybe a change that you have to make to accommodate this one coming from the institution, maybe he is MHCU who is working , he will be having questions like...ehmm, what are the times of service, am I allowed to come here during my lunch time because I'm working, you cannot tell him no after 12hoo I'm also on lunch you cannot come here, you have to make space , you can always play around with your lunch time because you are rendering a services and this person that is in need must always get the service anytime he wants, I mean if we go back to the BathoPele principles.....mhhhh

Facilitator: mhhhh do you mean your presence as a nurse must be there, I mean your nursing presence now comes in for your patient?

Participant 4: yes, mhhhh, yes.

Participant 3: can I continue, sorry for chipping in

Facilitator: no it's fine, you can continue

Participant 3: he raised something that is also troubling me , our patients come into this very very busy clinic and there's people running around and his file is been shuffled into you 'hokkie' for this patient just to come quickly in because there's a lot of people waiting behind him to be helped and the moment you show that you are not there for him fully.....,ehh, that you have all the time, that you are only in the presence of him now , your mind is on all the work outside , if he cannot feel that he has your full attention and time, he will now come up with simple symptoms that even you will feel it is not important , and that symptoms in the end will cause him to relapse , just because there was not assertive enough to stand up for his rights and tell you everything that is wrong with him, if you don't pulled it from him and see which is linked to him, you are going to miss something seriously and he will not trust you and the moment he is not trusting you, he will not tell you his problems or make a plan to tell you , he will go home with symptoms un... unsaid and that will be the cause of him relapsing in the end because of your attitude, your time schedules, your....., approach towards him , it's so important for us to have time for our patients

Facilitator: Mhhhh, ok in other words the clinics are... if I have to say this it means your clinics are so busy that you really don't have time to sit down and give your full attention to your patients

Participant 3: and your non-verbal is also playing a role because you don't know when are they going to finished today (using her hands to explained non-verbal communication and her watch hand for time schedules) the moment you are giving that impression to the patient, he is not going to tell you about his pain which is so deeply hidden that he even himself don't want to talk about it

Silence.....

Participant 5: nna (me) I just wanted to say, like I said that this integration of services within the clinics post a big problem especially on the nursing personnel, yes they are training us to be sensitive ,but I think at some point we don't reach our patients to a certain level, you can try to be sensitive , but you might miss some of the things due to this overworking and so on, because working with a MHCU is quite a challenge, they need to trust you, so what's happening now in the clinics is that you see different patients in one cubicle, previously used to be like you know today is psychiatric clinic and most of the clients that are coming there is psychiatric patients and they even build a relationship amongst themselves but when there is no trust...,hey...,now it is a hall full of people, we are mixed up, she wants sr*Fortein (not real name) and when she peeps in there and see that ohm..., sr A is not there today , she just goes back, so at times it is her or his due date and she is out of treatment and just goes back

Facilitator: so if understood your statement well it means the patient becomes so attached to a certain professional nurse who is rendering mental healthcare services that they actually don't want to be seen by another nurse or they are reluctant to see other professional nurses

Participant 5: JA, they actually bond and build trust and a relationship with the professional nurse

Facilitator: so in cases where the mental healthcare nurse is not there meaning that the MHCU will not see another professional nurse, now in such cases how do you address such an issue?

Participant 5: like I said this integration is really posing a problem and it is like we are working according to the statistics like we want to see 20 patients per day so..., it's kind of making us insensitive towards our MHCU's, instead of picking up you know those 'smallanyana' (minor) issues that we can address before they become bigger problems we miss them

Facilitator: do you mean those issues that you can picked up to prevent a relapse, those that triggering a relapse?

Participant 5: mhhhh

Participant 3: important what she says , sorry mam, then again because people think psych is just psych, it's really a specialized area and for our patients to keep on trusting us we need to be skilled full, we must not....., they must know that they cannot manipulate us , we know them and we understand them more than they understands themselves, so if we keep on integrating our work our level of skills will go down, we really need.... eh our quality of our service will go down, we need to be tip-top or like any other speciality, psych is also a specialised area. You cannot .., and no person is the same, everyone is unique. You need to have the..... For his situation, his unique situation, his unique personality plus his diagnosis that he have. With this dual diagnosis you can't treat a depressive patient with an alcohol problem the same as a schizophrenic patient, your counselling will be different, your understanding will be different, the integration of the symptoms is different, you need to have that deeper understanding to support your patient, you cannot just think that you will listen and it is enough., oh no the patient will manipulate you, you need enough skills

Participant 5: and it doesn't really give you time to listen attentively, he wants to tell you something, but due to time you can't be attentive

Facilitator: ok meaning that in your setting you are pressed for time like you have said in your previous statement that it is all about statistics, you don't have time to sit down with the MHCU when he or she comes for follow up and listening to his problems, but it's all about time

Group: nodding in agreement

Facilitator: I think we have exhausted this question....., laughing

Group: laughing

Participant 1: we should also allocate time for each question

Group: laughing, but agree

Facilitator: ok the second question. .. , are we all satisfied with the first question and it was good points that actually came out, because some of the things we are not aware of what is happening at PHC level , so for me it is good information. So when we come to holism for our MHCU's, what are your perceptions as PHC nurses working with this patient on holistically focusing on the needs of the MHCU

Participant 2: you must remember we are in PHC and in PHC it is 'sister my kop is seer', sister ek hoes vir 3 weke', now you come with your psych needs to me and the clinic is full and the day is short and the staff..., we are 3 sisters in the clinic and per month we see two thousand and

something patients, really it's a challenge to be holistic and then the other thing is my attitude of a PHC sister towards the same psychiatry. Remember I have done twenty years back psychiatry and was in an institution where I dealt with psychiatric patients, now I'm twenty years in PHC, what do I know now about psychiatry, so in the first place, no in the second place if you talk about holism for me it means not ignoring the psychiatric needs neh and don't only take into consideration your surgical, your medical or midwifery and all the others and ignore, so we must go holistically, we must see in all corners to give attentively and sympathetically or empathetically attention to this patients, but for me holism is ignoring, but it is not ignoring the psych and concentrate on the, sometimes...., in the meantime psych needs, as for this 20 years we miss them, they are hidden, you know it's not things that are obvious. You come with a headache, for me a headache means that patient that is....., or you never slept last night. So at the end of the day also my knowledge when it comes to holism will count as a PHC nurse to recognise, identify that need that this patient presented with and due to the fact that its hidden it's not easy and the integration it makes it, I'm telling you 'onmoontlik'(impossible) to go into their direction

Facilitator: do you feel sometimes depressed working with these patients

Participant 2: very depressed

Facilitator: I have arranged with a counsellor to come and see you if the need arise

Group: laughing, but nodding their heads in agreement

Participant 2: I think in PHC we are overworked, underpaid and not being recognised, so really, I really think we need debriefing sessions. Sometimes when you looked at the patients coming in and going out and you heard of a patient who died then you asked yourself oh what did I missed because we do miss a lot of things, the work is too much, it is an inhuman the situation at PHC

Participant 5: nna (me) I will also say holistically we even miss the social part that we should be taken into consideration because PHC nurses used to do home visits especially when you checked your files and see that this patient has not been attending clinic and was supposed be here for follow up on such and such a date and he has never come back, we used to go out and check what is the problem is there somebody at home taking care of this patient, is there somebody at home making sure that this patient is taking his medication on a regular basis, so that part of socially in order to nurse the client holistically we are missing it

Facilitator: is this due to time constraint

Participant 5: yes

Participant 1 : I would like to go back to the point of integrated services, where the MHCUs are to be seen with others , perhaps our challenges that we are having as PHC nurses is when the MHCUs come in the minute...., eh maybe when he produces his card to collect the follow up medication , I think sometimes we so miss some of their needs, just maybe putting our minds on the fact that he is just here for his treatment , so whatever other element he is having we need to take it into consideration ,so that we can be able to managed them, but this integrated issues it put us somehow aside because of the long queues and mixing users with others of physical ailments we miss some of their needs of which is very important , eh so we think if we can go back to that era where we can attend to them specifically maybe we won't be able to miss other things of them because perhaps the queues' won't be long as that of the others....,laughing

Facilitator : ok it goes back to the point, if I have understand your statement well, that the integration or re-engineering part of the PHC is actually not catering for the MHCU if I understand that statement of you well

Participant 1: mhhhh, not re-engineering, the integration of services

Facilitator: so that is how you cannot render a holistic care on the MHCU

Group: yes

Facilitator: anything else or can we move to the next question

Participant 4: I think sister (participant 5) has touch on a point that I want to talk about , community psychiatry which was there before and is no longer in place and one was able to picked up the defaulters and be able to use the government vehicle to follow up on the defaulters and on the very same day in the afternoon maybe after the clinic and you look at your stats and see ok so and so did not , report to the clinic so you have the contact numbers , the address everything and you go there to go and give the medication, it is not that maybe or most of the time that the patient don't want to come to the clinic , they have got other factors, if you put the patient in the middle and look at these other things that surrounds the patient that can also lead to the patient not coming to the clinic and the patient will ultimately relapse ,a patient that is not having food for example there is no urge to wake up and go to the clinic because of the empty stomach. The patient who is having physical ailments together with mental illness ,, really if he is not stable physically you won't expect him also to take care of his mental problemsmhhhh, socially as well, basic family support , there is nobody accompanying the patient to the clinic , there is nobody supervising the taking of medication , that can also lead to relapse because you know our patients will say I don't like this because it makes me drowsy so I won't take it , I won't take leponex , it makes me drowsy, I won't take largactil its does this and that to me, not taking into account the

importance of taking the medication or even reporting back to the clinic sister to say you gave me this last month and this it is what is doing to me , is there a problem or is it me who is the problem . with your expertise you can sit down with the patient and explain to him how the medication works and what can counteracts whatever he is experiencing, not for him to decide that I'm not going not going to take the medication because defaulting also on medication is going to bring back the symptoms and when the symptoms are back its re-admission. all this things surrounding the patient, the environment, our world outside is very cruel, I don't want to go to the clinic because there is this thing attached to it, there is this label attached to it "I'm mad and I don't want to be associated with mad people because going to the clinic I will meet other mad people, so I rather not go to the clinic because I don't want to be seen with mad people because they are also going to label me as being mad

Facilitator: ok , don't you think that the sister ehmm because most of the time they are still having those specific professional nurses who is only doing mental health clinics, don't you think the stigma is also attached , (ok just for interest sake) to the sister because she is the mental healthcare sister , it is not everybody that is running the mental healthcare clinic , because integration is a slow process taking place so there is only this one sister taking care of mental health like they would say the mad sister is taking care of the mad patients. Is it also not a stigma attached to the professional nurse who is rendering mental health services to the patient?

Silence ...

Participant 4: mhhhh not that much because really when we trained , we trained in different disciplines and end of the day one chooses what you want to specialise in , so if I have chosen to specialise in psychiatry I don't see how I can stigmatised myself or regard myself as a mad sister dealing with mad patients . The reason why I chose the speciality is because I have a passion in it and I know what to expect from this and I know the type of patient's I'm dealing with and I know the challenges in this discipline and I'm ready for it

Participant 3: but it's very important what you said (participant 4) in fact what all said. the bio psychosocial approach the one really affects the other one and there's no way that we can't expiry our" kennis"(knowledge) and have that holistic approach to the patient , but unfortunately due to all this factors we miss out

Group: mhhhh we missed it, we miss out

Facilitator: ok we've talked a lot about holism, these questions actually complement each other if you have listened well, so the following question talk about intimacy. What are your perceptions on your engaged availability when you see that patient, in other words your

interpersonal connectedness with the MHCU when you are dealing with that MHCU at the PHC level

Participant 3: I think it goes back also to the first question on attentiveness, sympathetic or whatever, I think it all goes around your rapport, your interaction, you're dealing, your sharing to the level of the patient and if there is like what participant 2 said previously that if there is something very heartfelt about the patient, what is your approach towards it, but if we can't even listen attentively how will we get to that deeper feelings and emotions, so I think this goes more about your rapport

Participant 2: and I think the building of the therapeutic relationship you will be working on it consciously and with follow up it will increase, but from the starting the responsibility is with you with your way, your professionalism, your caring, everything comes through to build that intimacy with the patient, but being very conscious about the professional level, not going into a too familiar situation, be there for the patient without losing your caregiver touch

Facilitator: what do you mean by saying the professional level not going into a too familiar situation?

Participant 2: yeah, I'm not saying eh you will be on the level empathetically with the patient, you will be there for him but still being objective not losing your objectivity to keep your therapeutic relationship

Participant 1: for the interpersonal relationship for our patient to prevent the relapse you find that it is not that much strong, it is weak because to make it strong we need more time to build in or to ..., we need more time to communicate so that whenever your patient leaves your clinic at the PHC at least he or she is sure about mommy as a nurse there that she can trust because of the time we had to be able to discuss the things maybe he was even afraid to bring them up because most of the time we have little time because of the numbers of patient you have to attend, so you will find it is a little bit less and being less it makes our users not to be free, not be able to raise everything up and also to trust us fully so that they can be with us all the time to prevent that relapse

Facilitator: mhhhh it goes back to time, timeframe in other words you people don't have time enough time to spent with the user hence it is not easy for you to pick up that the patient is on the verge of relapse

Group: mhhhh yes

Participant 1: yes because we are in the supermarket where it is just take and go, there is no time because as a psychiatric nurse to talk to the patient so that he can talk back it needs more time, so as PHC nurse we are looking at the patient to say shortly what he wants to say so that I can answer than you leave so that I can help the next one

Participant 2: so your body language is being influenced by your circumstances and all the patients and that patient who is already very sensitive and shy and intimidated will feel that

Group: yes and they are relapsing

Facilitator: time, timeframe ... laughing we can move to the next question. Our patients, our mental health community is a very vulnerable population so when you deal with a MHCU you are actually dealing with a very vulnerable person, so what is your view on mutual trust and sharing between the professional nurse and the MHCU when you see the MHCU at PHC level

Silence.....

Participant 1: ehh, the patient is highly vulnerable, ehh because as we are saying we are working on a time factor and a shortage of personnel, so simply because we don't give them that attention to be closer to us as PHC so the risk for him/her to relapse is very high so that's why that I'm saying that they are more vulnerable

Silence.....

Facilitator: anyone that wants to add something

Participant 2: yes the trust issue is a new thing in nursing more and more it plays a big role ,because we realised that trust is the basis of that therapeutic relationship and it is very important that you should also know in yourself what can influence the trust people have in you and also you have to have trust in your capabilities and your understanding , your knowledge , you must trust yourself to be the expert , and if you have trust and confidence in yourself the patient will sense that one to be able to follow you. You must also be very aware of your effect of your personality, the things that you say, sometimes you make a joke and in your context you understand it, but in his context he will not understand it and he will feel you are making a fool in front of people or whatever. so to be able for the patient to trust you must also be aware of all the factors that will affect his viewing of your relationship so that you should play that therapeutic role and be aware if you slipped up once even if is one small thing he won't be able to trust you anymore, it will affect everything that you do good in the future, so yes trust it plays a big big role in our relationships

Facilitator: yes especially with our MHCU

Participant 2: think about the paranoia that some of them are born with, they will in a normal situation not trust you, what if you say something under more suspicion

Facilitator : if I have to understand you well that one have to have the skill for you to work in a PHC clinic and working with this vulnerable population you must have the skills and the knowledge so that you have a good and understanding interpersonal relationship or that trust worth relationship with your MHCU

Participant 2: Ja, he must also know and he can sense and he will test you, how often do we tell the students working under us that if a patient saw you as a student or new nurse in environment, they will come and try you not because they want to be difficult but to see if they can really trust you

Facilitator: so meaning only a mental healthcare nurse will know a MHCU.... laughing

Group: *Laughing*, yes only those with the skills

Participant 3: I think the level of vulnerability in psychiatry per saying if you look in the clinics as we are working you can see there's a lot that you have heard in the community of money be given to HIV Programs ,but have you ever heard something about psychiatry? Even if you have to look as was said about the re-engineering process there is so much discrimination that makes a psychiatric patient and the system around psychiatry much more vulnerable than any other system and if especially when you compare psychiatry to HIV it is as if psychiatry is not part and parcel of health

Facilitator: it goes back to the re-engineering process if understand you well that psychiatry is not part of the re-engineering process or might be there but on the bottom of the list and not yet fully integrated in the re-engineering process

Group: yes

Participant 3: it is a problem, it is as if in psychiatry now for we as PHC nurses psychiatry is a lost case you know even it comes to knowledge as I said 20 years back we working in the institution where I did my psychiatry when I last heard about it and also due to the patient himself , due to the stigma that make the patient more vulnerable than the other patient , the ordinary medical patient you know and that's why at times where we comes to this thing of the patient posing more problems as a psych patient due to his vulnerable status or due to the stigma attached to him. He somatise his symptoms you know, he don't want to come up... he come up

with little things like headaches, sore throats you know , all those little symptoms such as pain in the back , what is that ?, stressors , you know pain in the neck, pain in the shoulders and we as PHC nurses we don't realised these things because we are not updated with skills , with knowledge and the resources are against us, the processes of integration and these things are against us and make even us more vulnerable to reach this patient who is by the way vulnerable. Even us as PHC nurses we can't reach.., you know if it comes to vulnerable that patient is really marginalised due to my lack of knowledge, due to attitude, you know I told you I was there 20 years back and I don't want anything to do with psychiatry, but if the opportunity appears..., I'm forced to you know and how will I do it to this already patient that is prone to vulnerability , so it means the trust , the thoughts(throwing her hands in the air)

Participant 2: chipped in, so you mean the affect and the accessibility of holistic care with your attitude and your lack of knowledge

Participant 3: yes yes, mhhhh

Facilitator: so it is also about the attitude of PHC nurses outside , it is time, the attitude , the resources for you to managed and be there in your nursing presence for you to be there for your patient , is all about these factors that you have just mentioned

Participant 3: yes to me as a PHC nurse I'm being paid to do PHC and when the patient come here with somaticized psych things, hi it's not my business

Group laugh....

Participant 1: so as I noted previously that mutual relationship is weak because of those staff shortages and whatever, but if the re-engineering can be implemented effectively it will increase our mutual relationship with both our MHCU and because they are vulnerable and our relationship will be more interpersonal when go back to that issue of home visits to increase our relationship more because if this mutual relationship is increased their vulnerability will be less and it will prevent the relapses

Participant 4 : I also think the environment makes the MHCU more vulnerable ,because if you look at the MHCU in the institution that environment is suitable for the MHCU to be able to recover and take treatment under supervision , he recover , the symptoms become less , he comes back to his senses and be discharged ,but what happens outside ?

Participant 1: that's why I was saying when he is now in the community, he visit the PHC clinic and the PHC clinic make a follow up and visit them at home to increase the personal relationship

and also to look into the environment , the supervision part and the social part that will also prevent relapse

Participant 3 : I agree, but it is really interesting to listen what you are saying , yes there is structure in the institution from where he comes from but outside they are thrown for the birds man(throwing her hands in the air), the birds can pick them up , because really they are out of themselves and it is .. you know when you are mad ..., when you are very sick like having a high temperature ,your Blood Pressure is high you feel weak you know and for some time you need to recover, the same with this discharged patients , ja they have fear you know and you have to be counselled with you know and wow (loud) there comes your date for PHC clinic to fetched your tablets , you are still in that process of “voetjie by voetjie”(walking slowly) and you get” ahaa”, the sister say hey hey kom (come) vat jou pille en gaan (take your pills and go) the patient will say “ suster my kop” (sister my head) the sister will say “ gee panado en gaan “ (give panado and go) (participant demonstrating with her hands) I don't have time ,as we said the system is against us , the integration is against us , the environment outside there is cruel to the poor psych patients and we know it , but we don't have time , we don't have resources

Group laughing....

Participant 5: this integration has caused a lot of problems. You will even find that it exposes the clients to this vulnerability because people end up doing what they don't love

Group: nodding the heads, mhhhh

Participant 5: continue: you end up not having love for what you are doing because if do what you love you will give it your best shot and your best interest , but now because of this HIV is brought to me , this TB is brought to me , I know I'm a PHC nurse and have to nurse a patient holistically , but we are not the same , I might be in love with TB with all my heart “wabona “(you see) so it is really causing a lot of problems because people no longer do what they love

Group: mmh and where is the emphasis

Participant 1: but if they can fast track this implementation of the re-engineering processes because now as a PHC nurse in the process of this re-engineering whatever the area that you are looking into, you will pick up all these things and you will increase your interpersonal relationship with your community that you are serving hence the vulnerability will be decrease and the relapse will decrease

Participant 3: JA it is true what participant 1 just said, now I'm finishing with this thing because I'm hungry now

Group: laughing out loud....

Participant 3 continue : participant 1 said they must check on the re-engineering process, it is very important , remember I always says there is a specialist for midwifery , there is a specialist for paediatrics, but there is no specialist for psychiatry and they expect me as generalist must cater for the specialized areas, it also a thing that we must be re trained into this thing , but there must be a specialist in the re-engineering process so that we can have a contact and even that same specialist can re- trained us so that our attitudes at the end can be changed and our skills can be improved by picking up these things , we can even have role plays with that specialist you know to show us this hidden symptoms sometimes when the patients come

Participant 2: we are now so focused on the psych patients not getting their due, but the HIV patients and all other patients. That psych label is everywhere in all our patients

Participant 1: that is why that holistic approach was brought to us on what is our perception with our MHCUs with other conditions that they are having too

Participant 2: arguing about other patients with medical condition for ± 5minutes

Participant: that goes back to effective re-engineering

Facilitator : in other words if I understand you well what is that all these patients with medical conditions and other problems lead to depression

Participant 2: mmh and denial of the seriousness of the problem and not taking medication leads to relapse

Facilitator: in other words it leads to psychosis 2^oAMC (Another Medical Condition)

Group: yes

Participant 3: and sometimes we sit there in the clinic every day with a doek op die kop toe getrek (doek covering our heads) participant demonstrating) because you don't know psychiatry and you will never know that the patient is depressed sitting with CA (cancer) of whatever. I'm so down as a nurse ek wil niks hoor of sien nie (don't want to hear anything) die doek is diep getrek, en ek sit daar met my (I sit there with my) attitude, my houding (my attitude) is depressing, its psych and psych is all over, but we really ignore it

Participant 4: continuity

Facilitator: continuity of care

Participant 4: it looks like we are working in isolation, what is important is for the user to continue with his treatment after discharged. It starts while he is admitted, we call it preparation for discharge , it starts there , he must know what to expect when he goes out there , you are still ill but you are going out to the society and this is what we expect you to do , go to you clinic on you scheduled date , never stop your medication, be able to see and picked up the symptoms and report to the clinic , do not wait for your follow up date if something is wrong with you ,just go to the clinic and seek advice

Facilitator: but what if they don't get the advice like, I'm just going back to participant 3's statement that she said you will be sitting with your head covered with a doek and concentrating on other ailments such as high blood, heartburn and you can't really see that patient is on the verge of relapse because you don't give your full attention. The MHCU will be going for follow up at the clinic and complaint about a headache, you give Panadol and let him go or he complaint about heartburn, you give an anti-acid and let him go , but the real issue is that the user is actually on the verge of relapse because there are some unresolved issues with the patient , so we do our duty in the ward , prepare the user for the outside world , but after one or two follow ups to the clinic the user is back in the ward , relapsed and re admitted , so actually what is going on down there at PHC level

Participant 3: and the other thing also is that you in the ward discharged patients so early then they come to us still not being "reg" (right), but you are packed there in psychiatry full wards

Participant 5: because they want empty beds

Participant 3: yes they want beds (loudly), the patient must go not even 'reg'. It makes the poor patient even more vulnerable to whatever is happening outside, so you are contributing even more to these things

Participant 4: of lately within a week they are back in the hospital, so we are actually working in circles

Facilitator: laughing, oh we have exhausted this question and participant 1 reminded me about time allocation for each question

Group: laughing and looking at their watches

Facilitator: our mental health population is a very vulnerable and sensitive population and we should really take good care of them and then our second last question talks about uniqueness and some of you already touch on that. What are your perceptions as a PHC nurse on adapting

to the uniqueness of the circumstances of the MHCU when the MHCU arrives at your clinic being discharged from the institution

Participant 1: sorry can you repeat yourself

Facilitator: re phrased the question

Participant 2: if you not be able to adapt to the uniqueness because it takes time to understand that uniqueness and if we don't take time to understand exactly where it comes from, say for instance your patient coming from the psych institution being discharged too early. are you aware of the substance abuse that is still lingering in him, overlapping with schizophrenic symptoms , not being understood by his family at home , not being understood by the community at large , stigmatized and now he comes here and you want to really understand his uniqueness with no time on your hands is very difficult and then also he is still in denial that something is really wrong because he is feeling ok today , he will give a false interpretation and he will also not understand the importance of certain of his own symptoms and if you don't have antennas I don't think you have a chance to be able to go through to him to understand his uniqueness and really assesses where he comes from because it is impossible in your time schedule now to get to that patient there and if that patient was not properly prepared for going out and be informed that the symptoms are still there, you must be very prepared for that.

Participant 1: to adapt to uniqueness is very difficult because every personal is an individual, so now as a PHC nurse maybe you meet this MHCU for the first time , so now you must have enough time as participant 2 indicated so that you can be able to understand his uniqueness and to adapt to his uniqueness so that you can be able also to reassure him that you are there for him for the way he is and to be able to come again next time for a follow up treatment so that he doesn't relapse . still going back to the proper implementation of the re-engineering it might be a better solution because as he is discharged to the community he comes to the clinic for the first time and you inform him that you still need to visit him at home to see how do you live as an individual and be able to adapt to his ways of living

Participant 2: yes that will be an answer neh if we can really go back to the homes because you don't have time now, so when they come back the user must not be queued, there must be somebody as the primary caregiver, they can't be a multiple situation like it is now for every sister will have to re adjust herself and get to know them from scratch and that will not be time efficient because you will lose your patient

Participant 1: but with re-engineering as a PHC nurse you are being allocated for a certain area

Participant 2: but in the clinic you must be that patient's primary caregiver

Participant 1: that's why I'm saying for re-engineering you are allocated for a certain area in the community , so in that area you will be knowing all your clients including the MHCU , so you will be able to know them and know all their conditions and that uniqueness will easily be there and the trust will be amongst yourself and it will increase the adaptation hence I'm saying proper implementation of the re-engineering system it will makes it at least easy not difficult as it is currently

Participant 3 : so what she also said (participant 1) is that she wants a primary caregiver because as we know from the past these patients, psych patients they like to cling to a certain person , you will get in some instances where they said , that sister wat mental health doen is nie vandag hier nie (the sister who is doing mental health is not here today) and really the patient will turn and go back, but when this re-engineering process is being implemented effectively looking after the MHCU you know , with the PHC who have the ward and on the process of the re-engineering system there is a specialist who can supervise this PHC nurse with her duties , the adaptation...(clapping hands) will be 100%

Facilitator: yoh, we are running out of time. Do we all understand the uniqueness?

Group: yes

Facilitator: yes if you don't have the skill to nurse a psychiatric patient it will be difficult for you really. So how do we limit..., our last question? So how do you think all these factors can contribute to limiting the relapse of the MHCU, how we limit the relapses from all the things that you have said, you have said such a lot of things

Participant 3: first don't discharge the patient too soon, secondly do home based care, the re-engineering process to be there and effectively, do home visits, educate the PHC, enhance resources, holistic approach

Participant 2 : be flexible to your patient's needs , don't tell him not to come today because the clinic is already full , if the patient is experiencing symptoms give him support ,don't show him the door telling him that today is full you can come next week, because next week will be too late , be more accessible in your service

Participant 5: maybe PHC sisters also need the spirit of "Ubuntu"

Group laughing

Participant 5 : laughing , you will find in this small areas , the sister in PHC they are taken so serious by the community neh , they will even go and knocked at your door at 10am at night when

they got problems (laughing) , so with the spirit of Ubuntu you will accommodate them, someone will say hey sister o qadile gape (she has started there at home again) , can you assist us , so you see so I think the spirit of Ubuntu is still needed .., laughing ..

Participant 1: I think all the factors that were discussing are the ones that will help to prevent relapses, like increasing the interpersonal relationship, attending to the holistic issues of those things ehh... , adapting to the uniqueness of a person and all these things if they are brought together they will decrease the relapse rate

Participant 3: that presence must be there

Facilitator: yes that nursing presence must be there

Participant 1: in totality

Facilitator: all in all in totality, so that you can nurse your patient in totality

Group: yes

Facilitator: thank you for your time, anyone that would still like to add anything? Do you still need a counsellor?

Participant 3: we will talk to you after this session

Facilitator: ok you will see the counsellor after this, because I can see there is a lot of things that are really frustrating you in PHC

Group laughing...

Facilitator: I can see there is a lot of work down there. I would like to thank you all for your contribution, for your participation. you are a unique group , you are a beautiful and good group and I have learnt so much today because there is a lot of things that we don't know about the happenings at PHC level ,so thank you for your information and thank you for your participation. If there is anything that I still need from you, can come back to you for more information?

Group: laughing, yes you can feel free, we are just a telephone call away

Facilitator: ok thank you very much everybody, there are some refreshments available for you.

Closure.

APPENDIX H: FIELD NOTES FOR ONE OF THE FOCUS GROUPS

Descriptive notes

The focus group interview was held on Friday the 13th November 2016 in one of the unused consulting rooms of the clinic in the morning before the routine started. This was the most convenient time, especially on Fridays, which is seen as the academic day. The participants maintained good eye contact throughout the focus group and most of them participated. They were all outspoken during the interview despite the fact that one of them was the acting operational manager for the day. Although two of the participants were quiet and responded only on certain questions, one would conclude that they were indeed actively listening by nodding their heads and at times they verbally agreed with other participants by saying “eyah,” or “ke nnete.” There was only interruption when the acting operational manager needed to sign some documents for the HR clerk. Participants respected each other and gave each other a chance to speak, though at times they became excited about certain questions and then all of them wanted to answer at the same time. The professional nurses appeared to be in a relaxed mood during the interview, even with the audio recorders on.

Reflective notes

The participants all looked relaxed and ready for the interview. There was an immediate response from the only gentleman in the group after the first questions was posed by the researcher. All participants were friendly and were willing to share their perceptions on nursing presence as an approach to prevent relapse of discharged Mental Health Care Users.

Demographic notes

The focus group interview was conducted with six professional nurses on the 13th November 2016 between 08h30 and 10h00 as per appointment. The participants were six in number, five females and one male. All professional nurses were on duty for the day and this was a convenient time for them to meet with the researcher. Most of them were wearing private clothes as it is a norm for them to wear their private clothes on Fridays, except for the male nurse, who were wearing navy blue pant with a white shirt with his distinguishing devices and black shoes. Seven chairs were placed in a circular pattern including that of the researcher and everybody had a full view of one another. A ‘do not disturb’ sign was placed on the door. The researcher used two audio recorders for quality purposes and for back-up. The room was a bit small, but we could all fit in. There were two big windows, which provided adequate ventilation. It was noise free with and fitted with an air-con for temperature control. The environment was thus conducive for the focus group interview.

APPENDIX I: DECLARATION OF LANGUAGE EDITING



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DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, hereby declare that I edited the research study with the title:

Exploring nursing presence as an approach to prevent relapse of discharged mental healthcare users

for Roselyn Motaung for the purpose of submission as a research study for examination. Changes were suggested in track changes and implementation was left up to the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accreditation nr: 1001066

Full member of PEG