Exploring community-based interventions for mentally ill patients to improve quality of care

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Mini-dissertation submitted in partial fulfillment for the Master's Degree in Psychiatric Nursing Science at the Potchefstroom Campus of the North-West University

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August 2013

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TO WHOM IT MAY CONCERN

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DECLARATION

I declare that the mini-dissertation with the title: *Exploring the community-based interventions for mentally ill patients to improve quality of care* is my own work and that all the sources used or quoted have been indicated and acknowledged by means of a complete reference and that this work has not been submitted previously for another degree at any other institution.

---------- …30.08.2013…….. …

Lydia Mamakhoa Mamabolo D**ate:**

DEDICATION

This mini-dissertation is dedicated to several people who play an important role in my life.

The first dedication is in memory of my loving late husband, Leeto Edward who will always be in my thoughts.

To my mother Susan, Aunt Margaret and uncle (Moja) for their support throughout my studies.

To my loving twins, Neo and Dineo, for their patience and understanding.

To my nephew, Paseka, for being understanding those attending lecture sessions at the university was a critical aspect of my studies.

To my brother, Mofihli, Sister-in-law, Mathabo, and family for their encouragement and support over these years.

To all my family members, friends and colleagues who contributed positively to make my studies a success.

ACKNOWLEDGEMENTS

I thank God Almighty for granting me strength, perseverance, support and wisdom throughout my studies, for without Him, I would not have made it a success.

My heartfelt gratitude goes to the Mamabolo and Setai families for their ceaselesssupport.

I am truly grateful to my dedicated supervisor, Prof DaleenKoen and co-supervisor Dr Emmerentia du Plessis for their guidance and support throughout my studies.

I extend my gratitude to my colleagues at the Free State School of Nursing Eastern Campus for their boundlessmotivation.

Acknowledgement is extended to Dr Vicki Koen for her assistance as co-coder.

I acknowledge the value contributed by Dr Kabane and Ms S.R Sibeko for granting me the opportunity and permission to conduct the research study in the Free State.

I thank Mr Mochoaro for granting me study leave to pursue my studies.

Special thanks are extended to Clinic managers, and non-governmental organization managers for allowing me to conduct interviews at the clinics and offices.

I thank the Free State Bursary section for assisting me financially to pursue the research.

I give special thanks to Mr Kolokome, Mr Thabo and Ms Tsie for assisting me with information technology services.

My gratitude goes to ECFSSON management Ms Maja, Dean of the campus, and heads of academic departments Ms Molotsi and Ms Thaele for granting me the opportunity to further my studies and for their endless support.

A thank you goes to friends and family, Puseletso, Pat, Junior, Tricia, Ethel, Tshidi, Soyi and Kuki for their encouragement and support.

I am extremely grateful for the encouragement, advice and support offered by my friends and colleagues Mantoa, Sesi and Khosi.

A particular thanks is extended to Makereke, ECFSSON librarian and the personnel of Ferdinand Postma library for their continued interest and unselfish provision of information.

I wish to thank Mokete for his patience and support in transporting me to the various destinations during the course of my studies.

I wish to express my appreciation to all the people I have encountered in my professional life who helped my learning and growth and enabled my learning.

Finally, I wish to extend my appreciation to all the people who participated and shared their information and understanding in this research.

ABSTRACT

Mentally ill patients need to be treated with dignity and their basic human rights must be respected. Community-based interventions are commonly used in many areas after deinstitutionalisation of mentally ill patients. However, it is unfortunate that mental health and mental disorders are neglected in many areas with no proper or standardized services in the community for treatment and support. As a result, most of the mentally ill patients roam in the streets in the rural communities. Exploring community-based interventions in rural areas could assist to improve the quality care of the mentally ill patients. The communities need to be aware of the interventions available to support the mentally ill patients and their family members so that community members who give care to mentally ill patients can be able to identify, implement, monitor and sustain effective interventions to meet the needs of the mentally ill patients in rural areas. Suggestions could also be made to the Department of Health with regard to the community-based interventions in order to improve quality of patient care.

The aim of this research was to explore and describe the current community-based interventions for the mentally ill patients as well as explore recommendations by the professional nurses and community caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community.

In order to obtain rich in-depth data, a qualitative research approach was followed. A case study design was used to complement the holistic in-depth investigation. Purposive sampling was used to identify professional nurses as participants in the community and snow-ball sampling was used to identify further community caregivers who meet the inclusion criteria. Ethics was considered during the identification and selection of participants. Triangulation of data collection method was undertaken where structured interviews, field notes and documents were used as methods of data collection. A semi-structured interview schedule was formulated which was evaluated by experts in qualitative research. A trial run interview was conducted prior to data collection. Voice recorders were used for the purpose of audio taping the interviews, thereafter the interviews were transcribed and prepared for data analysis. The researcher ensured that field notes were taken immediately after each interview. Data was collected until saturation was reached after ten interviews and analysis of six documents.

Data was analysed by means of a written record or transcripts as suggested by Neuwenhuis (2011:89). A specialist qualitative researcher was appointed as a co-coder to analyse the data. The interpretative pattern of data analysis for qualitative data analysis was followed and the guidelines prescribed by Terre Blanche, Durrheim and Kelly (2011:321) were adopted. The

identified themes were current interventions and utilizing current suggested interventions. Thus conclusions were drawn in relation to identified themes that with current interventions there are different categories of caregivers that are involved in the care of mentally ill patients in rural communities. Included are the health caregivers, non-governmental organisations, police officers, faith/spiritual healers, traditional healers, families and community members. However challenges were still identified for an example defaulting of treatment, relapse and readmissions of mentally ill patients. With regard to utilizing suggested interventions, participants emphasised more on the need to develop structures in order to support the mentally ill patients in their rural communities and continued community education mental illness and mental health. The recommendations were made to nursing practice, nursing research and nursing education.

Key concepts: community-based interventions, mentally ill patient, community, deinstitutionalisation, primary health care setting, mental health caregiver.

OPSOMMING

Geestelik siek pasiënte moet met waardigheid behandel word en hul basiese menseregte moet gerespekteer word. Gemeenskapsgebaseerde intervensies word algemeen gebruik in baie gebiede na deïnstitusionalisering van geestesongestelde pasiënte. Dit is egter jammer dat geestelike gesondheid en geestelike versteurings in baie gebiede met geen behoorlike of gestandaardiseerde dienste in die gemeenskap vir die behandeling en ondersteuning verwaarloos word. As 'n resultaat, dwaal die meeste van die geestelik siek pasiënte in die strate van die landelike gemeenskappe rond. Verkenning van gemeenskaps-gebaseerde intervensies in landelike gebiede kan help om die kwaliteit sorg van die geestelik siek pasiënte te verbeter. Die gemeenskappe het nodig om bewus te wees van die intervensies wat beskikbaar is om die geestesongestelde pasiënte en hul gesinslede mee te ondersteun, sodat lede van die gemeenskap wat sorg gee aan geestesongestelde pasiënte in staat kan wees om hierdie intervensies te identifiseer, te implementeer, te moniteer en te handhaaf teneinde aan die behoeftes van die geestesongestelde pasiënte in landelike gebiede te voldoen. Voorstelle kan ook gemaak word aan die Departement van Gesondheid met betrekking tot die gemeenskap-gebaseerde intervensies ten einde kwaliteit van pasiëntesorg te verbeter

Die doel van hierdie navorsing was om die benutting van die huidige gemeenskap-gebaseerde intervensies vir die geestesongestelde pasiënte te verken en te beskryf en om aanbevelings deur die professionele verpleegkundiges en gemeenskapslede en versorgers in 'n landelike gemeenskap te verken en te ondersteun.

Ten einde ryk in-diepte data te verkry, is 'n kwalitatiewe navorsingsbenadering gevolg. 'N gevallestudie-ontwerp is gebruik om die holistiese in-diepte ondersoek mee aan te vul. Doelbewuste steekproefneming is gebruik om professionele verpleegkundiges as deelnemers in die gemeenskap te identifiseer en sneeubal steekproefneming is gebruik om verdere gemeenskap versorgers wat aan die insluiting kriteria voldoen, te identifiseer. Etiek is tydens die identifisering en seleksie van deelnemers oorweeg. Triangulering van data-insamelingsmetode was onderneem waar gestruktureerde onderhoude, veldnotas en dokumente as metodes van data-insameling gebruik is. 'n Semi-gestruktureerde onderhoudskedule is geformuleer wat deur kundiges in kwalitatiewe navorsing geëvalueer is. 'n Proeflopie-onderhoud is uitgevoer voor data-insameling. Stem opnemers is gebruik vir die doel van klank opneem. Daarna is die onderhoude getranskribeer en voorberei vir data-analise. Die navorser het verseker dat veldnotas onmiddellik na elke onderhoud geneem is. Data is versamel totdat versadiging bereik is na tien onderhoude en die analise van ses dokumente.

Data is geanaliseer deur middel van 'n skriftelike rekord of transkripsies soos voorgestel deur Neuwenhuis (2011 89). 'n Spesialis kwalitatiewe navorser is aangestel as 'n mede-kodeerder om die data te analiseer. Die interpretatiewe patroon van data-analise vir kwalitatiewe data-analise is gevolg en die riglyne soos voorgeskryf deur Terre Blanche, Durrheim en Kelly (2011 321) is aangeneem. Die geïdentifiseerde temas was huidige intervensies en huidige voorgestelde intervensies is van gebruik gemaak. So is gevolgtrekkings gemaak met betrekking tot die geïdentifiseerde temas dat met die huidige intervensies daar verskillende kategorieë van die versorgers is wat betrokke is in die sorg van geestesongestelde pasiënte in landelike gemeenskappe. Die gesondheidsversorgers, nie-regeringsorganisasies, polisiebeamptes, geloof / geestelike genesers, tradisionele genesers, families en lede van die gemeenskap was ingesluit. Maar, uitdagings is steeds identifiseer soos byvoorbeeld die gebrek van behandeling, terugval en hertoelatings van geestesongestelde pasiënte. Met betrekking tot die benutting van voorgestelde intervensies, het deelnemers meer klem gelê op die behoefte aan om strukture te ontwikkel ten einde die geestesongestelde pasiënte in hul landelike gemeenskappe mee te ondersteun en voortdurende opleiding van die gemeenskap oor geestesongesteldheid en geestesgesondheid. Die aanbevelings is aan die verpleegpraktyk, verpleegnavorsing en verpleegonderrig gemaak.

Sleutel konsepte:

gemeenskapsgebaseerde intervensies, geestelik siek pasiënt, gemeenskap, deïnstitusionalisering, primêre gesondheidsorg omgewing, geestelike gesondheid versorger

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CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Caring for the mentally ill patients in the community is a problem in many areas (Kohn *et al.,* 2004:3). Contributing to this problem could have been the changes in the international health care system that took place when the process of deinstitutionalisation was introduced (Uys & Middleton, 2010:12). Deinstitutionalisation is referred to as a shift in the focus of care from large long term institutions to the community which is accomplished through discharging patients and avoiding unnecessary admissions (Stuart, 2009:751). This transformation was characterized by a shift from a curative and hospital based approach to a comprehensive health care approach (Peterson & Swart, 2002:69). Institutions had to be replaced by community mental health institutions and support systems to prompt mentally ill out patient's integration into their communities (Du Plessis *et al.,* 2004:3). According to Rifkin and Walt as quoted by Peterson and Swart (2002:9), the key characteristic of a comprehensive health care approach is community participation and empowerment, where communities are encouraged to play an active role in the care of their own health.

However deinstitutionalization resulted in some problems in rendering comprehensive care to mentally ill patients in rural communities. WHO (2011:1) alludes that the gap between need for treatment for mentally ill patients and their treatment is evident throughout the world. In addition, John and Talbott (2004:1112) cite that due to a lack of good planning and management of deinstitutionalization, large numbers of mentally ill patients were found roaming in the city streets, talking to themselves and acting in a bizarre ways. Hubert and Reese (2013:7) also supports this argument by indicating that mentally ill patients show a variety of behaviors that are disturbing to the public, for example, self-mutilation, eating glasses or pounding their heads against the walls. Janardhana and Naidu (2012:1) further state that people with a mental illness are denied their basic human rights like access to treatment and appropriate mental health care. Furthermore, in support of this argument, Stuart and Laraia (2001:696) identify that lack of parity in funding, stigma, and shortage of specialized psychiatric personnel as issues impacting in psychiatric care. According to Men (2011:4), the widespread discrimination and stigma associated with mentally ill patients and their families are regarded as challenges that have a negative outcome in reintegration of cured patients into their communities. In addition, Monahan *et al.* (2003:2) attribute the growth of populations with revolving door patients to in-effective community-based services and the lack of other needed community support.

In South Africa, mental illness is regarded as the third highest contributor to disease burden, and some of the mentally ill patients do not have anyone to care for them (Anon, 2009:24). Furthermore, Uys and Middleton (2004:1-2) and Thom (2008:1) indicate that no preparations were undertaken for the implementation of deinstitutionalization as a process and, therefore, this resulted in mentally ill patients being dumped into their communities without strengthening community-based interventions in order to improve the quality of life of the patients and their families. Furthermore, a discussion document on the re-engineering of primary health care in South Africa, (Department of Health, 2010:1) states that insufficient attention has been given to the implementation of the Primary Health care approach. In addition, Botha *et al.* (2008:272) report that reduction in the number of hospital beds did not coincide with the development of adequate community resources which contributed to a major obstacle in establishing community-based treatment in South Africa. In its report, the South African Medical Research Council (2008:1) alludes to the fact that patients with psychiatric illnesses do not get appropriate help and that mental health problems are largely forgotten in South Africa.

It is suggested that contracting institution-based treatment for mentally ill patients should be replaced by an increase in the availability of comprehensive community-based services (Salinsky & Loftis, 2007:17). Community-based interventions are defined as small-scale programs delivered in community settings (NICE 2007:5). In their study on community interventions and mental health services research, Wells *et al.* (2004:2) conclude that the community-based intervention approach is a major paradigm shift for affecting public health or addressing health disparities. More than a decade ago, Barton (1999) agreed that further research is needed to specify the effects of psychosocial interventions and determine the most effective of those interventions. Furthermore, Hague *et al.* (2002:673) state that an agreement was reached among stakeholders that there is a need to change in mental health services however the nature and how the change should be brought about are relatively under-explored. Manamela *et al.* (2003:95) support the same suggestions by indicating that community resources and support systems should be studied in more detail. Bagenstos (2012:2) indicates that more recently deinstitutionalisation advocates are focused to a greater extent on the goal of building up a robust community-based treatment system. This was also reflected in the 2001 World Health report where it states that appropriate programs and service developments are necessary to bridge the treatment gap for mental disorders (Kohn *et al*., 2004:7). In their findings, Hyun et al. (2008:11) support continuing efforts in building a community-mental health infrastructure in order to support treatment recovery for mentally ill patients.

Towards achieving this goal, the objective of the Mental Health Care Act 17 of 2002, is to provide for the care, treatment and rehabilitation of persons who are mentally ill equitably and efficiently (South Africa, 2002:2). The mental health care services in South Africa, along with other medical services, have been in the process of transformation. Mental health care services were integrated into primary health care. However, like in other countries, South Africa was also faced with many challenges in the process of incorporating mental health care services into primary health care. Emsley (2001:383) reports that integration of mental health care services into the primary health care is lagging behind because psychiatric hospitals frequently act as first-line facilities. Findings by Van Rensburg (2005:102) concerning placement and reintegration of service from long term mental health care facilities to communities indicate that there are some difficulties in the preparation and successful placement of mentally ill patients in appropriate settings after discharge. Furthermore, it is stated that South Africa is confronted by challenges that complicate successful implementation of some psychiatric support services due to reasons such as social circumstances, structure of primary health facilities and community resources (Botha *et al.,* 2008:272). Corrigan and Watson (2002:1) also states that mentally ill patients are robbed of the opportunities that define a quality life in their communities because of stereotypes and prejudice that result from misconceptions about mental illness. One of the effective strategies in the care of mentally ill patients is expanding evidence-based mental health interventions in general health services based on cost-effectiveness, affordability and feasibility (WHO, 2011:3). Effective and affordable interventions need to be developed in order to deal with the challenges and the treatment gap facing the process of integration of psychiatric patients into their rural communities.

Researchers suggest a number of community-based interventions that can be used to care for mentally ill patients. Such interventions include medical care, financial or income support, support for relatives, housing support, crises response services, and education (Manamela *et al*., 2003:95; Stuart & Laraia, 2001:712). In rural locations, health care services are said to be few and family members rely on natural supports like religious organizations which are offered free of charge (Johnson *et al.,* 2006:151). In their recommendations, John and Talbott (2004:1115) suggest that case study management as a community-based intervention for mentally ill patients should be established and should make use of existing manpower and resources. In addition, mental health problems can be effectively resolved by working together with people who are experiencing mental illness in their own homes and communities, as well as using resources and support networks available to them. Social support systems are regarded to be helpful because they emphasize the strengths of the

individuals and families thus focusing on health rather than illness (Stuart, 2009:178). Similar findings are emphasized by Rangan and Sekaar, (2006:128) who state that interventions that are based on the strength approach give the perspective the individual already is doing to better the situation; thus the individual can be assisted to identify the strengths and continue working in relation to goals and vision. Proper implementation of community-based interventions can assist with the involvement of the communities in their mental health care. Individuals with mental illness can be reintroduced into the community through supportive services and contribute to the life of their communities (Hyun *et a*l. 2008:11).

Community support systems are developed by community mental health centers that provide patients with necessary specialized mental health services (Stuart 2009:750). Similarly, Bronowski *et al.* (2011:31) state that the aim of community-based treatment is to reduce the number of hospitalizations and support maintenance of mentally ill patients in their communities. These findings are similar to those explained by Hyun *et al. (*2008:4) that proper utilization of community services shows a decrease in probability of hospitalization, length of stay and importantly, improved quality of life.

Lam and Rosenbeck as quoted by Stuart and Laraia (2001:214) state that given the opportunity to participate in treatment programs that address their needs, many mentally ill patients can be helped to achieve sustained improvements in their lives. Similar findings are supported by Barton (1999) in his study on examining the place of psychosocial rehabilitation services within community support systems, who report that the psychosocial interventions showed success in reduction of symptoms, community adjustment, and medication compliance, relapse prevention and reduced hospital use. In addition, Uys and Middleton (2010:434) emphasize the requirement of the additional specific support services for mentally ill patients, which include outpatient's services, home visits, and crisis volunteers. Khawaled *et al.* (2009) even suggest a limited response team that comprises of one psychiatrist per shift who can provide a viable service for mentally ill patients and who can increase the number of referrals to outpatient clinics in the community and the number of voluntary or involuntary admissions.

Although research has been conducted on community-based interventions as strategies to improve and sustain quality of care for mentally ill patients (Wells *et al.*, 2004:2; Hyun *et al.,* 2008:11), limited research has explored the availability of community-based interventions in rural communities. Moreover, in the discussion document on the re-engineering of Primary Health care by the Department of Health (2010:33), it is recommended that each province and district should build from the current situation meaning that implementation will have to start where the district is currently. Equally important, Dennhill *et al.* (2004:7) emphasize that

in implementing community-based health care each community should assess their own health needs and also determine how to plan their own services in order to meet their needs. Furthermore, WHO (2011:3) recommends improvement of good quality treatment and care for mental health conditions through for an example expanding evidenced-based mental health interventions and including such in packages of care. Therefore, there is thus a need for further research on community-based interventions to improve quality of care for the psychiatric patients in rural communities.

1.2 PROBLEM STATEMENT

The care of mentally ill patients after discharge from hospitals has been reported to be a growing public concern (WHO, 2004:1). Furthermore, Raja *et al.* (2012:2) state that people who live in conditions of social disadvantage are at greater risk of developing mental illness. There is no effective follow-up care for discharged patients and this leads to mentally ill patients experiencing problems like continued re-admission, the situation which is sometimes referred to as a revolving door syndrome. Stuart (2009:629) emphasizes the hope that community centers together with living arrangements provided by families would allow people to live humane lives in their own communities. However, some of these patients became homeless. It was reported in the United States of America that some mentally ill patients live in subway tunnels and die under cardboard boxes (Stuart, 2009:632). Similarly, psychiatric illness has been categorized as the most neglected health issue in South Africa (Anon, 2009:7). Similar findings are confirmed in the mental health and poverty project 2008 where it has been indicated that mental health has not been given the priority it deserves in South Africa (Mental Health and Poverty Project 2008).

This problem is mostly attributed to the process of deinstitutionalization which created a gap in the care rendered to psychiatric patients in the communities. Patients were transferred to communities without preparation for the influx in the primary health care institutions (Uys & Middleton, 2004:12). Consequently, primary health care nurses have to deal with huge clinical loads (Thom, 2008:1; Uys & Middleton, 2004:12). It seems that the needs for mentally ill patients are not met after discharge from institutions, and during reintegration to their communities. The World Health Organization confirms that there is a wide gap between the need for treatment for mental disorders and its provision throughout the world (WHO, 2011:1).

It follows that there is a need to explore and describe the use of community-based interventions as strategies to improve quality of care for the mentally ill patients. Community-based interventions are defined as interventions or small-scale programs delivered in community settings (NICE, 2007:2). Janardhana and Naidu (2012:6) suggest that there can be an effective resolution of mental health problems through working together with people experiencing mental illness and communities in their own homes. In addition, the Bulletin for World Health Organization (2004:1) indicates that many individuals with mental illness remain untreated despite the existence of effective treatments. Van Rensburg (2005:102) highlighted the difficulty to select and anticipate the successful placement of long term mentally ill patients in an appropriate alternative setting. These findings are affirmed in a study in Hong Kong on mental health promotion, where it has been cited that mental health promotion should be refined and affirmed, utilizing a sectorial multi-level approach to affect the goal of mental health for all and by all (Ip, 2002:4). In addition, WHO (2011:I) recommends the evidence-based mental health interventions in general health services as one of the strategies that can provide good-quality treatment and care for mentally ill patients.

In addition, Botha *et al.* (2008:272) suggest a need for a renewed approach to address a revolving door syndrome that is facing many patients in South Africa. Even though a mentally ill patient may have several potential support network members, he or she cannot always recognize or make use of them, and needs to be helped to recognize the benefits of mutual exchange of support by health professionals (Robertson *et al.,* 2001:432). Similar findings are supported by Manamela *et al.* (2003:92) who report that when people have mental health problems, their ability to meet their health needs independently could be adversely affected. In addition, John and Talbott (2004:1115) confirm that the needs of chronic mentally ill patients should be assessed and services should be designed or revised in order that such needs are met. Similarly, such findings are supported by Korhonen *et al.* (2008:775) who conclude that attention to awareness of psychosocial environments including family support should be a fundamental strategy in the management of psychiatric patients. WHO (2007:4) concluded that neither the hospital only approach nor the community services alone can provide satisfactory comprehensive care, and that professional nurses' opinion and results from available studies can support balanced care. Based on the fact that mentally ill patients cannot recognize several potential networks, the professional nurses and other community health caregivers are going to be interviewed regarding the community-based interventions for the psychiatric patients in rural area (Janardhana & Naidu, 2012:4)

In line with this view, South Africa has designed a Re-engineering of Primary Health Care program (South Africa, 2010:1) based on the principle of high quality care in district health services. This discussion document further acknowledges the fact that little attention has been given to the implementation of a Primary Health Care approach leading to insufficient improvement and measurement of health outcomes. The recommendations are supported by John and Talbott (2004:115) who suggest that community-based approaches should make use of existing manpower and resources. Therefore, these arguments confirm a need for rural communities to be aware of their strengths as well as their needs.

The researcher has noted that the rural areas of the Free State Province is well-known for an increasing number of mentally ill patients who are found roaming around and sleeping in the streets. Most of them are adult males. They eat from the rubbish bins with no one to take care of them in the communities. Some of them stay in their homes with their family members, however, they roam in the shopping complexes from morning till night. This happens on a daily basis. Their personal hygiene and grooming is very poor. Furthermore, Emsley (2001:383) emphasizes that psychiatric services are poorly developed in the rural areas. The researcher therefore identified the need to explore and describe the current community-based interventions as the strategies that can be used to give quality care for the mentally ill patients in this rural area.

Beebe *et al.* (2011:537) suggest that researchers must commit to conducting high quality community-based psychiatric nursing intervention investigations. Similarly, Kenneth *et al. (*2004:2) conclude that the current challenges for health services research as to strengthen sustain and disseminate practice interventions that improve quality of care so that care is affordable to all. The above suggestions confirm what the researcher, as a lecturer who is teaching mental health nursing science observed that in the Free State Province, in Thabo Mofutsanyana district as a rural area, there is a need to explore and describe community-based interventions that can mitigate the problems experienced by the mentally ill patients in their rural communities. Wells *et al.* (2004:2) confirm that current challenges for health services research are to strengthen, sustain and disseminate practice interventions that improve the quality of care, promote access for those with unmet needs and increase efficiency so that care is affordable to all.

Research on exploring community-based interventions for mentally ill patients to improve quality of care is also done as a sub-study in an overarching research project, namely the RISE study. The purpose of the above mentioned project is to develop a comprehensive, multi-facet approach to strengthen the resilience of health caregivers and risk groups (Koen

& Du Plessis 2011:5). In the project a risk group is defined as people belonging to a group or sub-group that is stereotyped, discriminated against or has limited access to health and social services. Therefore, a group of mentally ill patients is classified under such groups who are in need of quality health care (Koen & Du Plessis 2011:1). In this research community-based interventions are viewed as characteristic of the strengths of a community to render quality care to mentally ill patients.

The above argument leads to the formulation of the following research questions.

1.3 RESEARCH QUESTIONS

- What are current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life?
- How do nurses and other health caregivers suggest these community-based interventions can be utilized to support mentally ill patients in a rural community to improve quality of care?

1.4 RESEARCH OBJECTIVES

The following objectives were set for this study:

- To explore and describe current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life.
- To explore and describe the suggestions by nurses and other community caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of care.

1.5 PARADIGMATIC PERSPECTIVE

The discussion includes the meta-theoretical, the theoretical and the methodological assumptions of the researcher.

1.5.1 Meta-theoretical assumptions

The researcher's meta-theoretical assumption is based upon the researcher's beliefs as well as relevant literature for nursing practice whereby the assumptions about the person/man, environment, health and nursing are described.

Man: Reihl-Sisca (1989:64) views man as unique individuals who are a composite of characteristics within a normal range of responses. His/her state of wellness and illness is interrelated to physiological, psychological, socio-cultural, and developmental dimensions and s/he is continuously interacting with his/her environment. For the purpose of this study man is viewed as any individual who, due to interaction with his/her environment, suffered mental illness whether in an acute, chronic, or controlled state. He/she should be taken care of in the rural community. Man can also be a professional nurse or other community caregiver who is responsible for rendering health care to the mentally ill patients in the rural community.

Nursing: Is defined as a unique profession that concerns itself with problems that affect an individual's response to stressors. In nursing the highest intervention is sought in order to assist the individual to reach the highest potential level of stability (Reihl–Sisca, 1989:64). In this study nursing will be referred to as the current community-based interventions for mentally ill patients in the rural area which may contribute to their quality of life.

Health: The ability of an individual to make use of their defense mechanism against stressors in order to maintain equilibrium. In order for a person to maintain equilibrium, the total needs must be met (Reihl–Sisca, 1989:64). In this study the focus is on the community-based interventions that are utilized by the professional nurses and other health caregivers to care for and meet the needs of mentally ill patients in the rural community which may contribute to their quality of life.

Environment: the environment is divided into external and internal factors with the internal being the flexible line of defense against stressors e.g. immune response whilst the external consists of coping ability of the individual (Reihl–Sisca, 1989:65). In this study the internal environment can be viewed as formed by the mentally ill patients who receive their community based interventions in the rural environment and the external environment can be formed by the professional nurses and other health caregivers who render these interventions to improve the quality of care of the mentally ill patient.

1.5.2 Theoretical assumptions

The researcher's theoretical assumptions are based on the existing theory as described in relevant sources. In the context of this study the following concepts will serve as a framework.

1.5.2.1 Central theoretical statement

The exploration and description of the community-based interventions and the exploration and description of suggestions by nurses and other community caregivers about utilization of community-based interventions to support mentally ill patients in a rural community will lead to the improvement of quality of care for mentally ill patients.

1.5.2.2 Theoretical definitions

The conceptual definitions that are applicable in this study include:

- community-based interventions;
- mentally ill patient;
- community;
- deinstitutionalization;
- primary health care setting; and
- mental health caregiver.

- **Community based-interventions**

According to the National Institute for Health and Clinical Excellence (2007:5), community based interventions are defined as interventions or small-scale programs delivered to the community settings with the aim to change the risk factors for the target population. In this study, community-based interventions are described as programs and actions that are provided in rural community setting by the professional and other mental health care givers to the population of the psychiatric patients in order to reduce their unmet needs and to improve quality care.

- **Mentally ill patient**

Mentally ill patient means a person receiving care treatment and rehabilitation services or using a health service at the health establishment aimed at entering the mental health status as a user (South Africa, 2002:10). For the purpose of this study, the term is used interchangeably with psychiatric patient or mental health care user. It is referred to as a person who has been diagnosed as suffering from mental illness according to the DSM-IV-TR classification and this person should be receiving mental health care services in the rural community.

- **Community**

Vlok (2001:1) defines community as a group of interacting individuals, occupying the same territory that are united by the commonly shared beliefs, values and norms which are characterized by community sentiment, community involvement and group solidarity. For the purpose of this study, community shall mean all the people including mentally ill patients and their family members, professional staff members, other community mental health caregivers in the rural area who are interacting in rendering care to the mentally ill patients for the purpose of improving quality mental health care for the mentally ill patients in Thabo-Mofutsanyana District in the Free State Province, Maluti-a-Phofung area.

- **Deinstitutionalisation**

Deinstitutionalisation is defined as a shift in focus of care from the large, long term institution to the community, accomplished by discharging long term patients and avoiding unnecessary admission (Stuart & Laraia, 2005:629). Therefore, in this study the term is referred as offering community-based interventions to the mentally ill patients in their own rural community aiming at optimizing the capabilities and also improving quality of life for such patients.

- **Primary health care setting**

The primary health care setting is regarded as the most important point of contact between the patients who seek help for their mental health problems with the health care system (Stuart & Laraia, 2005:635). For the purpose of this study primary health care setting means the clinics and community setting where deinstitutionalised mental health care users are attended to by the mental health care practitioners.

- **Mental health caregiver**

This is an individual such as a physician, a nurse, or social worker who assists in identification, prevention, or treatment of an illness or disability (free online Dictionary 2009:1). In this study, mental health caregiver is used interchangeably with mental health care providers/workers, and will thus be described as a person who renders mental health care to the mentally ill patients in the rural communities in order to improve quality of life.

1.5.3 Methodological assumptions

In this study the methodological assumptions are going to be discussed based on the Botes Model which is described as research decisions that should be considered within the framework of determining the research decisions (Botes, 2002:8). The first order in the model is nursing practice. It is emphasised that a practice situation is the primary source of research themes and practice is constituted by the practitioner who is in interaction with the patient (Botes, 2002:8). Therefore, in this research a primary health care setting and non-governmental organizations in the rural area will be utilized for data collection. The practice in this research is rendering of community-based interventions. Mental health care professional nurses as well as the staff from non-governmental organizations who are rendering mental health to mentally ill patients will be interviewed.

The second order is nursing theory and research methodology. The aim of research on this level is described as functional because knowledge of nursing which is generated is applied in nursing practice (Botes, 2002:8). Therefore, the qualitative approach is chosen which aims at exploring and describing the phenomenon of concern because of its rich, in-depth probing and its naturalistic nature and multi-perspective approach (Polit & Beck, 2006:17). The phenomenological approach is regarded as the most appropriate in this study because focus is on what is happening and the alterations that are needed in community-based interventions of mentally ill patients in rural areas (Brink *et al,.* 2012:122).

On the third order is the paradigmatic perspective (Botes, 2002:8). Reihl-Sisca's philosophy is found to be relevantly influencing, guiding the improvement of the quality of community-based interventions for the mentally ill patients in a rural community. The philosophy also takes into consideration the multidimensional perspective of man as it talks about man as composed of physiological, psychological, socio-cultural and developmental being. In this regard it becomes apparent that the community-based interventions should be holistic in

approach so as to enhance quality given to the mentally ill patients. In the definition of the Environment, it becomes clear that the patient should also be actively involved and responsible in promoting his/her wellbeing through applying internal factors as defenses to stressors together with mental health caregivers'. Community-based interventions will play a major role in altering the environment to improve the quality care of the mentally ill patients as recipients of community-based interventions.

Basic actions that the researcher will use during enquiry are derived from Brink *et al*. (2012:122) as follows:

Bracketing: The researcher will bracket any preconceived ideas and consider every available perspective.

Describing: The researcher will also describe and provide a thorough description of her findings.

Analysis: Data will be reviewed repeatedly until there is common understanding. In the analysis, data will be compared and contrasted to determine the emerging themes, sub themes and further themes.

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1.6 RESEARCH DESIGN AND METHOD

This section gives a brief summary of the research design, method, and data analysis.

1.6.1 Research design

For the purpose of this research, the design of choice was qualitative research, more specifically the case study because this approach assisted the researcher with an in-depth study on community-based interventions for mentally ill patients in their own rural community (Burns & Grove, 2005:27; Polit & Beck, 2008:227). Case studies also provide for descriptive information and present explanatory information. This will allow for exploring and describing the community-based interventions for mentally ill patients in the rural community (Brink *et al.,* 2008:110). The community-based interventions for people with mental illness are best described by the professional nurses and other health caregivers who are actively participating in the holistic care of mental health care users in the community setting. The approach will also allow for in-depth interviews with the professional nurses and other health caregivers when they describe the community-based interventions, their characteristics and

suggestions on the utilization to support the psychiatric patients in the rural communities (Polit & Beck, 2006:212).

1.6.2 Research method

Population, sampling, sampling size and the data as used in this study are discussed collection method are briefly discussed.

1.7 POPULATION

For the purpose of this research the professional nurses and other community mental health caregivers in the rural community were selected as the sampling population. The accessible population was the professional nurses and other community mental health caregivers in the primary health care settings who were based in a rural district and rendered community-based interventions for the mentally ill patients.

1.7.1 Sampling

Sampling refers to selection of participants for participating in the study. In this study non-probability sampling was used to allow the researcher to select the unit of analysis who know most about the phenomenon of interest (Welman *et al.,* 2005:67; Brink *et al.,* 2008:133). Purposive sampling was used whereby professional nurses in the clinics, as information rich participants are consciously selected by the researcher (Burns & Grove, 2005:352). These professional nurses were regarded as the people who understood and involved in the implementation of community-based interventions for the mentally ill patients. The maximum number of professional nurses working in each clinic ranges between four to five professional nurses and one professional nurse was selected from four clinics. Snow-ball sampling (Brink *et al.,* 2008:134; Burns & Grove, 2007:314) was used to expand the sample size with other community caregivers who were taking care of mentally ill patients in the community and who were also willing to participate in the study. The professional nurses were requested to assist the researcher to obtain other community health caregivers who could provide essential information on community-based interventions for mentally ill patients in the rural area. Documents were also identified as sources of data in this study and therefore convenience or accidental sampling was done because patients files are readily available in the clinics.

1.7.1.1 Sample size

In qualitative research the sample size is determined by the purpose of the study and must be large enough to meet the purpose (Burns & Grove, 2005:358). The sample size was determined by the depth and richness of data. Therefore, the number of participants was regarded as enough when saturation of information occurred. Data saturation was reached after ten interviews and analysis of six documents.

1.7.2 Method of data collection

In data collection, focus is on the following important element: broad traditions research, sources of data, different methods of collecting data or techniques (Rule &John, 2011:59). It follows that in qualitative research there are different procedures and techniques that are used to collect data based on a naturalistic approach that seek to understand the phenomenon in the real world (Niewenhuis, 2011:78). In this study a case study method of data collection was followed. In case study method of data collection, the choice of data collection method is determined by factors such as purpose of the study, key research question, research ethics and resource constraints (Rule & John 2011:6).Therefore the preferred methods of data collection in this study were semi-structured interviews, field notes and analysis of existing records (patient's files). In qualitative research data are collected by either interviews, or by observing and recording human behavior in the context of interaction. An interview schedule was formulated and was used by the researcher for data collection

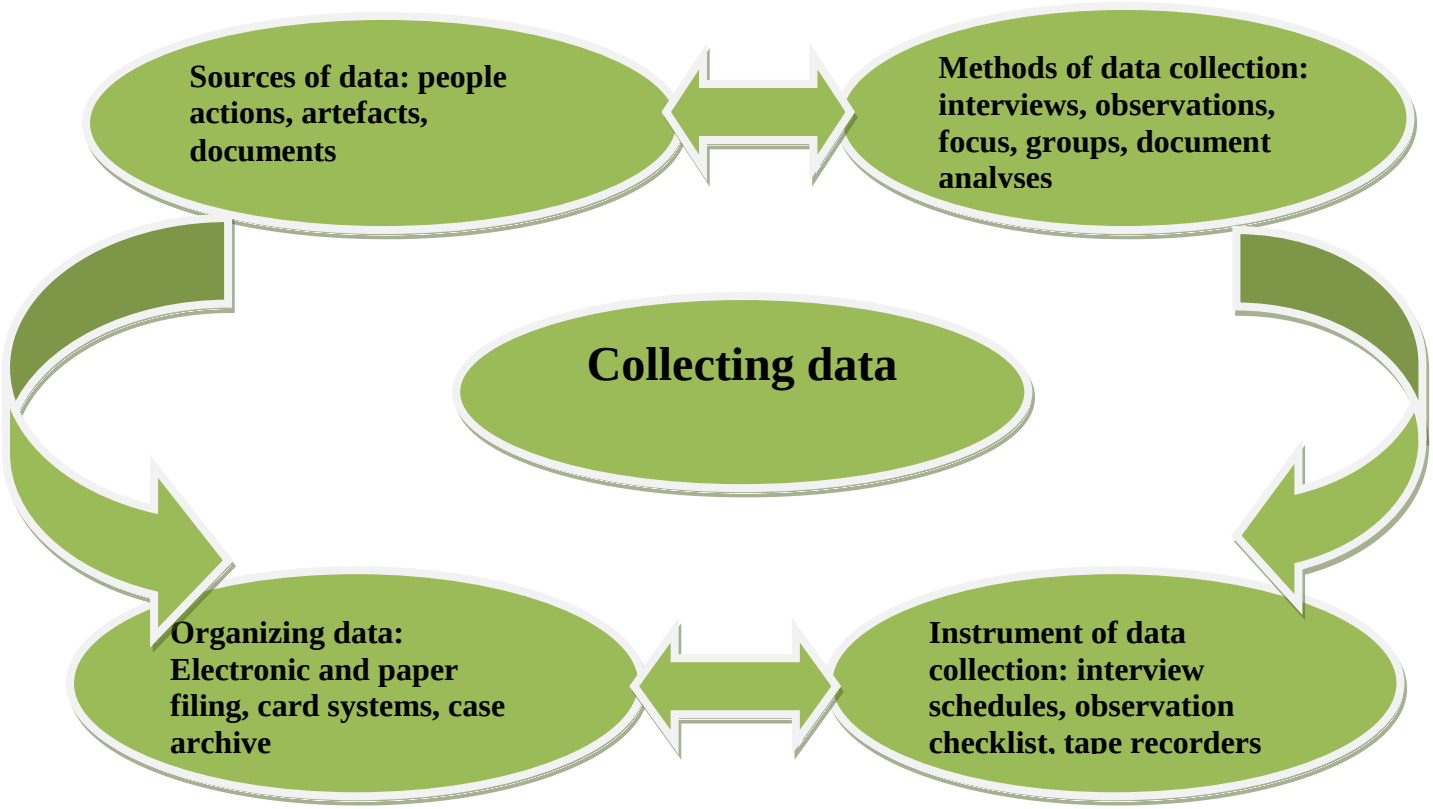

Fig 1.3 Important elements of data collection (Rule & John, 2011:59).

Semi-structured interviews are regarded as a relevant method of data collection in qualitative approach and are inherent in the caring professionals and other community mental health caregivers and are also relevant in case studies (De Vos, 1998:90; Brink *et al.,* 2008:150). The interviews were held in a room, and privacy and confidentiality were maintained. Semi-structured questions were utilized in this study whereby a certain number of specific questions and additional probes were asked because the respondents were from divergent backgrounds (Welman *et al.,* 2005:166*)*. The participants were formed from the professional nurses and other community-based care-givers. These questions included:

- What are current community-based interventions for mentally ill patients in your community which may contribute to their quality of life?
- What are your suggestions about the utilization of community-based interventions to support psychiatric patients in a rural community to improve quality of life?

The interview schedule was refined and submitted to experts for adjustment and guidance prior to the collection of data. A trial run was also conducted to test the interview schedule. Communication techniques like listening, probing and clarification were used in order to understand what was being said (Stuart & Laraia, 2001:30). Recording of face-to-face interviews was done on a voice recorder. The researcher stayed behind after each interview for the purpose of recording the field notes. Field notes are descriptions of events from point of view of the observer (Stommel & Wills, 2004:286).

Document analysis was also done as data gathering techniques. Polit and Beck, 2006:288) cite that an important data source for the nurse is records that include the hospital records, nursing charts, order sheets and care plan statements. In addition records are regarded as economical and convenient sources of information (Brink et al., 2006:155; Polit & Beck 2006:288) document analysis is one of data collecting techniques that can yield rich and useful data in a case study ((Rule & John 2011:63; Polit & Beck 2006:288).

In the study the focus on document analysis was on communication that might shed light on: Exploring the community-based interventions for mentally ill patients to improve quality of life. The patient clinical files were preferred documents because these were believed to shed more light on communications between the multidisciplinary health care teams thus communication of community-based interventions, current and suggested, for mentally ill patients as well. For the purpose of this study data from the documents were only analysed for the current interventions and to corroborate the evidence from other sources for the purpose of triangulation. The criteria according to Niewenhuis, (2011:83) for selecting document were followed:

- What kind of document are you dealing with? (Primary or secondary source, official or unofficial communication etc.).
- What was the purpose or intent of the document? Also consider the context in which it was formulated.
- What are the main points or arguments put forward and how do these relate to your study?

1.7.3 Data analysis

According to Brink *et al.* (2008:11), data analysis is the method used to organize and display data in the manner that will answer the research question. In this qualitative study data

analysis was in the form of words. Data was captured from the written responses and the voice recorders. Some of the participants were contacted telephonically for clarity during data analysis. Data was analyzed by means of making written record or transcript as suggested by Nieuwenhuis (2011:89). The data was organized into core categories or themes by using constant comparison of data. The data was also put together by connecting the categories. A color code was used on each page. An independent co-coder was also involved to assist the researcher in coding.

1.8 RIGOUR

Trustworthiness was used in the study to ensure rigour. Four aspects of trustworthiness were taken into consideration namely: credibility, dependability, conformability and transferability which are based on Lincoln and Guba's framework (Polit & Beck, 2006:539).

1.8.1 Credibility

Truth value was obtained through reflecting the researcher's credentials and personal connections to participants; and also having the research participant's review and member checking in order to ensure that the facts were not mis-constructed (Burns & Grove, 2005:334; Brink *et al.,* 2008:118). Furthermore, the use of audiotape and triangulation of different methods of data collection namely: semi-structured interviews, field notes, documents also ensured the truth value in this study. Prolonged engagement was also involved where the researcher had two visits to the participants as well as spending enough time with them during the interview (Polit & Beck, 2006:332).the purpose of the first visit was to explain about the important aspects related to the study whilst the second was on interview. The interview schedule was also assessed by the researcher's supervisors at North-West University, Potchefstroom Campus.

1.8.2 Dependability

The data was sufficient to allow for transferability and comparison. A portion of data analysis relevant documents was scrutinized by external consultants. An independent co-coder and the researcher analysed data independently and a meeting was scheduled where an agreement was reached on the themes that emerged. The verbatim capturing of interviews on tape recorders together with written field notes ensured dependability.

1.8.3 Conformability

Audit trials were utilized whereby approaches to data collection, decisions about what data to collect, and about the interpretation of data were documented.

1.8.4 Transferability

A very detailed description of the following aspects ensured transferability: nature of the study participants, their reported experiences, and the researcher's observation. More than one data gathering method was used in order to ensure transferability. Rich thick descriptions about the research context, participants, research design and method ensured transferability. In this qualitative study the aim was to provide rich descriptions and not necessarily to generalize the findings of the study.

1.9 ETHICAL CONSIDERATIONS

The ethical manner of conducting a study was considered in this research. The fundamental principles according to Brink *et al.* (2006:11) were used to guide the study.

1.9.1 Principle of respect to person

The participants were informed at regular intervals that they have the right to decide to participate in the study. They were also informed that they have the right to discontinue their participation if they felt like it during the process of the study. The purpose of the study was also explained to them.

1.9.2 Principle of beneficence

Harm to the participants was avoided at all costs. The questions that were asked were structured and the participants were monitored for any discomfort during the process of participation in the study.

1.9.3 Principle of justice

This principle includes the participant's right to fair selection, treatment and privacy (Polit & Beck, 2006:173).

1.9.3.1 Right to fair selection and treatment

The professional nurses and other health caregivers in the community were selected as the population in this study that can best describe the phenomenon of interest. The purpose of the study is for the betterment of the mental health services in the community. The researcher treated the participants fairly by respecting the agreements, punctuality and honoring the appointments. The participants were willing to be involved in this study.

1.9.3.2 Right to privacy

Covert data was avoided as the data that was collected only pertains to the community support systems to the mentally ill patients. The participants were also ensured that the data collected will be as confidential as possible.

1.9.3.3 Ensuring confidentiality

The collected data was kept confidential and not divulged or made available to any other person. The participants were informed that the data will be published for the benefit of other researchers.

1.9.4 Anonymity

Anonymity was ensured by keeping the participant's identities a secret. The questionnaires did not require any personal information. Numbers were used for coding of the institution and the participants, instead of names. The list is kept in a safe place.

1.9.5 Informed consent

Informed voluntary participation was encouraged through giving the participants information about their rights and signing the informed consent forms. The information was given verbally and in writing. English was utilized as it is understood by the professional nurses

and any other language (as deemed necessary) that was best understood by other community care givers.

1.10 Ethical approval

This research was undertaken as a sub-study as part of the RISE project. RISE study is a research program that intends to strengthen the resilience of health care givers as well as risk groups, such as mentally ill patients in terms of participation in research (Koen & Du Pessis, 2011:10). Authorization to do the study was obtained from North-West University's Ethical Committee (see appendix A), the Department of Health in the Free State Province (see appendix C) and the identified institutions through the District Health Manager (see appendix E).

1.11 DIVISION OF CHAPTERS

The division of chapters in this research is as follows:

- Chapter 1: Overview of the research
- Chapter 2: Research methodology
- Chapter 3: Results and discussion
- Chapter 4: Conclusions, limitations and recommendations

CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In this chapter a detailed description of the research design and method was explained. In the previous chapter the introduction and the problem statement together with a brief discussion of the research design and methodology were presented. The following aspects will be discussed, namely: Research design and method, trustworthiness, and ethical considerations. A step-by-step description of how, where and in what sequence the data was collected is also provided.

2.2 RESEARCH DESIGN

The study aimed to explore and describe the community-based interventions to improve quality of care for the mentally ill patients; therefore, the qualitative approach was followed. Brink *et al.* (2008:113) confirms that qualitative designs can be effective if a researcher wants to explore the meaning, describe and promote understanding of human experiences or unfamiliar phenomena. In this study the main feature of the qualitative approach that was considered is that these are used to understand the needs and perspectives of populations and to tailor more generic interventions to meet the needs of populations (Stommel & Wills, 2004:178). The qualitative approach enabled the researcher to explore measures that can be utilized in the rural community to improve quality of care for the mentally ill patients. Burns and Grove (2007:3) describe qualitative research as a systematic, subjective approach that is used to describe life experiences and give them meaning. In addition, a qualitative researcher aims to explore new phenomena and to capture individual interpretation of the meaning and the process (Given 2008:1). Thus, the subjective information which was obtained from the professional nurses and other health caregivers will assist in understanding community-based interventions that are used in the rural area in order to improve the quality of life of the mentally ill patients. Qualitative research also attempts to collect rich descriptive data in respect of a particular phenomenon with the aim of understanding what is being observed or studied in a naturalistic context (Niewenhuis, 2011:47).

In this research, primary health care clinics and non-organisational institutions which render care for mentally ill patients were identified as the naturalistic-context in this rural community of Thabo Mofutsanyana Region, Maluti-a-Phofung district. The Free State Province is

divided into five districts namely, Motheo District (replaced by Mangaung in the map, which is one of the municipality areas in Motheo District), Xhariep, Fezile Dabi, Lejweleputswa and Thabo Mofutsanyana districts. The latter is a rural area in the Free State Province and is divided into five sub- regions namely: Maluti-a-Phofung, Dihlabeng, Phumelela, Nketoane and Setsoto. Primary health care clinics were identified in Maluti-a-Phofung sub-region as follows: Boiketlo and Phuthaditjhaba clinics in Qwa- Qwa, Kopanong clinic in Kestell and Lesedi clinic in Harrismith. Qwa- Qwa is the biggest rural area in Maluti-a-Phofung hence two clinics were identified in this area. Other naturalistic-contexts in Qwa-Qwa were determined through snowball or a chain of references whereby the participants were used to penetrate their social networks to refer the researcher to other community-based caregivers who render community-based interventions to mentally ill patients to improve their quality of care. The examples of these naturalistic areas included the church and non-governmental organizations.

Figure 1: Map of the Thabo Mofutsanyana in the Free State Province (Wikipedia, 2012b:

There are a number of qualitative designs used in research. However, for the purpose of this study, a case study design was used. This design has been selected because it provides significant amounts of descriptive information and can also present explanatory information, and its strength is the depth that is possible when a limited number of individuals or groups is being investigated (Brink *et al.,* 2008:110; Polit & Beck, 2006:242; Burns & Grove, 2011:262). A case study can be described as an in-depth investigation of a single entity, small entities which may be an individual, family, group, institution community or other social unit (Polit & Beck, 2006:242). In this study, data was collected from the professional nurses and other mental health caregivers who are directly involved with the care of the mentally ill patients. The case study design can be used when holistic in-depth investigation is necessary and can also be used to explore situations in which the intervention being evaluated has no clear set of outcomes (Tellis, 1997:2). Case studies also allow for data collection from a single person, a group event or community (McLeod, 2008:1). Consequently, the researcher was able to gather information from the professional nurses and other health caregivers in the rural community. Shuttleworth (2008:1) indicates that case study research design has been used over few years and proved to be useful tools for investigating trends and specific situations and many scientific disciplines. A case study, as a qualitative design also allows for investigation of a phenomenon within its real-life context thus will enhance the opportunity for data collection in the community where care is rendered to the mentally ill patients. In addition, the key strength of a case study method is that it involves the use of multiple sources and techniques in data gathering process (Soy, 2006:3). In this study the professional nurses and other health caregivers were interviewed as multiple sources of information and semi-structured interviews, field notes and patients records were used as different techniques for data collection.

A case study method was used to answer the following questions:

- What are current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life?
- How do nurses and other health caregivers suggest these community-based interventions can be utilized to support mentally ill patients in a rural community to improve quality of life?

Case studies are believed to support deeper and more detailed investigations of the type that answers the how and why questions, however the “what” questions and the “who” questions can be investigated through documents and interviews (Rowley, 2002:17). In this

study the semi-structured interviews were used to collect data from the professional nurses and the other mental health caregivers in order to answer the research questions. The patient's clinical documents were also looked into in relation to the community-based interventions that were recorded. Case study research also opens the possibility of giving a voice to the powerless and the voiceless like the marginalized groups (Nieuwenhuis, 2011:75). A case study allows investigations of real-life phenomena through detailed analysis of limited number of events or conditions and their relationship (Zainal, 2007:2).

The mentally ill patients were regarded as the powerless and the marginalized group of people. Therefore, the professional nurses and other health caregivers in the rural community were selected as the unit of analysis who would have a voice. Koen and Du Plessis, (2011:3) classify a group of mentally ill patients under a risk group of people that are discriminated against and have limited access to health. Thus, individuals and documents were involved as units of analysis.

2.3 RESEARCH METHOD

In this section, sampling, data collection, data analysis, ethical aspects and trustworthiness are discussed in more detail.

2.3.1 Sampling and sampling method

In this instance sampling and sampling method were discussed simultaneously in all three different samples.

2.3.1.1 Sampling

For the purpose of this study the following three different samples were identified, namely professional nurses, other community-based caregivers, and clinical records.

2.3.1.2 Sampling method

Crystallization or triangulation of sampling methods was utilized in this study. Crystallization or triangulation is said to be one of the six strategies to ensure internal validity in qualitative research which uses several investigators, sources and methods and these should be used to compare the findings with one another (Kobus & Van Der Westhuizen, 2011:38). In this

study, purposive sampling method, snowball and convenience sampling methods were utilized in order to provide for a complex and deeper understanding of the phenomenon. Telephone and personal methods of recruitment were used

Sample One:

Sample one consisted of professional nurses working in primary health care clinics within Maluti-a-Phofung sub-region in the Boiketlo and Phuthaditjhaba clinics in Qwa-qwa, Lesedi clinic in Harrismith and Kopanong clinic in Kestell. Inclusion criteria included that these professional nurses should have been directly involved in rendering the community-based interventions for mentally ill patients in order to improve quality of care. They should be registered with the South African Nursing Council.

Stratified purposive sampling which can sometimes be referred to as judgmental sampling is described as a means of selecting participants according to pre selected criteria which is relevant to a particular research question (Nieuwenhuis, 2011:79; Polit & Beck, 2006:264). Professional nurses who render community-based interventions to the mentally ill patients in Maluti-a-Phofung in the rural community clinics were selected. Therefore, purposive sampling method was used to select the professional nurses in the primary health care clinics, in Qwa-Qwa, Harrismith and Kestell. The professional nurses, who were regarded by the researcher as knowledgeable, could explain and describe the community-based interventions rendered to the mentally ill patients in this area. The same professional nurses should also have knowledge of other mental health caregivers in their community who could be eligible for inclusion as participants.

The researcher identified the clinics in three different areas of Maluti-a-Phofung. The criteria of selection were based on where mental health services are rendered. The professional nurses who met the criteria were the coordinators of mental health services in each clinic and were recruited. In Kestell there was only one clinic for the entire community, while in Harrismith out of three clinics, only one rendered mental health services. In Qwa-qwa there were about twenty six (26) clinics and mental health services are rendered at each. The researcher decided to collect data from the professional nurses in two clinics in Qwa-qwa because one of the clinics was the only one that was utilized by the visiting team of the mental health care professionals from the psychiatric complex in Bloemfotein and the other clinic seemed to have a larger catchment area. In addition, the participants were selected based on the fact that they were responsible for coordinating mental health services in the clinics as professional nurses who meet the selection criteria.

Telephonic and personal recruitment methods were used. Recruitment of participants was done through the District coordinator who phoned the identified clinic to announce the researcher's visits. During the first visit in each clinic the researcher met with the clinic Manager who identified the clinic coordinator. Appointments were secured for data collection. Information with regard to research was also given to the participants.

Sample Two*:*

Sample two was composed of caregivers who also render community-based interventions to the mentally ill patients. Inclusion criteria were that they should have been members of the community who render care to the mentally ill patients in the areas that were identified, namely: Qwa-Qwa, Harrismith and Kestell. These caregivers might have had no formal training in psychiatric nursing science.

Snowball or chain referral sampling was used to select the mental health caregivers in the community. This is the method used to find the appropriate case that a person is able to lead the researcher to others and sometimes in cases where the participants are difficult to trace (Terre Blanche *et al.,* 2011:291). The professional nurses in the primary health clinics as early sample members helped the researcher to identify other health caregivers. The health caregivers were the people who also rendered community-based interventions to the mentally ill patients in Qwa-qwa, Harrismith and Kestell. The sample consisted of the managers of the non-governmental organizations, faith healers and traditional healers.

The participants were contacted telephonically for the initial meeting for which the appointments were secured and information was provided. In the non-governmental organizations the managers were selected as they showed willingness and interest to participate in the research. The chairperson of the traditional healers was also contacted telephonically. An agreement was reached that the researcher should join the traditional forum meeting. The chairperson of traditional healers insisted that the researcher should explain the purpose of her visit in the forum. The forum agreed that their chairperson could be interviewed for the purpose of this research. The researcher went personally to the faith healer to secure an appointment to conduct the interview and provide information about the study. One member from each organisation was selected.

Sample Three:

Patient's clinical records were selected in each of the above mentioned clinics. These records were expected to show the community-based interventions that were implemented

in the care of the mentally ill patients. Recordings of interventions should be completed by all professional nurses and the other multidisciplinary team members who are involved in the care of mentally ill patients.

Convenience sampling or accidental sampling was utilized to select the patients' clinical records as primary sources of data in the selected clinics for the same purpose of exploring and describing the recorded community-based interventions in the primary health clinics in Qwa-Qwa, Harrismith and Kestell. Convenience sampling referred to as availability sampling involved the choice of readily available patient's clinical records (Brink *et al.,* 2008:132; Polit & Beck, 2006:262). The focus was on all the written communication that shed light on the community-based interventions that were rendered to the mentally ill patients.

After each interview, the mental health coordinator in the clinic selected any two clinic files for the mentally ill patients. All the clinical records for the mentally ill patients are kept in the clinics for safety and treatment control.

2.3.1.3 Sample size

The sample size was determined by data saturation. Interim data analysis was done to determine if rich descriptive data and saturation were achieved This was evidenced after additional cases no longer provided new information that challenges or adds to the emerging interpretative account. There was evidence that the data was nearing a complete and adequate form or redundancy (Terre Blanche *et al.,* 2011:288; Polit & Beck, 2006:273). Data saturation was reached after four interviews with professional nurses, six interviews with other caregivers and six patient's files.

2.4 DATA COLLECTION

This section involves a detailed description of data collection which includes the role of researcher, physical setting data collection method and field notes.

2.4.1 Role of researcher

The researcher had to request permission to conduct research in Maluti-A-Phofung (see appendices B and C). The first letter was sent to the Head of Department Health in the Free State Province. After receiving a letter of approval (see appendix C), the researcher wrote

another letter to the District Health Manager requesting permission to conduct research in the above mentioned area. The letter was accompanied by approval from the Head of the Department of Health. In this letter, specific areas and clinics in Maluti-A-Phofung were specified as follows: Qwa-Qwa Boiketlo and Phuthaditjhaba clinics, Kopanong clinic in Kestell and in Harrismith the Lesedi Clinic. The interviews were collected by the same researcher.

Permission from the Health District Manager, Maluti-A-Phofung, enabled the researcher to approach the Local Area Managers in different clinics and requested them to act as mediators. The request letter was also submitted to the mediator when the following aspects were explained: their roles in research, objectives, importance research and criteria of inclusion of the study units. Briefing sessions were also arranged prior to the actual data collection dates. Ethical aspects placed emphasis on confidentiality, the purpose of the study was explained to the participants, and lastly, an indication was provided of how long the interviews or series of interviews would take (Welman *et al.,* 2011:198). Interview dates were then arranged together with the setting.

The researcher was in the clinics on the planned date. Punctuality was observed by the interviewer. The room for the interview was organized before the actual interviews were conducted and privacy and quietness' was ensured. The tape recorder was checked as to whether it was in working order, put on a soft cushion to help improve the sound quality and plugged in readiness for use. The new batteries were also availed in case of power failure. The lights were checked and the materials for taking of field notes as well as the interview schedule were also placed in readiness. Refreshments were also arranged. The participant was shown into the prepared room and emphasis on confidentiality, and the summary of what the research entailed was explained. The participant was reassured that anonymity would be maintained by making use of numbers and the participants and their institutions would not be addressed by their names. The alphabet was used to refer to institutions whilst the numbers were used to refer to the participants. Before the interviews started, the participants were informed that the discussions would be tape recorded with the participant's permission.

2.4.2 Field notes

Field notes can be described as detailed notes and observations that are made by the researcher (Welman *et al.,* 2011:198). Field notes also allow the researcher to keep a full record of the interview without having to be distracted by detailed note keeping (Terre

Blanche *et al*., 2011:298). The researcher would write down all events during the interview that may not be obvious from listening to the tape recorder. The recording would also include the non-verbal cues of the participant like pause during the interview, sitting arrangements and body gestures (Welman *et al.,* 2011:199). The categories of field notes were observed according to Polit and Beck (2006:307) as follows:

- *Descriptive notes:* Describes objectively the events and conversation.
- *Reflective notes:* Documents researchers personal experiences, reflections, and progress while in the field.
- *Theoretical notes*: Interpretative attempts to attach meaning to observations.
- *Methodological notes:* The instructions or reminders about how subsequent observations will be made.

2.4.3 Physical setting

Polit and Beck (2006:510) describe the physical setting as a physical location and conditions in which data collection takes place. The physical location of the interview room was at the selected clinic or any place determined by other caregivers. The room should have an adequate degree of privacy in order to avoid unduly disturbance. The researcher also ensured that the participant planned to give the interview an undivided attention. Chairs were arranged squarely to enhance an effective interview and to facilitate eye contact. The researcher ensured that she knew the interview schedule very well and avoided referring continuously as this could have interrupted the flow and the eye contact (Terre Blanche *et al.,* 2011:298).

2.4.4 Method of data collection

Samples one and two

Semi-structured interviews were used as a method of data collection in this study. An interview schedule was compiled and same were given to the mediator as well as to experts at the School of Nursing Science at the North-West University, Potchefstroom, with experience in qualitative research for evaluation. The interview schedule was adjusted according to their suggestions and thereafter it was utilized for data collection. The interview was practiced with a colleague who was also a nurse educator before the researcher started gathering data (Nieuwenhuis, 2011:88). A trial run was also conducted to test the

applicability of the instrument which proved to be a success. The data collected in the trial run could be included in for data analysis.

In the semi-structured interview, the interviewer asked a certain number of specific questions namely:

- What are the current community-based interventions for the mentally ill patients in a rural community which may contribute to their quality of life?
- How do nurses and other community mental health care givers suggest these community-based interventions can be utilized to support mentally ill patients in a rural community to improve quality of life?

However, the researcher also used probing to enrich data (Brink *et al.,* 2008:152). The guidelines as cited by Niewenhuis (2011: 88) and Terre Blanche *et al.* (2011:299) were followed during the interview as follows:

- Find person who best qualified in terms of the research question to provide information: professional nurses and other community mental health caregivers who render community-based interventions to the mentally ill patients were selected during sampling stage as such persons..
- The aim is to collect rich and descriptive data on the phenomenon and to saturate data: The aim of the interview was explained to the participants and the interview questions were based on the aim. The researcher also ensured that the participants were willing to take part in the interviews by explaining to them that they had their right to refuse..
- Ask open ended questions which do not presume an answer: The researcher took precautions regarding the questioning strategy, that is, avoided asking closed questions and ensured that the questions were clear and neutral. In some cases the participants were asked to rephrase their questions to ensure that the researcher understood clearly what was discussed. The interview was not too long as the questions were kept to a minimum.
- Listen more talk less: The interviewer understood that she was there to listen and not to dominate the interview. During the interview session communication techniques were also taken into consideration. Probing and clarification of questions were asked to enhance understanding of the participant's perceptions and understanding. The questions like tell me more about or can you explain further about the community-based interventions for the mentally ill patients in your community, were asked to opinion and value questions: what do you think about the

community-based interventions for the mentally ill patients in order to improve quality of care in your community? This was asked as a knowledge question (Nieuwenhuis, 2011:88). Paraphrasing was also used whereby the participant's words were repeated in order to understand what was said. The researcher avoided being judgmental, criticism and leading questions.

- Observe the respondents and researchers non-verbal communication: The participant's and the interviewer's non-verbal cues were also observed. There was no barrier between the interviewer and the interviewee. The interviewer maintained an open and upright posture and employed the minimal verbal responses like nodding of the head, I see, and "mm" to show the participant that she was interested and listening and also to encourage the participant to talk more. Eye contact was maintained.

The interviews lasted between 20 minutes to an hour and a half since the interviewees found it difficult to concentrate beyond that (Terre Blanche *et al*., 2011:300). At the end of the discussion the participants were asked if they had anything to add. Detailed field notes were taken from any input made after the tape recorder was switched off. . The participants were informed that should there be a need for a follow-up interview he/she would be contacted on time. The notes were written up immediately after the interviews to ensure that no information was ignored. The tape recorder was kept in a safe place.

Sample three

Documents were also analysed as part of data gathering. These included two patient's clinical files from each clinic which were selected by means of convenience or accidental sampling. The focus was on the written communications that shed light on the community-based interventions for the mentally ill patients as recorded by the health caregivers. The documents also served to corroborate the evidence from the data collected from the professional nurses and other health caregivers (Nieuwenhuis, 2011:83).

The following process according to Nieuwenhuis (2011:83) was followed:

- What kind of document was the researcher dealing with? In this research the patient's files were the primary official documents that were used to collect data. They were classified as such because they were the original official and communication source documents which were gathered directly from the clinics (Nieuwenhuis, 2011:82).

- What was the purpose or intention of the document? The documents were used to record everything about the patient including the management and the treatment received in the clinic.
- What are the main points or arguments put forward and how do these relate to your own study? In this case the community-based interventions that were implemented in the holistic management of the patient were basically the point of interest that was related to the study: Exploring community-based interventions for the mentally ill patients to improve quality care.

2.5. DATA ANALYSIS

Before data was analyzed, the semi-structured interviews were transcribed. Each transcript was divided into three columns as follows: first column is for recording own reflective notes and observation. The middle larger column is for transcript and the third column is for coding. Transcripts were developed through listening to the tape and reviewing the notes. At the same time reflection on the interview was done so as to identify the gaps that need to be explored in a follow up interview. Each transcript was read through thoroughly and the research questions that guided the study, aims and objectives were kept in mind. The interpretative pattern of data analysis for qualitative data analysis was followed and the guidelines prescribed by Terre Blanche, Durrheim and Kelly (2011:321) were adopted. The purpose of this pattern was to provide a thick descriptive of the characteristics, processes, transactions, and contexts that constitute the phenomenon being studied. The following steps were followed:

- *Familiarization and immersion*

In this step the text was read through many times to ensure familiarity with what is found where, what kinds of interpretations are likely to be supported by data and what are not. Notes were made and diagrams drawn.

- *Inducing themes*

The material is looked into and organizing principles that naturally underlie the material are worked out. The identification of themes was grouped into main categories, sub categories and further categories.

- *Coding*

Coding was done simultaneously during the activity of developing themes. In this instance marking different sections of data as being relevant to one or more of the themes was considered. Codes were written in the third column of the transcript. The same codes were reapplied to similar segments of data.

- *Elaboration*

The linear and chronological order of events and what people said was looked into at this juncture. The field notes and the transcript were looked into in a linear sequence and events or remarks that were distant from each other were brought together. The main purpose was to keep structuring the material until one felt that he/she can give a good account of what was going on in the data.

- *Interpretation and checking*

The interpretations were put together as a written account of the phenomenon under study. The researcher also gave some indication of how her personal involvement in the phenomenon may have colored the way in which data was collected and analyzed.

A qualitative researcher was appointed as a co-coder to analyze the data. The list of the transcripts and the interview schedule were given to the co-coder. After the co-coder and the researcher had each analyzed the data independently, a meeting was scheduled to compare the results to come to an agreement about the categories that emerged from the data.

2.6 TRUSTWORTHINESS

Trustworthiness is the criteria used by the qualitative researchers in evaluating a study's quality (Polit & Beck, 2006:41). Different forms of trustworthiness were applied as described by Stommel and Wills (2004) as well as by Polit and Beck (2006:40). The identified criteria include conformability, dependability, transferability and credibility. The following figure describes trustworthiness in this research:

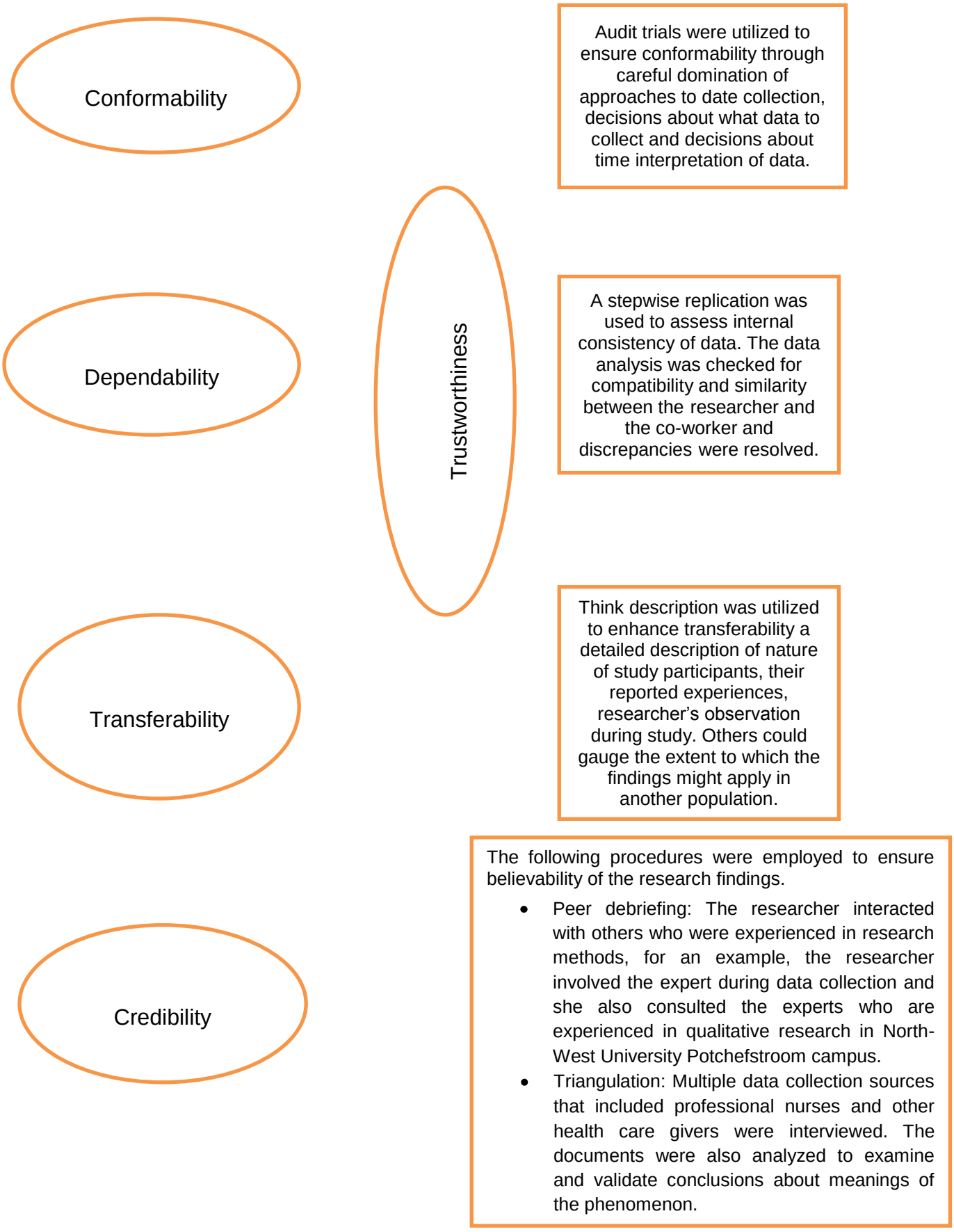

Figure 2: Trustworthiness in research

2.7 ETHICAL ASPECTS

The researcher undertook the responsibility to conduct the study in an ethical manner through carrying out the research competently and honestly, acknowledging fairly those who contributed guidance to the research, communicating accurate results and considering the consequences of the research for the field of study in particular and for society in general (Brink *et al.,* 2008:30). The study was done as a sub-study and was conducted in the school of nursing science supported by the Faculty of Health science. The research was granted ethical clearance as a sub-study within the Rise project (Strengthening the resilience of health caregivers and risk groups, Koen and Du Plessis reference number: NWU-0036-11-SI) see appendix A. Philosophical principles guiding the research as prescribed by Wassenaar (2011:67) were adopted to guide the ethical consideration in this research as follows:

- *Autonomy and respect for the dignity of persons*

Information was given to the participants and their right to participation in the study without the risk of prejudicial treatment was emphasized. They were also informed of their right to withdraw from the study at any time. The consent form was formulated and the all the participants who were willing to participate signed the voluntary informed consent. Confidentiality of the institution and participants was protected by avoiding the use of their names. I Instead, numbers were used.

- *Non-malfeasance*

The researcher ensured that no harm would befall the participants as a direct or indirect consequence of the research. The unobtrusive research method was used. The design, methodology and data analysis was justifiable, feasible and lead to valid answers. The information about the name and the contact numbers of a person who would have assisted with counseling facilities in case where discomforts associated with research were experienced was also availed to the participants.

- *Beneficence*

The research was undertaken to address questions that are of value to the rural communities in society. The Department of Health, the mental health caregivers as well as the mental health care users could benefit from the study because the community-based interventions will be of value to the participants and society at large. The participants would also be monitored for the signs of distress during the interviews.

- *Justice*

The participants were treated with fairness throughout the research process. Purposive selection of the participants for the study included those who can answer the research questions on community-based interventions in the rural area. The participants were also willing to take part in the study and would benefit from the outcomes of the study in the sense that there would be improved quality care of the mentally ill patients. The interviewer was punctual and the interviews were completed at the agreed time. The interviews were held in a private room and the information which was shared was kept confidential. A request was made to record the conversation during the interview sessions.

In the next chapter discussion of the research findings and literature control will be dealt with.

CHAPTER 3 DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

In the previous chapter the research design and method were described. In this chapter the focus will be on the realization of data collection and analysis, and the discussion of the results with direct quotations from interviews and references to existing literature to support the findings and to ensure data quality.

3.2 REALIZATION OF DATA COLLECTION AND ANALYSIS

3.2.1 The realization of data collection

Four professional nurses formed the sample from the total population of professional nurses in the four clinics and six community members who rendered community-based interventions for the mentally ill patients. The latter were identified through snowball sampling. The selected individuals of professional nurses work in the clinics in Maluti-a-Phofung Region. The professional nurses assisted in the identification of community members such as three managers of the non-governmental institutions or organizations, a South African Police Officer, a Faith healer, and the chairperson of the Traditional healers in Qwa-Qwa. Documents were also used as data collection method where a sample of six patient's records was identified in three clinics. In one of the clinics patient's records could not be availed.

The interviews were conducted by the researcher who teaches Psychiatric Nursing Science in the Free State School of Nursing who is experienced in using therapeutic communication skills. Language differences were taken into consideration during interview sessions. The language of choice used to interview the professional nurses was English whilst the other community mental health caregivers preferred to be interviewed in Sesotho. Written and verbal information was given to each participant prior to the interview. The written information was in English which was interpreted to the community caregivers who were interviewed in Sesotho. Before the interview, an appointment was scheduled with each participant and a consent form was signed. The consent form was also written in English and interpretation was based on the need of the participant. The cultural background of the participants was also taken into consideration. For example, when the researcher had to

meet the Faith healer and the Traditional healer, the dress code was considered. The interviews were recorded and were later transcribed. After each interview, the field notes were taken immediately. Data saturation was achieved after four interviews with professional nurses, six interviews with community members and document analysis of six patient files.

3.2.2 The realization of data analysis

Data analysis was undertaken by the researcher independently, and by the independent co-coder. Thereafter, a meeting for consensus was scheduled where the researcher and the co-coder reached the agreement on the major themes, sub themes and further themes. A summary is found in table 3.4. Two major themes were identified as follows:

- Current interventions
- Suggestions regarding utilization of community-based interventions.

The sub-themes and further themes also emerged – see summary in table 3.1. The table of findings was divided into two columns namely: column one is for the themes, subthemes and further themes and two for frequency or number of appearance of theme.

3.3 DISCUSSION OF FINDINGS AND LITERATURE CONTROL

A summary of the findings is found in the table below (table 3.1). A discussion of findings and literature control follows table 3.1.

Table 3.2.1 Summary of various categories and subcategories of Community-based interventions for the mentally ill patients to ensure quality of care

Themes for interview schedule question 1: Current interventions	Frequency/Number of themes
Attempts to monitor or implement measures to control the treatment and intake of medication of patients	7 reports (70%)
Getting patients appropriate treatment and/or medication	7 reports (70%)
Working with other organizations/institutions/departments to manage the care of patients & referring patients to them for help	5 reports (50%)
Getting assistance from the SAPS when needed to handle or manage patients	5 reports (50%)
Sending home-based care-givers to patients' homes	5 reports (50%)
Educating communities about mental illness	4 reports (40%)
Educating families about mental illness and the care of mentally ill family members	4 reports (40%)
Referring patients to district hospitals after 72 hour assessment when needed	3 reports (30%)
Providing group therapy and/or counselling for patients and their family members	3 reports (30%)

Having celebrations for patients to encourage and support them	3 reports (30%)
Visiting doctors/psychiatrists/psychologists to attend to patients (usually on a monthly basis)	3 reports (30%)
Giving patients health education and information	2 reports (20%)
Teaching patients skills (e.g. gardening, cleaning, cooking)	2 reports (20%)
Encouraging family members to be responsible and to be involved in the treatment and rehabilitation of patients	2 reports (20%)
Encouraging patients to be active in the community	1 report (10%)
Supporting patients' family members	1 report (10%)
Attending to mentally ill patients as soon as possible (ASAP) or fast-tracking them to prevent them leaving before getting treatment or getting irritable	1 report (10%)
Picking up and transporting patients from their homes when their families can't handle them	1 report (10%)
Availability of a mental health care forum	1 report (10%)
Themes for interview schedule question 2: Utilizing suggested interventions	
The development and availability of community care centres or homes for the mentally ill: - **That teach them skills (social, communication, domestic, self-care) and help them become independent and where they can participate in recreational**	8 reports (80%)

activities - **That have multi-disciplinary teams available to deal with the needs of patients** - **Where patients can be monitored and cared for** - **Where social grants of patients can be controlled**	
Continued community education (on a larger scale) on mental illness and the role of the community	5 reports (50%)
Social grants of patients/mentally ill must be controlled so that they can't be misused by their family members/others	5 reports (50%)
Training nurses, care-givers and other professionals to handle the mentally ill	3 reports (30%)
Availability of sufficient numbers of staff trained in mental health care	3 reports (30%)
Continuous monitoring and support of the mentally ill after release	3 reports (30%)
Inclusion of religious institutions/healers or traditional healers in care and rehabilitation of the mentally ill	3 reports (30%)
An improved system to identify patients that default on treatment	3 reports (30%)
Establishing support groups for families of the mentally ill	2 reports (20%)
Encouraging family members to take responsibility and help with the monitoring and treatment of patients after their release	2 reports (20%)
Mental health awareness campaigns should be held more often	2 reports (20%)
Training emergency department staff, police, etc. to handle the mentally ill	2 reports (20%)
Sending professional nurses with home-based care-givers	2 reports (20%)
Availability and/or improvement of mobile clinics that also cater for the mentally ill	2 reports (20%)

Renewal of grants should be reviewed	1report (10%)
Collaboration between patients, patients' families, professionals and communities regarding the care and treatment of the mentally ill	1 report (10%)
Referral/admission of mentally ill patients directly to regional hospitals (skipping district hospitals)	1 report (10%)
Establishing a district council responsible for mental health/illness to monitor health services	1 report (10%)
Improvement and availability of toll-free numbers that provide information on mental illness	1 report (10%)
Encouraging community members to be more involved in community centres for the mentally ill	1 report (10%)
Attention given to mental health services from National level and upward	1 report (10%)

.3.1 Current Interventions

3.3.1.1 Attempts to monitor or implement measures to control the treatment and intake of medication of patients:

Mentally ill patients visit the clinic on monthly basis to receive their treatment and also for assessment in relation to response to treatment. They are divided into groups and come for follow-up visits on Fridays only. Most of the patients receive treatment in an injection form as it is seen to be the most reliable method of enhancing treatment compliance. The injection is only given once a month. However, if oral medication is given the doses are reduced to at least twice or once a day and not more except on very rare cases where a mental health care user can take the medication three times a day. This also increases compliance. The patients' files are also left in the clinic so that they do not get lost and for treatment control purposes. All the mental health care users who collected their medication for the particular month are recorded in the registers so that those that default their treatment can be identified. The family members are also encouraged to accompany their mentally ill patients to the clinic for follow-up treatment.

There are those patients who default their treatment and in such instances the short message services are sent to some of the patient's cell phones in order to remind them about the treatment. The community health caregivers are also sent to the community in order that they can trace the defaulters. From the non-governmental institutions the patients are taken to the nearby clinics for their treatment on a monthly basis. They are being monitored even at their homes to ascertain that they take their medication. Sometimes, medication education is done to the mentally ill patients so that they know everything about their treatment. Most of the mentally ill patients are reported to be roaming around the shopping complex and if they are seen by the nurses they are reminded to come for their treatment. Regardless of all the efforts to ensure that the patients receive their monthly treatment there are those patients who still default and as a result relapse thus resulting to the revolving door syndrome. Some of the patients experience side effects from the treatment they are receiving. The relatives of the mentally ill patient blame the members of the non-governmental organization as responsible for their family member to have tremors or drooling saliva .On the other hand in some of the organizations and by the professional nurses treatment for mentally ill patients is regarded as effective because it is stated that after initiation of the treatment the patients' conditions become under control.

The following quotes illustrate these findings:

"In our clinic we grouped our mentally ill patients so that they come for follow-up treatment on Fridays"

"On monthly basis when the mental health care users come to collect their medication they are recorded in the register to ensure that the defaulters are identified. At the end of the month if there are those who did not turn up, the health caregiver from the non-governmental organization goes to make a follow-up so that is how the community caregivers are utilized in our clinic."

"Other patients like to go to the shopping mall and these are the ones that are not violent and are well orientated to date, place and time but like to go to shopping complexes every day. When such patients are met by the nurse at the shopping complex, they are being reminded to come to the clinic for treatment and they do respond positively."

"...that is why the mentally ill patients are loitering most of the time and roaming around but once they are here we organize treatment for them. They become under control".

Stuart (2009:501) emphasizes that the key role of the professional nurse is to maximize therapeutic effects of drug treatment and to minimize the side effects resulting in a patient being a true collaborator in managing medication regimen. However, Monahan *et al.* (2003) in their study Mandated Treatment In The Community For People With Mental Disorders, highlight that some courts follow subject's treatment participation and apply sanctions for non-adherence and they use courts to mandate treatment.

3.3.1.2 Getting patients appropriate treatment and/or medication

The mentally ill patients get different medication in the form of injection or oral medication. The medication that is administered includes amongst others largactil, clopixol, fluenzol and modecate in an injection form. Most of the mentally ill patients are diagnosed as suffering from schizophrenia and therefore are receiving modecate in an injection form as their treatment which they receive once a month. Seranace is mostly used by those that are on oral

me4edication. However, those who according to the DSM-IV-TR are diagnosed as suffering from depression receive deprassin or haloperidol for treatment.

The initial prescription of psychiatric treatment is done at the regional hospital by the psychiatrist. In some of the clinics there are general practitioners (medical doctors) that visit the clinics whereas in some visits are done by the psychiatrists (mental health care specialists). Seemingly, in other clinics visits are on monthly basis in others they are reported to be done on Mondays and Wednesdays. The main aims of visits are to review the patients in terms of the treatment, to see the new patients. Depending on the condition of the patient treatment can be changed. However even though there are some means of the doctors and psychiatrists review of the patient's treatment in the clinics, sometimes it becomes impossible. The reason being that the patient-doctor ratio poses a problem because the community members are too many for only one doctor. Some of the patients are referred to the regional hospital for treatment review after six months and thus increasing the workload of the psychiatrist in the hospital.
In one clinic the professional nurse also indicated that the patients are also assed for medical and social conditions which include HIV/AIDS and receive appropriate treatment.

In one of the non-governmental organizations a concern was raised that sometimes the patient adheres to the treatment and never defaults but do not get cured in as far as their mental status is concerned. Therefore this brings about frustration to people that are giving support to such patients.

The following quotes illustrate these findings:

"…most of them are getting modecate as they are diagnosed with schizophrenia, so they usually get the injection which is administered once a month. There are those who are having depression who are on deprasin and haloperidol. Most of the drugs that re used also include clopixol, fluenzol and modecate in an injection form.

"…the psychiatric doctor is here to see what they can do for the patients in terms of treatment review and changing treatment to suite the condition of the patient and also in relation to social and medical problems.

"…every person who is on chronic treatment must be reviewed in six months' time. At some stage it is not possible because eh here at the clinic we are having referrals from about three clinics. During the visits the mandate is that the she should consult only fifteen patients. There are patients with different illness for an example she sees diabetic patients, hypertensive patients and epileptic patients, that is everybody who is sick or having minor ailments. So the patients are referred from different clinics to see this only doctor here in the clinic. Therefore the doctor-patient ratio is problematic. The community members in this area are too many for one doctor".

Stuart, (2009:532) support that using the simplest regimen as possible and involving patients, families or support systems in decision making enhance effective medication management. The use of psychotropic medication should be carefully monitored in line with broader quality improvement (National Mental Health policy 2010:220).

3.3.1.3 Working with other organizations/institutions/departments to manage the care of patients and referring patients to them for help.

It is reported that there is interdepartmental or inter-institutional collaboration between governmental and non-governmental institutions. Most of the non-governmental institutions refer the mentally ill patients to the clinics where assessment is done. Thereafter the patient will be referred to the district hospital for seventy two hour assessment after which the patient can be discharged or referred to the regional hospital for further management depending on the condition. When discharged from the regional hospital the patient is referred back to the clinic for monitoring, support and treatment. When the patient is in the community the health care workers which are only trained in basic nursing care from the non-governmental institutions are then utilized to continue to support the mentally ill patients within their families.

The non-governmental institutions and the professional nurses in the clinics also get support from the department of social development when assisting the patients to get the identity books, social grants and food parcels. The traditional healers and professional nurses also report to receive support from the psychologist.

One of the non-governmental institutions is also receiving referrals from the clinics for those patients who are abusing substance and are willing to be rehabilitated. If the patient is not

improving from the support given in that organization he/she is referred to a rehabilitation center. The South African police services are also utilized in cases of a violent mentally ill patient in the community.

The following quotes illustrate these findings:

"…yes we refer those patients that report to have social problems to the social worker. The social worker does home visits and situational analysis in other instances and comes up with the solution".

"…a questionnaire for substance abuse is filled if there are more than two yes it means that the patient has a problem. During assessment the severity of the condition is also taken into consideration. If the patient is aggressive he/she is referred to the district hospital and if she understands that he/she needs help he/she is referred to the organization".

Ip (2002:3) supports an intersectoral and multi-level approach in promoting mental health in Hong Kong and further states that sectors that are involved in caring for mentally ill patients include: department of health, other governmental agencies, hospitals authorities, non-governmental organizations and other community. Thus the situation in this rural area tallies with situations in other areas similarly the National Mental Health policy (2010:26) support national, Provincial, traditional, faith based, non-governmental and other private sector organization partnership persuasion in mental health care.

3.3.1.4 Getting assistance from SAPS when needed to handle or manage patients

It becomes apparent that the South African Police officers are called to intervene when there is a violent mentally ill patient in the community. Most of the time they receive calls from the family or community members to come and help. Some of the non-organizations allude to the fact that the police officers are responding quickly when summoned. However some members report that there is some delay or no help at all from the police officers. One of the participants indicated that the police officers should make their discretion to decide whether or not to attend to the crisis situation because if it happens that the patient breaks the police vehicle that specific officer will be held responsible for the damage.

The professional nurses also report that once they receive the information about a violent patient, they call the police officers to attend to the situation in the community and transport him/her to the clinic for assessment before he/she can be referred to the district or regional hospital.

The following quotes illustrates these findings

"…we seek assistance from the South African Police Services so that the violent patient can be fetched wherever he or she is and be brought to the clinic".

"…they are actually not sure about the role they need to play especially police officers who should help us with the mentally ill patients who are staying on the mountains and those that are dangerous".

Cordner, (2006:2) confirms the involvement of the police officers interventions in mental health when he indicates that a family member, friend or other concerned person usually calls the police for help during a psychiatric emergency".

3.3.1.5 Sending home-based caregivers to patients' homes

The community-based home caregivers also play a role in the care and support of mentally ill patients. Currently in few clinics in this district there are community home-based caregivers who are allocated from non-governmental organizations. In some of the clinics the community-based caregivers are only requested when needed. These community-based care givers are responsible for site visits or home visits for the mentally ill patients. They identify the mentally ill patients in their families or in the community, do follow up visits in case of those who default the treatment, support them when taking treatment. These community based caregivers have elementary training in home-based care and assist any patient at basic levels. There are some challenges though, that are facing the community-based caregivers during the process of supporting the mentally ill patients at their homes. It is reported that sometimes it becomes dangerous for them to enter in some homes. The females are in more danger because some of the male patients attempt to rape them. Another participant reported that the mentally ill patient cannot be handled by different people and have a tendency of refusing instructions from any

other person. They sort of have trust in one person or professionals that they are used to, if they are treated by an unfamiliar person they become difficult.

The following quotations illustrate these findings

"…there are home-based caregivers at the clinic and they are from the non-governmental organizations so they are not part of the clinic staff".

"…we must utilize the home-based caregivers to attend to the mentally ill patients in their homes which according to my opinion is totally not good at all".

"…now let us imagine if the patient refuses to be given treatment by the professional person what about the community-based caregiver? It becomes worse, it does not work".

Janardhana 7 Naidu, 2012: endorse that community-based services should be provided by minimally qualified nonprofessionals who are minimally qualified as change agents.

3.3.1.6 Educating communities about mental illness

Some participants further mention that one of the important community-based interventions that they offer is to improve quality when caring for the mentally ill patients is to educate communities about mental health and mental illness. There are used different strategies that are used to educate community members and these include the use of the information pamphlets, door to door campaigns, the mental health professionals visiting shopping complexes and give education. Loud speakers are used to announce about the event so that people can be gathered at one place to receive information. One of the non-governmental organizations further indicates that they also utilize the radio slots to give the information to the community members to make them aware of the services that they render towards mental health.

In July month the individual clinics as well as the non-governmental organizations organize a day to celebrate mental health awareness. On that day the patients and their relatives as well as other members of the community are invited. Health education is given surrounding the aspects that are related to mental health. The non-governmental institutions make use of the mental health nurses to give information during their selected campaign days. There are different topics that are addressed for an example: causes of mental illness, signs and symptoms of mental

illness and substance abuse, stress and stress related conditions. They are also made aware that social problems can also contribute to mental illness like depression so that the community members can be aware of such. The community members are also taught about what to expect when a person is mentally ill, when to bring the patient to the clinic, when and how to summon for help from the police services. They are also made aware of the importance of giving proper history and serious consequences if a person is not diagnosed on time such as committing a serious crime.

The following quotes illustrate these findings:

"…so one of the aims of primary health care is nurses is to give health talk and information".

"…I think the awareness campaigns should be done almost every time and not wait for the July month".

"…the community needs to be made aware of all the aspects surrounding mental illness including the causes".

"…nowadays the most prominent cause of mental illness is drug abuse. Most of the young people abuse the drugs therefore we also talk about drug abuse".
One of the goals of community-based nursing care is consultation and education where information about mental health principles are provided to the community members to increase awareness of mental health practices to enhance primary health prevention (Stuart, 2009:628).

3.3.1.7 Educating families about mental illness and the care of mentally ill family members

The professional nurses emphasize that health education is given to family members and the mentally ill patients in the clinics. The family members of the mentally ill patients are sometimes accompanying their mentally ill relatives to the clinic because they are believed to understand the treatment for the mentally ill patients more than the patients themselves. In the clinics different services are rendered on different days like for instance on Mondays there are services for epileptic patients and minor ailments, Tuesday is a specifically for patients diagnosed with hypertension, Wednesday those that are diagnosed with diabetes mellitus,

Thursday is the clinic for asthmatic patients whilst Fridays' there is a clinic for the mentally ill patients. However the people with minor ailments report to the clinic every day.

Health education on different topics is covered from Monday to Friday on different conditions. Sometimes the patients are all given the health talk on mental illness and how to handle threat regardless of the condition that brought them to the clinic. Some of the patients are believed not to be aware of mental illness and are therefore prepared for future when they are faced with challenges of a person with mental illness and should know what to do. Different topics that are also dealt with include causes, signs and symptoms, how to deal with a mentally ill patient and the referral system to other institutions.

Families are also given information during door to door campaigns where there is an opportunity to talk with the patient and his/her family members about mental illness. Mental health education is regarded as one of the powerful intervention or strategy that assists to improve quality care of mentally ill patients in the community. One of the professional nurses reported that after receiving the education, many people came to the clinic to get help and more information about mental illness. The number of those that default treatment is reduced and new cases are being reported most often.

The following quotations illustrate these findings:

"…family members are also encouraged to accompany their mentally ill patients so that they can also develop an understanding about treatment".

"…Every community member should know about this problem".

"…most of the time, maybe once a month you find that there will be a family member who will report at the clinic looking for who is responsible for mental health, seeking for information or help on mental illness.

Jones, (2009:1) suggest that targeting family members increases awareness and aids in diagnosis because if having insight about mental illness, family members will recognize early onset of disease and encourage early contact with medical services.

3.3.1.8 Referring patients to district hospitals for 72 hours assessment when needed

The professional nurses mention that according to the referral system, from the clinic and after basic assessment, the mentally ill patients are referred to the district hospital for seventy two hours observations. The patient that are reported to have that first episode of mental illness are the ones that are referred to the district hospital and the ones with chronic mental illness are referred straight to the regional hospital in case of a relapse. After that period of seventy two hours, if there is no improvement observed from the condition of the patient then that patent is referred to a regional hospital where she/he will be hospitalized. Once improvement in the patient's condition is observed, the patient is referred to back to the clinic for follow up management.

In the district hospital the mentally ill patients are said to be managed by professional as well as the general practitioners. This is reported to be posing some challenges during the referral process to the district hospital. It is reported that if the patient is referred for seventy two hours observation, within two hours the patient is seen within the community having been discharged from the hospital. The very patient will be reported by family members to be still aggressive and destructive yet the patient was seen from the district hospital for treatment and management. This leads to family members taking the patient to the hospital from time to time. The mental health coordinators report that they are trying to advocate fo the mentally ill patients in the district hospital but in vain.

The following quotations illustrate these findings:

"…the reason being that if a new patient who comes to the clinic for the first time and is being reported to be sleeping away from home, being violent and destroying property, one would assess the patient and refer him/her to the district hospital where one is expecting that the patient will be observed for seventy two hours".

"…she was referred to the district hospital but to the great disappointment that lady was not institutionalized as she was seen roaming around two hours after referral".

"…all district hospitals are utilizing medical doctors who do not have interest in mentally ill patients".

The head of health establishment grants the medical practitioners or other mental health care practitioners to assess the physical and mental health status for seventy two hours as per prescripts (Mental Health Care Act, 2002:36).

3.3.1.9 Providing group therapy and/or counseling for patients and their family members

- Group therapy:

In one of the clinics the professional nurse gave information that the patients are grouped according to dates in order to facilitate group therapies. In the groups the patients are said to be coming together, share their experiences and problems. The positive aspects about group therapy are that the patients turn to accept their status and do not feel ashamed when they learn that they are not the only ones who are having mental illness. Rehabilitation is also enhanced.

- Counseling for the patients and their family members.

The traditional healers also report that they work hand in hand with the psychologist if it comes to their realization that the patient is ill because of stress. The psychologist will then talk to the patient and assists in identifying the patient's problems.

Similarly from the clinic, those patients who are regarded as having social problems are referred to the social workers and they are counseled. The family members are also invited for counseling however sometimes they do not turn up for solutions to the problems.

The psychologists form part of the outreach team which is from the Psychiatric complex in Bloemfontein. They also take part in counseling patients. They are involved as sometimes the mentally ill patients lose hope and wish to die. Sometimes they even communicate about suicide. Therefore the interventions by the psychologists become imperative in such situations. One way of the psychologist to assist the patients to solve their problems is to refer the patients to the psychiatrists.

The following quotes illustrate these findings:

'…therefore this grouping becomes more important as they learn to accept their illness.".

"…we are working with the psychologist from the government sector because we cannot work with the independent ones because it can be too expensive. So we ask help from them so that they come and check the mind status of our patients".

"…one of the patients who would just breakdown without any stimulus also was discovered to have so many problems was referred to the psychologist who suggested that the patient should also be seen by a psychiatrist".

Bronowski *et al.* (2011:1) concluded that social support means presence of friends and close people who can be reliable in difficult crisis situation. In addition support groups aim at maintaining homeostasis, provide psychosocial networks and offer opportunity for problem sharing (Johansson & Werbat, 2009:3).

3.3.1.10 Having celebrations for patients to encourage and support them

Other participants report that they do celebrate the mental health awareness with the patients in July. Donations are requested from members and also financial assistance is requested from the business people so as to make the celebrations a success. In other organizations the mentally ill patients are made to play games like soccer so that they are able to realize their importance in the community. In the celebrations people with mental illness and their families are invited. Different topics on mental illness are presented.

The following quotes illustrate these findings:

"…the other thing that we do is that we sometimes do celebrations for them".

"…in reality the most important department is the department of health. Because of the knowledge they have on mental health issues, they teach our community members about mental illness and treatment thereof".

3.3.1.11 Visiting doctors/psychiatrist/psychologists to attend to patients (usually on monthly basis)

According to professional nurse's report, there are doctors who usually visit the clinics. In some of the clinics, visiting doctors are the general practitioners who consult the referrals even from other clinics as well. These are the patients who present with different conditions including those that are diagnosed with mental illness. During the doctor's visit and according to the agreements the doctor is allowed to see only fifteen patients per visit.

The visiting doctors come on different days as reported from different clinics. Some are said to be visiting on Mondays and Wednesdays. In one clinic there are psychiatrists who are involved in community outreach and these psychiatrists are based in the psychiatric complex in Bloemfontein. They visit the clinic once a month and all the mentally patients from Thabo Mofutsanyana district are seen from this particular clinic. These doctors are said to be reviewing the patients' treatment which is done after every six months.

However promising as it is, this intervention is viewed as ineffective because of the doctor patient ratios. There are more patients as compared to doctors. Therefore it sometimes happen that some of the patients treatment is not being reviewed after six months by the visiting psychiatrist. In some instances such patients are referred to the psychiatrist in the regional hospital and his is also a problem because the psychiatrist in the hospital experiences work overload.

The above discussions are supported by Bronowski *et al*. who concur that home care services are provided by interdisciplinary teams including psychiatric nurse, psychologist, psychiatrist and psychiatrist. In addition according to the National Metal Health policy (2010:41) primary health doctors are allowed to prescribe all medications in the essential medicines list.
The following quotes illustrate these findings:

"...the visiting doctors come on monthly basis on the third week of the month to review patient's treatment and to see the new cases. So when they arrive they reassess the patients and prescribe treatment."

"…during the visits the mandate is, she should consult about fifteen patients. There are patients with different illnesses for an example she sees the diabetic patients, hypertensive patients and epileptic patients including everybody who is sick or having minor ailments."

3.3.1.12. Giving patients health education and information regarding mental health/illness:

The patients are given health education during the mental health awareness month where they receive the health talks on Fridays. Also during door to door campaigns the patients are given the health talks. The patients are taught about their treatment so that they should know about the treatment receive. They are also taught about their return dates for treatment so that they do not forget and know the importance of coming to the clinic for follow-up. In some occasions, if they miss their return dates to the clinic, they are being taught to come immediately. They remember even if it is on weekends, more especially in those clinics that are fully functional on weekends.

There are also problems that are experienced because some of the patients cannot understand much about the treatment that they get. Such patients need to be accompanied to the clinics by their relatives so that they can be supported as the family members have a better understanding about psychotherapy. There are very few patients that are accompanied by their relatives. Therefore, the return cards are mostly used as the reminders for the return dates where the nurse who attended to the patient will indicate the date on which the patient attended the mental health clinic, the medication that was given, and also the return date.

The following quotes illustrate these findings:

"...during door to door 2 reports (20%) campaign we talk to the patients and their family members."

"...each and every patient is taught about the treatment he or she is taking so that they know exactly about their treatment."

"…each patient is taught about the treatment he or she taking to enable them to know exactly about the treatment".

3.3.1.13. Teaching patients skills (e.g. gardening, cleaning, and cooking):

In order to improve the patient's quality of life, attempts are made to empower the mentally ill patients on certain skills like gardening and communication. The mentally ill patients are invited to do gardening in the clinics and at the homes in other institutions. From the clinics the seeds are obtained from the Department of Agriculture.

The biggest challenge is that the mentally ill patients are not responding to the invitations. The only time that they will respond is when there are some meals that are prepared for them and if not they do not come. What the mentally ill patients are observed to be enjoying is roaming around in the shopping complexes requesting for hand-outs.

Rangan and Sekaar (2006:128) affirm that the strength approach is valuable in making the mentally ill family members responsible and valued members of the groups of the community. In addition, Kruger, Murray and Zanjani (2011:10) conclude that extension programs that are designed to promote mental health among aging in rural areas promote mental health, independence and lead to quality of life. In addition patients are taught structured ways of modifying their own thoughts and behavior in order that they can manage difficult situations and live happy and successful lives, skills can include holding conversations, establishing and maintaining friendships, dating, managing medications and grooming (Stuart 2009:208).

3.3.1.14. Encouraging patients to be active in the community:

Some organizations are reported to be willing to help the mentally ill patients to be involved in the community participation and activities. In one instance one of the organizations managed to organize wheelchairs for the mentally ill patients in need of wheelchairs to promote mobility.
Integration of the mentally ill patient to his/her family members becomes easy if the patient is active in the community. The mentally ill patients are also assisted to take care of themselves and to realize their potential. The patients should be encouraged to use their talents and be developed to become active community members.

Huyn*et al*.(2008:11), suggest that individuals with mental illness can be re-introduced to the community with supportive services and develop the ability to contribute to the life of their communities. In addition, Aarti & Sekar (2008:128) in their study on Strengths Perspective in Mental Health, conclude that a strength approach ascribes people that people need to be citizens, responsible and valued members in their groups of communities.

The following quotes illustrate these findings:

"The other victory is that we have managed to organize some wheelchairs for some of the patients who are mentally ill and are in need of wheelchairs. We are really trying to help patients according to their needs."

3.3.1.15. Supporting patients' family members:

One participant indicated that they also inform the family members about their services so as to support them. They believe that the family members should know that the organizations are dependent upon them in managing the mentally ill patients. Family members are visited by the home-based caregivers and they give advice on the importance of taking the patient for follow-up visits. They are also taught about the rights of the patients. Some of the workers assist family members in organizing so that their mentally ill patient receives birth certificate, identity book and social grants.

Johnson, Walker, Polamo-Gonzalez and Curry concluded that it is important to consider the well-being of all family members and help them identify and access public and community support when necessary.
The following quotes illustrate these findings:

"...we assist in terms of organizing that the patients should receive the social grants so that he/she can access the clinic services or our services."

3.3.1.16. Attending to mentally ill patients as soon as possible (ASAP) or fast-tracking them to prevent them leaving before getting treatment or getting irritable:

In one of the clinics the professional nurse reported that the clinic for the mentally ill patient is on Friday. On that day the mentally ill patients are given the first priority in terms of consultation so as not to stay for a long time in the clinic. Therefore they are attended to first be released.

3.3.1.17. Picking up and transporting patients from their homes when their families cannot handle them:

In most cases it is reported that the violent mentally ill patients are transported to the clinics by police officers using government vehicles. The police officers are regarded as the ones that are trained to handle the violent patients in the community.

In some of the organizations the mentally ill patients are transported by the family members to the clinics or hospitals. The community-based caregivers also do house to house visits and identify the mentally ill patients. They also take the mentally ill patients that default treatment to the clinics for proper management.

Contrary to the community-based interventions that are reported to be implemented, the reports also indicate that there are many patients who are staying at the shopping complex who need people to support them who are in need of treatment. These are the patients that are reported to be in the shopping malls in the morning and in the evening they are back at their homes and this is what they do on daily basis.

According to the National Mental Health Policy (2010:20), the Department Of Health allows engagement of non-health sectors including justice to ensure an inter-sectoral approach to mental health. In support of the above implementation with regard to services rendered to mentally ill patients police officers are called for help during psychiatric emergencies by family members, friends and other concerned persons (Cordner 2006:2).

The following quotes illustrate these findings:

"…with the ones that are dangerous to themselves or other people we call for assistance from the police services. There are those that stay on the mountains and those that are very dangerous where one finds that this organization cannot handle their situation."

3.3.1.18. Availability of a mental health care forum:

One of the participants also indicated that there is a mental health care forum in this area. It is in this forum where the problems related to mental health care issues are reported. Information with regard to the constituency of the forum was requested later from a professional nurse in one of the clinics who gave the information as follows: it is formed by the District mental health coordinator ,mental health services coordinators from all the clinics in Thabo-Mofutsanyana District, a representative from the hospital review board, chairperson of the traditional healers, a representative from the religious healers, different non-governmental organizations with different programs, psychologist, social worker, and police officers. There are meetings held on a quarterly basis where events, problems with regard to mental health and their solutions are discussed.

The following quotes illustrate these findings:

"...we also have a mental health care forum where we actually discuss the problems that we are encountering when it comes to supporting the mentally ill patients."

Stuart (2009:173) suggests that community forums can be valuable in assessing the community needs. It is regarded to be one of the District health services to develop inter-sectoral collaboration between ranges of sectors involved in mental health through establishment of the District Multi-Sectoral Forum for mental health (National Mental Health Policy, 2010:25).

3.3.2 Utilizing suggested interventions

3.3.2.1 The development and availability of community care centers or homes for mentally ill patients

Out of the participants that were interviewed they all suggested that there should be community centers or homes that should be developed for mentally ill patients. The participants have different views when it comes to the name given to these institutions. Some refer to them as community centers, the others as half-way houses, homes, whilst the others refer to them as hospices. However, they all believe that if the mentally ill patients can be accommodated in

specific places after they are discharged from the institutions, this can improve their quality of life.

Some base their arguments on the fact that the patients are admitted to the hospitals, get treatment and are discharged to the very same environment which might have triggered the condition. This ends up with the situation where the patients are in and out of the hospital. Some add by saying that sometimes the patients are taken to hospitals by the relatives unnecessarily; more especially if they no longer accept their family member with mental illness. Some argue this point by saying that the traumatized family members are sometimes justified to reject the mentally ill patient who is violent and destructive and that it happens that the patient is discharged from the institution before recovery.

The homes, half-way houses, and day care centers can be appropriate to house the patients who are homeless and found roaming in the streets. If the patients are grouped together in the same place they will be accessed more easily by the clinic staff.

Other reasons for motivating for the aforementioned suggestion are that the mentally ill patients are neglected by their family members and the community at large. Others are even abused and are made to work as slaves by the community members at the shopping complexes where they are mostly found to be roaming around. The examples of abusive measures that are sited include that they are made to carry heavy buckets of water and litres of paraffin for the hawkers at the malls. The patients will also be freed from being chained by their families.

Other participants also cite the reasons for the patient's roaming around and not staying with their relatives. Such reasons include amongst others abuse, hunger, and misuse of their social grants.

Utilization of community care centers or homes for mentally ill patients:

Various suggestions are given by different participants.

- The mental health care users can utilize the centers during the day and in the afternoon they go back to their homes and are with their families.
- Others suggest that the centers should be used for both long- and short term periods. That is with those patients who are still well cared for by their family members, care should only be given during the day and in the afternoons they must go back to their

respective homes. Those that are neglected by their families should be cared for in the centers for the rest of their lives.

- Lastly, others suggest that because some of the patients are discharged from the institutions before recovery, in such instances the patient can be cared for in the center until full recovery and there after the patient should be left to be independent in his/her home.
- One participant also stated that approval for admission in the day care center should be through the Department of Justice.

The participants also looked into how the community centers/homes can benefit the mentally ill patients:

- Teach them skills (social, communication, domestic, self-care) and help them become independent and where they can participate in recreational activities

They can participate in many activities and programs like support groups, church services, relaxation techniques to help them focus and keep them away from destructive behaviors, empowered on communication skills, taught on how to be independent, and assist in performing some house hold chores. The patients should also perform activities and utilize their talents. For instance, those that are poets should write poetry or stories and the ones specializing in handcraft can make use of the opportunities.
They can also be taught about the activities of daily living, how to prepare their meals and many more skills.

- That have multi-disciplinary teams available to deal with the needs of patients:

Suggestions are also made that there should be two or more psychiatrists in the center who will be readily available when needed. Professional nurses should also be part of the community team. The inclusion of physiotherapists, social workers as well as psychotherapists is also important. Stake holders like the non-governmental organizations and other community members can be included. The traditional healers and religious healers need to form part of the team as well.

- Where patients can be monitored and cared for:

Participants believe that in the community centers treatment for the mentally ill patients will be monitored and there will be control over those patients that default their treatment.

- Where social grants of patients can be controlled:

All the participants are showing concern about the disability grant that is received by the mentally ill patients as they state that from what they observe, this grant does not benefit the mentally ill patients only but mostly used to support family members. Therefore, the suggestion or the solution to this problem should include placing the patients in the community center. There should be measures put in place to see to it that the grants are properly controlled and utilized to benefit the mentally ill patients only.

The following quotes illustrate these findings:

"...the place should be utilized during the day and the night for the patients. In reality some of the patients do not have where to sleep they sleep at the bus tops."

"If there can be two or three psychiatrists who are readily available so that the long process can be shortened."

Botha, Koen, Oosthuizen, Joska and Hering (2008:275) support the above suggestion by indicating that there is tremendous shortage of residential placements facilities for individuals with severe mental illness in South Africa. In addition to the support, Monahan et al. in their study, illustrate that to avoid subsidizing houses for people with severe mental illness through homelessness, government should provide a number of housing options in the community.

3.3.2.2. Continued community education (on a larger scale) on mental illness and the role of the community:

Most of the participants believe that the community members are still not aware about mental illness. Therefore, the department of Health needs to increase more effort in community education around the aspects of mental health/illness. The community members should also be made aware that if there is one member in a family who is declared mentally ill, the entire community might be affected. Community members should be taught how to support the patient and the patient's family members.

One of the participants further suggested that the school curriculum should also include mental health care issues. The school children sometimes discriminate against other children by saying that they are mad if it happens that one of them becomes affected. The point on high rate of substance-use in schools has been highlighted as the biggest cause of mental illness in school children.

Members of the non-governmental institutions also indicate that there is a great need to increase the resources to enhance education in the community. The example that is illustrated is the availability of posters or booklets that should be written in different languages so that the community members should be able to understand the information or the message.

The following quotes illustrate these findings:

"...mental illness is not a family problem however it affects the entire community if one family member becomes mentally ill.

"...in schools the children are abusing dagga, drugs, glues and many more."

"...for an example if the Zulu speaking people receive a poster that says: "iidakwamizwa ziyalimaza" (drugs are dangerous) they will be able to understand.

3.3.2.3. Social grants of patients/mentally ill must be controlled so that they cannot be misused by their family members/others:

Measures should be put in place to control patients' social grants which are misused by the relatives. It emerged from the participants reports that most of the mentally ill patients are not taken care of by their families. After receiving the social grant on a monthly basis some of the mentally ill family members are chased away from their homes. Others are made to sleep in the streets or shacks when the family members are sleeping in the house. The personal hygiene of these patients is also not taken care of, even their clothing is not considered. Therefore, there is a strong feeling from the participants that both the National and Provincial department of Health should devise some measures to control and administer the social grants for the mentally ill patients. Some also indicated that the social workers can be of help in this regard.

The above suggestion is supported by Monahan, Swartz and Bonie (2003:4) when stating that there are challenges facing the mentally ill patients when it comes to managing money which include: impaired ability to manage money, victimization, and inappropriate usage of it. Therefore, systems like the Social Security Administration who may appoint a representative payee to manage disability benefits can be of importance.

One of the ways to encourage establishment of tertiary preventive programs include health education. The community members can be educated about mental illness, needs of mentally ill patients and experiences of people who have serious mental illness stigma to promote community acceptance and lead to development of better services (Stuart:2009:213).

3.3.2.4 Training nurses, care-givers and other professionals to handle the mentally ill:

The participants indicated a great need to train all the stake holders who are responsible for mentally ill patients. They cited a great need to increase training of the psychiatric specialists to curb the shortage thereof in the District hospitals and clinics. One of the participants also encouraged the Tuba Model where the physicians are trained towards one specialty and not as a general practitioner. It also emanated from other professional nurses that there is a need to train more psychiatric nurses so as to improve the quality of care for the mentally ill patients because if there is no psychiatric nurse in the clinic, patients are often turned away without receiving help. This brings about a negative impact on the patient's side in terms of costs and compliance.

A suggestion is also made that the supporting family members should also be trained on how to handle and support the mentally ill patients more effectively at their homes. The non-governmental officers and the community-based workers are also appealing to the Department of Health to empower them on certain aspects of mental health so that they can render their services effectively.

The following quotes illustrate these findings:

"...I think we should have as many psychiatrists as possible"

"...if the department can provide more training of nurses on mental health nursing science."

"...indeed we do gain some information from nurses during awareness campaigns however, that is not enough we need further training so that we can be able to care and support the mentally ill patients".

Jenny et al. (2008:3) affirm the need to this training when reporting that one of the challenges that exist to the decentralization of health services and development of community services is the development of strategies to train professional nurses in the community.

3.3.2.5 Availability of sufficient numbers of staff trained in mental health care:

Participants from both sides of the professional nurses and non-governmental organizations agree that there is a shortage of staff to offer support and quality care to mentally ill patients. In all the clinics the mentally ill patients are the sole responsibility of one mental health coordinator. In some instances the patients are turned away by other professional nurses if the mental health care coordinator is off duty. There are not so many professional nurses who are having psychiatric nursing science as one of their qualifications in the clinics. Therefore, the suggestion is that the department of Health should provide more training of professional nurses on psychiatric nursing science.

The other suggestion pertains to training of psychiatrists to cap the shortage and poor management of mentally ill patients in the district hospitals. There is also a cry from the non-governmental organizations that there is a shortage of nurses in the clinics who could go for home visits with the community-based caregivers the reason being that the home-based caregivers are not trained in the procedures used to handle mentally ill patients in the community. The non-governmental organizations' members are also appealing to the Department of Health to offer them training so that they can also be able to handle the mentally ill patients independently.

Huynet al. (2008:3) identified development of trained professionals in the community as one of the challenges that exist to decentralization of health services. In addition Hague et al (2002:697) conclude that integrated training of nursing courses at either post basic levels would mitigate the problem. Training of advanced psychiatric nurses can be of value in the sense that they are capable of making diagnosis, determining treatment interventions, monitoring responses, complementing care providers and referring to other mental health specialists when necessary (Moller & Haber 2010:5).

3.3.2.6 Inclusion of religious institutions/healers or traditional healers in care and rehabilitation of the mentally ill:

It is apparent that the religious healers and the traditional healers are consulted by the relatives of the mentally ill patients in the rural areas. Therefore, the department of Health in the Thabo-Mofutsanyana region has considered working hand in hand with these groups of people in the management of mentally ill patients. Therefore, both groups also suggested that they be considered in the team responsible for managing the mentally ill patients in the community center.

Other literatures consider the reintegration of Traditional healing with biomedicine. In his study, Gureje (2010:336) attributes the utilization of traditional healers/religious healers as caused by unmet needs of mentally ill patients in the low income countries as the only available source of help for patients and their families. Furthermore, Appiah- Kubi, Raja and Boyce (2006:14) state that traditional, herbal and faith healers are the ones who treat the majority of mental patients.

Therefore, also in Thabo-Mofutsanyana rural District some of the mentally ill patients receive their interventions from the traditional and faith healers.

3.3.2.7 An improved system to identify patients that default on treatment:

Some of the participants suggest a need on improved system for tracing the defaulters.
At the present moment nurses are not doing the home visits in this district, instead the visits are done by the community-based caregivers alone.
There should be mental health care nurses who do home visits together with the home-based caregivers and other members of the non-governmental institutions.
There should be availability of transport for the nurses so that they avoid using their own cars in times of crisis interventions in the community.
Another suggestion is considering the use of a roving team that would be moving from place to place identifying and managing the defaulter rate.
Shortage of vehicles meant that mental health workers were unable to visit patients at home with staff experiencing great difficulty even when transferring patients (Thom 2008:1).

3.3.2.8 Establishing support groups for families of the mentally ill:

Few participants believe that any person can be affected by mental illness directly or indirectly, therefore there is a great need for families with relative suffering mental illness to support each other. One of the participants added by indicating that, support plays a major role in improving conditions for mentally ill patients and their families.

The following quotes illustrate these findings:

"...support groups of families should be established.

Kelvin (2009:526) suggests that peer to peer empowerment programs as support for family members can improve their own emotional well-being and maximize the chances of recovery for patients. Thus, this case confirms the suggestions made by the participants. In addition, Johansson and Werbart (2009:10) support the statement by citing that group therapy has been used successfully and is effective in reducing social isolation and it increases the use of adaptive strategies.

3.3.2.9. Encouraging family members to take responsibility and help with the monitoring and treatment of patients after their release:

Few family members are believed to support their mentally ill members in terms of accompanying their members to the clinic for follow-up visits. They also take responsibility in reporting the mentally ill patients who default treatment and having other related problems. The mental health coordinators also enhance the collaboration between the health caregivers and the family members of the mentally ill patients. Sometimes the social worker gets involved if it has been identified that the patient is having a social problem. The social worker will assist in solving family problems. However, problems are still identified where some of the family members do not honor the sessions with the social worker.

A suggestion was made that strategies should be devised for families who are looking after a mentally ill patient in order to support them.

Conclusions are made that attention to and awareness of the psychosocial environment including family support network should be a fundamental strategy for all nurses (Korhonen et al., 2008:774).

The following quotes illustrate these findings:

"...few family members take care of their mentally ill patients.'

"...they only request the health caregivers to work with family members in case of the patient who default treatment."

"Sometimes the family members find it to be a huge responsibility to care for the mentally ill patient especially if diagnosed for the first time."

3.3.2.10. Mental health awareness campaigns should be held more often:

It is also the feeling of other participants that it is important for the family members and the community at large to receive continuing education and information on mental health issues. Teaching should also cover the important aspects like how the mentally ill patients should `be handled, the rights of mentally ill people, and the fact that they only receive the information once during the campaign and it is not enough. This will assist to develop understanding on mental health by the family members and also strengthen the mental health services.

According to Wells et al (2004:4), regional campaigns are regarded as public health interventions that help to address the public health mission of reaching at-risk individuals thus also preventing others to be at risk.

The following quotes illustrate these findings:

"...I think the awareness campaigns should be done almost every time and not wait for the July month.
"...if I can suggest it can be on quarterly basis."

3.3.2.11. Training emergency department staff, police, etc. to handle the mentally ill:

One point of view from one of the participants is that the emergency department officers should be involved in intervening during a crisis situation experienced by a mentally ill patient. They should give injections as a means of first aid to the mentally ill patients. The participant believes that if a mentally ill patient gets the injection, violence and aggression stop. He claims that when the violent mentally ill patient is assisted by the police officers they are handcuffed and that is not good because mentally ill patients should be handled like a person who is involved in a car accident and not as criminals. He further added by saying that when the mentally ill patient sees the police officers they become more violent because most of the time the officers are viewed by the community members in different ways. The police can be considered as manpower in assisting to transport the mentally ill patients.

Khawaled et al. (2006:209) confirm by stating that there is a need for emergency psychiatric services for early detection and treatment of emerging mental illness and of which one model could be based on mental health ambulance services that can be given specific training in psychiatric interventions.

3.3.2.12. Sending professional nurses to accompany home-based care-givers:

The professional nurse's non-governmental organization staff alludes to the fact that nurses are experiencing a work overload that could be attributed to a shortage of staff. As a result it becomes a problem for the nurses to do follow-up visits in the villages or even to trace those that defaulted treatment. They further indicate that there is absolutely no time for the professional nurses to do home visits because of the pressure at work. This also contributes to the patients staying without treatment for a long time. The other problem facing the issue of home visits is that there is no transport that can be utilized. The professional nurses sometimes use their own transport in cases of a dire need in a crisis situation.
On the other hand the non-governmental institutions suggest that the home-based caregivers should go out to the communities and the family members with the professional nurse. It is also their feeling that the nurses should also witness the maltreatment that is done to the mentally ill patients by their families where the others go to an extent of sleeping at the bus stops. Nurses are believed to have more knowledge about mental illness and therefore the mentally ill patients can receive the support they deserve from them.

The following quotes illustrate these findings:

"...There is no time for the professional nurses to go out of the clinics because of the pressure of work."

"...the nurses should do home visits with us because sometimes when we are at certain homes we are not taken seriously and sometimes not helped as expected."
"…It could be very wise if the professional nurse can go with the health care worker to the patient's home."

3.3.2.13. Availability and/or improvement of mobile clinics that also cater for the mentally ill:

It has been mentioned that some of the mentally ill patients stay at the farms in this District. Because of a lack of mobile clinics for these patients, services are not well distributed.
A suggestion has been made that mobile services need to be improved in order to strengthen the mental health services. Coupled with this suggestion one participant also suggested that there should be a team of professional nurses who manages the mentally health services in the community on a daily basis as this can be one of the means to support the mentally ill patients.

Mobile services are said to be an essential part of effective emergency mental health services system because they reduce hospitalization as patients are diverted to community-based treatment (Guo et al., 2001:1).

The following quotes illustrate these findings:

"Therefore there is also a need to improve the mobile services because mentally ill patients can be identified and referred to the clinics."

3.3.2.14. Renewal of grants should be reviewed:

Renewal of the social grants for the mentally ill patients seems to be posing a big challenge. The participant feels that one of the causes of the patients relapsing is the system of renewing social grants and that this needs to be reviewed. The example that is cited is that when the mentally ill patient is taking the treatment well, the patient's condition will improve. As the condition improves the social grant also stops. This frustrates the vulnerable patient who will in turn resort to ineffective defense mechanisms which will include smoking dagga, abusing alcohol, thus mental illness.

In support of the suggestion, Monahan et al. (2003:4) report that people with disabilities, including the ones with serious mental disorders, qualify under current state laws to receive social benefits such as income.

3.3.2.15. Collaboration between patients, patients' families, professionals and communities regarding the care and treatment of the mentally ill:

One of the participants suggests a need to have a common goal in the care of the mentally ill patients. The health professional, the patients, family members as well as the community at large need to come to a consensus and agree on the measures that can be used in order to improve the quality of life for the mentally ill patient at their homes. She believes that the involvement of all the stakeholders in the community can bring about new ideas and inputs towards the proper care of mentally ill patients. A community survey was therefore suggested where the community members should be asked to give inputs on what worked, what did not work and what should be done to improve the quality of care for the mentally ill patients.

Furthermore, Wells et al (2004:5) indicate that agreeing on goals as well as expectations, and equal partnership can help mitigate mental illness problems.

The following quotes illustrate these findings:

"...may be the other solutions would be appropriate and we can be able to see what can be done about the patients unlike when we just know that the patient only comes to the clinic just to get modecate and goes back home."

3.3.2.16. Referral/admission of mentally ill patients directly to regional hospitals (skipping district hospitals):

Few participants feel that the referral system for the mentally ill patients takes a long time and thereby needs to be shortened. Indication is also made that the regional hospital is sometimes far from other areas. Therefore, it is important to take the patient straight to the regional hospital and not via the district hospital. The other delay is said to be caused by the forms that need to be filled in at the district hospital and whereas the patient will still be transferred to the regional hospital or not. One of the advantages that they state is that in the regional hospital the doctors are already experts in dealing with the mentally ill patient.

The following quotes illustrate these findings:

"..They already know what to do to assist the mentally ill patient and sometimes after treatment the family members can go home with their mentally ill patient."

3.3.2.17. Establishing a district council responsible for mental health/illness to monitor health services:

One of the participants feels that the services for mentally ill patients are not benefiting all the community members. Therefore, there is a need for establishment of the district council that will look into the mental health care issues and equal distribution in order to improve the quality of care. When talking about membership in this district council he indicated that the council should be formed from the members of the community. He cited for members, the following: police officers, Mayors, different non-governmental organizations with different programs, and the Department of Justice because if the mentally patients commit crimes the department of Justice becomes involved. Business to assist where possible should a need arise, Department of Transport to assist with taking of the mentally ill patients who are on the roads all the time to the relevant facilities. Representation from the family members that are having relatives who suffer mental illness:

The two major advantages for establishing the council are:

It becomes easy to identify new cases so that they get treatment early.
Availability of the appropriate statistics because at the present moment nobody can state the actual number of the patients that are suffering from mental illness.

According to Kenneth et al. (2004:7), emphasis is on developing an evidence-based community which utilizes participatory public health intervention principles to achieve community need and priorities.

The following quotes illustrate these findings:

"…for an example there can be a representative from the department of health to assist with the management of crisis that the area is experiencing as well as the relevant statistics. As it is of now there is no proper statistics, nobody knows as to how many patients are suffering from mental illness in this area.

3.3.2.18. Improvement and availability of toll-free numbers that provide information on mental illness:

The intervention was cited by one of the participants who feels that toll free numbers can also be valuable in improving quality of care rendered to mentally ill patients. He feels that the present toll free number is not user-friendly where people are not receiving assistance immediately or are not assisted at all. He feels that the proper use and accessibility of the local toll free number will assist the community members to report the matters about mental health with ease and thus will improve communication system.

Shrivastava et al. (2012:1) conclude and suggest that some first episode patients with mental illness access services by using help-lines and that help-lines are immune to stigma and allow safe alternative if used.

The following quotes illustrate these findings:

"...but with the mentally ill patients it becomes a problem to report and they are not helped, they sometimes end up having injured other people because of the delayed services. Sometimes one waits for a long time or it is engaged."

3.3.2.19. Encouraging community members to be more involved in community centers for the mentally ill:

In one of the non-organizational institutions the participant feels that such organizations do not belong to the staff members only, but the community members should also take responsibility in running them. An appeal that the community members are free to come more especially on weekends has been made. The activities that can be done include amongst others: bathing the patients, cleaning, and also cooking for the patients.

There is also a belief that if the community members are unaware of the behaviors that are displayed by the mentally ill patient, it poses a problem. The community members need to have the information surrounding mental illness issues so that whenever they come across a person who is acting strangely in their vicinity, they should make it their responsibility to bring or report that person to the clinic staff.

Recent reviews suggest that greater community involvement may promote intervention adoption and sustainability (Wells, et al. 2004:5).

The following quotes illustrate these findings:

"...therefore we can rejoice to see the community members coming in large numbers to give a helping hand."

"...given the information that if they see a person who is acting strangely in their area they should come to the clinic and report to the person responsible for mental health services."

3.3.2.20. Attention given to mental health services from National level and downward

The participants feel that the mental health care services are marginalized and neglected from the National, Provincial and also local levels of care. They indicate that all the programs with the exception of mental health care programs are having indicators to evaluate the performance on a monthly basis but with mental health there is absolutely nothing. They further indicates that this issue is also impacting on the performance of the mental health care services coordinators as it cannot be measured against any yard stick.
Furthermore, the Medical Research Council of South Africa confirms the professional nurse's statement by indicating that they are trying to raise the awareness to the government that mental health should get more attention and more money. In addition, IP (2002:4) confirms to the suggestions by stating that the importance of mental health promotion should reach the policy makers in order that vision is formed, policy adopted and finally, funding approved.

The following quotes illustrate these findings:

"...I think mental health services should also be given the attention they deserve right from the National level."

3.3.3 Current interventions obtained from the records

It appeared from the patients' records that the information that could share light in relation to exploring community-based interventions for mentally ill patients in order to improve quality of care is very scanty. From the sampled files there was a discharge referral from the regional hospital with the following information about the interventions: vital information about Axis 1 DSM-IV-TR diagnosis of the patient, prescribed treatment by the psychiatrist and clinical findings. Inclusion of standardized basic mental health assessment form which was filled in by the professional nurses at the patient's first visit. In the patient's progress report on monthly basis, the comments seem similar in all the visits and with all patients. An indication is given that the patient is for monthly treatment, issued medication, the route and the return date. In one of the records there was no referral letter only the progress report documents were located. Thus the recorded interventions include information on vital data of the patient, prescribed treatment, referral from regional hospital, treatment administration and monitoring. In one of the clinics patient's records could not be availed. There were no suggested interventions either.

3.3.4 Conclusion remarks

It becomes apparent from the findings that community members are keen to play major roles providing community mental health care and to support mentally ill patients. However the issues of inadequate resources, both human and material, hinder the processes of providing quality of care to mentally patients. Therefore suggested improvements need to be looked into. There seem to be a great need to strengthen the community service delivery system for the mentally ill patients in this area. Standardization of mental health services and the delivery thereof is essential in order to ensure equality and fair distribution of services to the entire community in the area.

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter three the findings were discussed. A literature control was also done in order to verify the findings against the existing literature and to highlight the unique findings from the research. In this chapter, the conclusions, limitations as well as recommendations of the research are discussed. The conclusions will be discussed in relation to the questions that were asked. Recommendations will apply to nursing research, clinical practice and nursing education in order to improve quality of care for the mentally ill patients in rural areas.

4.2 CONCLUSIONS

The two main themes or categories will be discussed and thereafter general conclusions will be drawn.

4.2.1 Current interventions

From the table it seems that two main themes, sub-themes and further themes were identified through qualitative research analysis namely: current interventions and utilizing current suggested interventions.

In as far as the current interventions are concerned; the researcher realized that besides the medical and professional staff, there are other categories of people who render community-based interventions to mentally ill patients in rural areas. The current interventions vary according to the categories of health caregivers. Included in the categories are the multidisciplinary teams in the Department of Health and Social Development: psychiatrists, medical doctors, professional nurses, psychologists, social workers. However, the human resources were very limited as there was only one multidisciplinary team of professionals for the large community in Maluti-a-Phofung region. This could affect the community-based interventions adversely because some of the patients live very far from the clinic. Non-governmental organizations with different approaches were also involved as well as the Police officers, Traditional healers, Faith/Spiritual healers, Family members and to a lesser extent other community members.

Apparently many patients also consult the traditional and faith healers for mental illness treatment. Some are new cases and others are chronic cases who are already on treatment. Kubi, Raja and Boyce (2006:14) confirm that traditional herbal and faith healers apparently treat the majority of mentally ill patients. From the information received, many mentally ill patients use traditional healing as their first line of treatment, that is, before they consult mental health professionals. Therefore, it is clear that the Department of Health should incorporate these organizations in developing the strategies on how to work together to achieve the goal of giving quality care to mentally ill patients. It was also interesting to learn that respect and observation of other people's culture was very important during data collection. When the traditional healers were visited, the dress code had to be observed, that is, a dress and a hat were worn. This action also enhanced cooperation between the researcher and faith healer as well as the traditional healer.

The theme: Attempts to monitor or implement measures to control the treatment and intake of medication and getting patients appropriate treatment appeared from many respondents. It was apparent that the professional nurses concentrated on medications more than other community-based interventions. The patients visited the clinics on a monthly basis for follow up treatment and control. The initial psychiatric treatment was prescribed by the psychiatrist. The medical doctors reviewed the effect after six months and took a decision to either change, increase or decrease the treatment according to their observations. The treatment follow up is done in the clinics by professional nurses. The data from community caregivers showed that they also refer the mentally ill patients to the clinics for follow up treatment. For an example the traditional healers also refer the patients to the clinic even though they also use traditional treatment. Faith healers use holy water and prayers to treat the mentally ill patients. Some family and community members take their relatives for treatment to the clinics.

However, it was apparent that relapse and treatment defaulting pose a challenge. Another challenge is the shortage of mental health professional nurses, work overload and a shortage of vehicles that impact on home visits by mental health coordinators. All these challenges impact on measures to implement, control and monitor treatment. It is also apparent that education about side effects and their management is not given effectively as in some instances the non-governmental organization members also report that some mentally ill patients are taking regular medication without improvement and that some are experiencing side effects from the

medication which pose problems to the patient's family members. It is also difficult to implement treatment regimen to some of the patients who are homeless and found to be sleeping in the streets and some are reported to be staying on the mountains.

It appears from the interviews that there is collaboration between mental health professionals and other organizations/institutions/departments in the management of mentally ill patients and referring patients to them. There is interdepartmental and interpersonal collaboration between the different categories of caregivers. It is a well- known phenomenon in this area that when the mentally ill patient becomes violent the police officers are the only ones who can handle the patient and take the patient either to the clinic, District or Regional hospital. This is in line with the Mental Health Care Act, (2002:45) section 40, in which it is stated that member of the South African Police Service may use constraining measures when apprehending a person or performing any function. Thereafter the patient should be transferred as prescribed by the law and the transportation procedure is not quite clear as to who is supposed to transport the patient and how. Patients who develop mental illness due to substance abuse are referred to one of the non-governmental organization for rehabilitation and through that organization the patient can be referred to a rehabilitation center. The Department of Social Development also gets involved if the mentally ill patient has social problems, and is without an identity document, food parcels or disability grant. However, not all the patients receive the same services because of a lack of facilities. Services are only limited to certain areas in the same district. Challenges are also reported that it is sometimes difficult to get assistance from the police officers who also report that they need to make a proper decision before they can respond to a call because if the vehicle becomes damaged the responsible officer will be accountable.

Sending home caregivers to visit the mentally ill patients and their families was also reported. The home caregivers are based in one of the non-governmental institutions and are distributed in few clinics in this area because they are not many. They are the ones who visit the homes to identify if there is a mentally ill patient who needs to be helped, monitor and assist the family members in terms of treatment administration, and trace those that default treatment. In one of the organizations the officials of the organizations are the ones that visit the patient's homes. They also report to have assisted the mentally ill patients to get their birth certificates, identity documents, disability grants and wheel chairs for the needy. However, there are still challenges that are experienced. The home caregivers and the officials are not trained on how to handle or care for a mentally ill patient. Even when they do the home visits they are alone without the

mental health care services coordinators. They are sometimes helped by family members and are exposed to dangerous situations which are difficult for them to handle, such as attempted rape, assault and aggressive patients and family members.

Educating patients, family members, and the community about mental illness and the care of the mentally ill family member (40%): report is given that education about mental illness is the primary role of the mental health coordinators/ professional nurses in the clinics. Emanating from the discussions professional nurses reported that they are only giving health educations mostly during the mental health awareness month which is in July. During these month campaigns and door to door visits are conducted by the mental health professional nurses where education about mental illness and how to care for mentally ill patients using different topics is presented. . At this time education is given to the patient, family members and the community at large. Health education is also given on certain days to all the patients regardless of the problem that brought the patients to the clinics. Topics on mental health are provided for the whole month of July because all the mentally ill patients are given access to services on Fridays in all the clinics. The non- governmental awareness campaigns are in the form of celebrations with the mentally ill patients and these are held in June. Nurses are invited to present health education talks on the day of the celebrations. The challenges are that not all the community patients, family members or community members receive health education during the campaign.

It is apparent that referring patients to District hospital for seventy two hours assessment when needed seem to be one of the reported intervention. According to the referral system in this rural area, the mentally ill patient is first taken to the clinic for basic assessment. Thereafter he/she is referred to the district hospital for physical and mental assessment. Depending on the results of the assessment, the patient can be referred to a regional hospital for further management. Some of the experienced challenges include:

- That the patients are not observed for seventy two hours but only for a few hours and get discharged without treatment. Such patients continue with mental illness and be brought to the clinic again, sent back to the hospital and are discharged.
- There are no psychiatrists in the district hospital to make precise decisions about the mentally ill patient but the patients are treated by the general practitioners who sometimes lack interest in interacting with mentally ill patients.

- Professional nurses working in district hospitals casualty section lack skills in handling mentally ill patients

  The patient doctor ratio is too high for a doctor to handle.
- 30% of the participants reported visiting doctors/psychiatrists/psychologists/to attends to patients: some medical doctors are reported to visit the clinics for two to three days in a week. However, they consult patients with different illnesses including mentally ill patients on their visits and from different clinics. They are also allowed to see about fifteen patients per visit and not more. The psychiatric team comprising of the psychiatrist, psychologist visit one clinic and caters for all the population of mentally ill patients in this rural area. They visit the clinic once a month to review the treatment and see new cases. The psychologist offer psychotherapy to those patients that are referred to her for counseling. The challenge is that some of the mentally ill patients do not receive the services resulting in their treatment not being reviewed due to patient doctor ratio. The services are limited because they are being offered in one clinic once a month for the entire community of Maluti-a-Phofung.

Teaching patients skills and encouraging them to be active in the community: (20% reported). It seems that professional nurses and members from non-governmental organizations are concerned about teaching the mentally ill patients certain skills in order that they are acceptable by the members of the community and their family members. Arrangements are made for them on how to do gardening, cleaning, cooking as examples of the skills. In one of the organizations report is given that the recovered patients are hired on voluntary basis and receive a stipend in order to ensure that they are as independent as possible in their community. However, the mentally ill patients are reported not to show interest in such activities. They prefer to loiter in the streets and in the shopping malls from morning until sunset. Therefore, this leads to difficulty in implementing such programs.

It appears from the interviews that the mentally ill patients are fast-tracked' when they visit the clinics. The reason for starting with these patients is that they easily get bored and irritable which is appraisable. In order to enhance compliance they are attended to first when they visit the clinics on Fridays. Only one day in a week is scheduled for consultation of the mentally ill patients in the clinics which also contributes to impairment of quality service delivery.

Availability of mental health care forums: there is one mental health care forum in the entire district that comprises of different stakeholders namely: the mental health coordinators from different clinics in the area, psychiatrist from the regional hospital, psychologist, social worker, police officer, chairperson of the traditional healers, faith healer, representation from the hospital review board, mental health care users and social worker. The forum meets on a regular basis to discuss the problems and the events surrounding mental health care issues. One of the problems identified by one participant is that the challenges are reported in the forum however, nothing is done to resolve the reported problems.

4.2.2 UTILIZING SUGGESTED INTERVENTIONS

All participants reported the need for availability and development of community day care centers, homes and half way house for the mentally ill patients. It seems that the feeling is that if the mentally ill patients can be cared for in one place or community center by the members of the community that could bring about improved quality care of the mentally ill patient. Some of the reasons include:

- That the homeless mentally ill patients will be housed after discharge as some are discharged back to the streets after treatment.
- That the mentally ill patients will be involved in activities/skills for empowerment so that they become active members of the community and gain independence.
- That it will be much easier for access to all the necessary services for mentally ill patients that will benefit many of them.
- High rate of abuse of the mentally ill patients by their family and community members will be reduced.
- That it will be easy to monitor and care for them in terms of their treatment regimen.
- Their social grant will be controlled and utilized effectively.

With regard to continued community education (on a larger scale on mental illness and the role of the community (50%) suggested that education should not be given during mental health awareness months only but should be done continuously. Some even suggested quarterly. For their effective implementation different strategies were suggested.

From the findings suggestions are forwarded on social grants of mentally ill patients must be controlled so that they cannot be misused by their family members. It is also suggested that

from the social development there should be a person who is responsible for administration of the social grants for mentally ill patients. Review of renewal of grants is also suggested whereby continuous receipt of is suggested so as to prevent relapse that it should not be guided by the condition of the patient.

Training nurses, caregivers and psychiatrist is also suggested by the participants. Seemingly the participants feel that if more members of the community are trained on mental health care it will be of value as there will be improved quality care. This will also lead to availability of sufficient members of trained staff in mental health care.

Including religious institutions/ traditional or faith healers in the care and rehabilitation of mentally ill. Apparently some of the mentally ill patients consult the traditional and faith healers when they are ill in the rural area. Included under the roles and responsibilities of the Department of Health is to develop inter-sectoral partnership between government department traditional healers, faith based non-governmental and other private sectors (National mental health policy Framework: 2010:26). Therefore, there is a need for them to form part of the inter-sectoral team so as to discuss the quality care of mentally ill patients because reports yield that some of traditional caregivers are chaining and making the patients to starve in their mode of care. In contrary, Kubiet *et al.*(2000:14), support that very often the intervention methods employed by the traditional and herbal healers are very cruel and tend to violate the rights of the patients.

An improved system to identify patients that default treatment is suggested (30%) that the home-base care-givers should always be in the company of mental health professional nurses when doing home visits. Other participants suggest that there should be roving teams that move around between the clinics to identify the mentally ill patients that default treatment, do follow up and take the patient to the clinic.

Suggestions are also made that the family members should be encouraged to take responsibility and help with monitoring and treatment of the patients after their release from the hospital. The suggestion means that the family members should encourage the mentally ill patient compliance to treatment, good personal hygiene and getting nutritious food. They should also accompany the patient to the clinics because they seem to understand psycho education better than the patients. Every family member should also be supported through the

establishment of family support groups so that they can understand the dynamics about the mentally ill patient and offer them the support they deserve.

It emanated from the interviews that there is a need to train the emergency department staff so that they can work in collaboration with the police officers to handle the violent mentally ill patient in the community. The police officers form manpower and the emergency department staff gives mental health first aid like they would do in cases of accidents.

1% of the participants suggest availability and or improvements of mobile clinics that also cater for the mentally ill patients. The participant believes that the services can be accessible to a larger community because there are mentally ill patients in the most remote areas like farms who experience problems in accessing the services.

The theme of referral/admission of mentally ill patients directly to regional hospitals skipping district hospital was suggested by 1% of the participant. This will in turn assist in avoiding paper-work. Furthermore, in the regional hospital the psychiatrist knows how to handle a mentally ill patient to an extent that some of the patients after being consulted are sent back home in an improved state. There is no need to admit them.

Establishing a district council responsible for mental health/illness to monitor health services is suggested as one of the measures that can improve the quality care for mentally ill patients. The council should be formed from different stakeholders with different expertise.

4.3 LIMITATIONS OF THE RESEARCH

The following are the limitations that are identified by the researcher:

- The sophisticated voice recorder was difficult to manipulate during some of the interview sessions and this lead to one voice recorder being used effectively instead of two for back up.
- The quality of recording of one of the interview sessions was very poor and this lead to the interviewer taking a longer period during transcribing.
- There were some disturbances in many settings in the middle of the interviews and some of the noises affected the quality of interviews.

- The study was taken in a very small area of the Free State Province, however, qualitative studies do not aim to generalize.
- In one of the clinics patient's records could not be availed to the researcher for data collection.

4.4 RECOMMENDATIONS

Recommendations for nursing service and nursing research will be made in this chapter based on research findings and conclusions drawn.

4.4.1 Recommendations for nursing practice

Recommendations for nursing practice are aimed at strengthening and improving the current community-based interventions to support the mentally ill patients and to improve quality of care in the rural areas. Also to enhance health/illness issues to be given the attention it deserves from the National, Provincial as well as Local spheres of management in order to restore the dignity and the denied basic human rights for the mentally ill patients in their communities. The following recommendations are made:

- To improve quality of care and ensure proper reintegration of mentally ill patients in the community implementation of the National Mental Health Policy Frame Work should be practiced in the department of health by the mental health professionals.
- A build on the already existing community-based interventions principle should be adhered to, to avoid organizing the programs from the start which can lead to a delayed process in improving quality of care to mentally ill patients. Which community-based interventions for mentally ill patients are most effective in terms of costs and needs of the mentally ill patients and their family members?
- It is recommended that the fragmented community-based interventions should be consolidated and organized into one multi-component standardized program to meet the needs for the entire population of the mentally ill patients. A model for community-based interventions may be necessary.
- For the personnel to offer quality services training, supervision and monitoring plays a major role for quality assurance. All the people that are responsible for rendering services for the mentally ill patients should undergo relevant training on how to deal with mental health/illness issues.

- Programs to support the mentally ill patients and their families on community-based interventions should be developed and these should be standardized by the Department of Health so that the entire community of mentally ill patients receives equal and affordable quality care.
- Support structures like homes for the homeless, halfway-houses and day care centers are an evident need from the research findings. These can also include community mental health centers where the mentally ill patients educated and developed in order to enhance their reintegration to their community.
- Standardized records and recording, what to record how to record in the patient's record should be developed this will assist in following the scientific method of patient care where there will be a necessity to assess, make a nursing diagnosis, plan, implement and evaluate all the community-based interventions that are rendered to the mentally ill patients.
- Bench marking on how to render services for mentally ill patients in other developed areas is necessary in the Free State.

4.4.2 Recommendations for nursing research

Based on the findings from the study on exploring community-based interventions for mentally ill patients to improve quality of care it becomes necessary that more research is imperative. The following are the recommendations for nursing research:

- There is a need to further explore the involvement and incorporation of the traditional and Faith healers in mental health care.
- Experiences and perceptions of mentally ill patients as consumers on community-based interventions need to be studied further.
- Further studies on community based-interventions are necessary.

4.4.3 Recommendations for nursing education

Nursing education forms fundamental foundation in preparing the professionals to render quality services to the mentally ill patients. Therefore the following are the recommendations to nursing education:

- There is a need to review the curriculum for the four year integrated training program in the Free State School of Nursing by nurse educators in order that the students are able to render community psychiatric nursing. This should also include increasing of exposure of the students in community mental health nursing as presently only two weeks are spent (according to the present curriculum).
- There is also a need to reintroduce one year psychiatric nursing science training in the Free State which can be offered by the nursing schools or nursing training colleges to develop the professional nurses who are not qualified in this field. This will increase the number of psychiatric nurses in the clinics thus leading to the improvement of quality mental health care. The one year psychiatric nursing science training program is presently being offered by the University of the Free State thus leading to the slow production of psychiatric nurses.
- Training and support mental health programs for other community-mental health caregivers should also be developed in the nursing schools or nursing colleges in order to empower them on mental health issues so that they can be able to render quality care and prevent maltreatment when implementing some of their treatment modalities to the mentally ill patients.

4.4.3 SUMMARY

The two main objectives of research have been achieved namely: to explore and describe current community-based interventions for mentally ill patients in a rural community which may contribute to their quality life and to explore and describe the suggestions by nurses and other caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of life. The research was conducted in Maluti-a-Phofung region which is one of the rural areas in Thabo Mofutsanyana District in the Free State.

Included in the findings is to discover that except the health care institutions there are other sectors that are offering care to the mentally ill patients in this area that is the non-governmental institutions, faith and traditional healers. There are some wards at the faith healers institutions that are specifically built to accommodate mentally ill patients whilst receiving treatment. Despite the joint efforts made in this area, community-based interventions for the mentally ill patients still remain ineffective due to uncoordinated and fragmented services. Not all the community of mentally ill patients accesses the services. There are many challenges regarding community-

based interventions for mentally ill patients that need to be addressed as indicated by the findings of the study. Shortage of professional staff and lack of training to other community mental health caregivers in handling of mentally ill patients has become evident and impacts negatively on quality patient care. More importantly, the lack of material resources like homes for the mentally ill patients, half way houses and day care centers make the quality care impossible and result in the streets, mountains and bus stops being better homes for the mentally ill patients.

The researcher also made the recommendations for nursing services and research. Recommendations are also based from the suggestions made by the research participants.

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APPENDICES

APPENDIX A: ETHICAL APPROVAL

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

School of Nursing Science
Tel: 018 2991884
Fax: 018 2991827
Email: emmerentia.duplessis@nwu.ac.za.

Date: 15.07.2012

To whom it may concern

Confirmation of ethical clearance

Regarding the project: Exploring community-based interventions for mentally ill patients to improve quality of care

This research will focus on community-based interventions with the following objectives:

- To explore and describe current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life.
- To explore and describe the suggestions by the nurses and other community caregivers about their utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of care.

This research is a sub-study in an overarching research project, entitled: *Strengthening the research of health caregivers and risk group*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00036-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

Background information: Strengthening the resilience of health caregivers and risk groups

The co-investigators identified the problem that the resilience of health caregivers as well as risk groups should be strengthened by means of a comprehensive, multi-faceted approach and that research should be conducted on how resilience of health caregivers and risk groups can be strengthened by means of such an approach. The purpose of the research is thus to develop a comprehensive, multi-faceted approach to strengthen the resilience of health caregivers as well as risk groups. We intend to reach this purpose through the following objectives:

- To explore and describe the resilience of health caregivers and risk groups
- To implement and validate strategies developed by Koen, Van Eeden and Wissing (2010c) to strengthen resilience of professional nurses and other health caregivers and risk groups
- To explore and describe faith community nursing as intervention to strengthen the resilience of health caregivers and risk groups
- To explore and describe sensory stimulation as intervention to strengthen the resilience of health caregivers and risk groups

To achieve these objectives, it is necessary to explore and describe various health caregivers and risk groups. Within this overarching research project, (Lydia Mamakhoa Mamabolo) intend to focus on Exploring community-based interventions for the mentally ill patients in the rural community to improve their quality of life and care. Mentally ill patients are viewed as risks groups in terms of their wellbeing and, in line with the objectives of overarching research project. There is a need to explore and describe the community-based interventions which are regarded in this research as characteristics of the strengths of a community to render quality care to mentally ill patients. The results of this sub-study will contribute to reaching the objectives of the overarching project strengthening the resilience of risks groups. We therefore confirm that the sub-study of (Lydia Mamakhoa Mamabolo) is covered by the above-mentioned ethical clearance.

Yours sincerely

Prof MP Koen
Co-investigator

Dr E du Plessis
Co-investigator

APPENDIX B: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Free School of Nursing Eastern Campus

Private bag X 833

Witsieshoek

9870

13.5.2012

The Head of Department

Free State Department of Health

Bloemfontein

Dear Sir / Madam

Subject: Request for permission to conduct research

As a lecturer at the Free State School of Nursing, I am presently studying for M. Cur degree in Psychiatric Nursing Science at North-West University, Potchefstroom Campus. I hereby request permission to conduct research on: **Exploring community based nursing interventions for psychiatric patients to improve quality of care** in the Thabo Mofutsanyana District (Maluti-A-Phofung).

The research will be done under the supervision of experts in Psychiatric Nursing Science and Nursing Research at the School of Nursing Science Potchefstroom University.

The following are the objectives of the study:

- To explore and describe current community-based interventions for mentally ill patients in a rural community which contribute to their quality of care.
- To explore and describe suggestions by nurses and health caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of life.

Attached kindly find the research proposal that has been approved by the Research committee of the School of Nursing Science, North West University (Potchefstroom Campus). The research has ethical clearance as a sub-study within the RISE project (Strengthening the resilience of health

caregivers and risk groups, Koen and Du Plessis, reference number (NWU-0036-11-SI). The period which I plan to do data collection is from June-July 2012.

Hoping that my application will reach your favourable consideration and the response at your earliest convenience will be appreciated.

Thank you

Yours faithfully

.....

Mrs L.M. Mamabolo

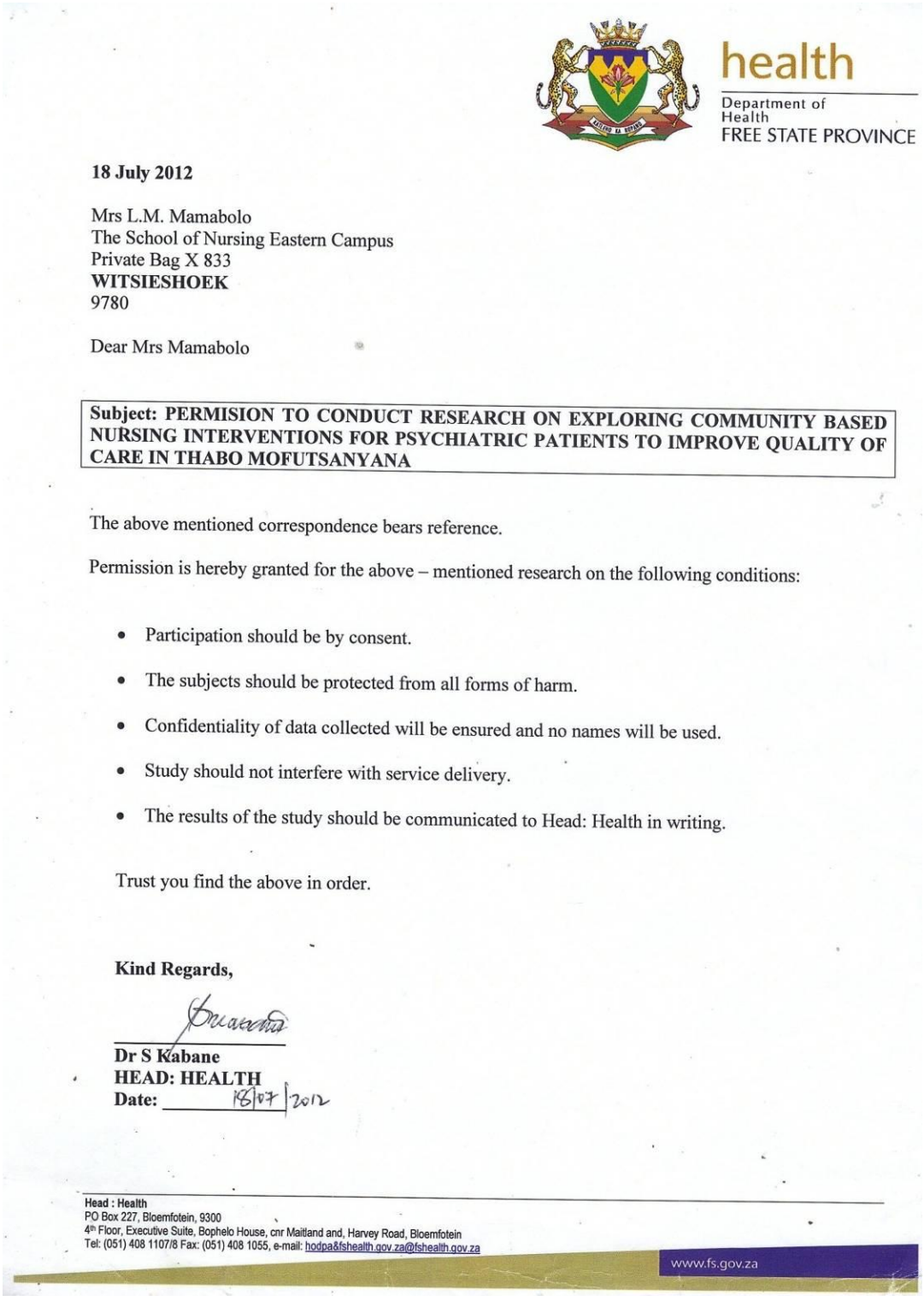
.....

Supervisor: Prof M.P. Koen

.....

Co-supervisor: Dr E. du Plessis

APPENDIX C: WRITTEN PERMISSION TO CONDUCT THE RESEARCH



health
Department of Health
FREE STATE PROVINCE

18 July 2012

Mrs L.M. Mamabolo
The School of Nursing Eastern Campus
Private Bag X 833
WITSIESHOEK
9780

Dear Mrs Mamabolo

Subject: PERMISION TO CONDUCT RESEARCH ON EXPLORING COMMUNITY BASED NURSING INTERVENTIONS FOR PSYCHIATRIC PATIENTS TO IMPROVE QUALITY OF CARE IN THABO MOFUTSANYANA

The above mentioned correspondence bears reference.

Permission is hereby granted for the above – mentioned research on the following conditions:

- Participation should be by consent.
- The subjects should be protected from all forms of harm.
- Confidentiality of data collected will be ensured and no names will be used.
- Study should not interfere with service delivery.
- The results of the study should be communicated to Head: Health in writing.

Trust you find the above in order.

Kind Regards,

Dr S Kabane
HEAD: HEALTH
Date: 18/07/2012

Head : Health
PO Box 227, Bloemfotein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfotein
Tel: (051) 408 1107/8 Fax: (051) 408 1055, e-mail: hodpa&fshealth.gov.za@fshealth.gov.za

www.fs.gov.za

APPENDIX D:

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THEDISTRICT

Free State School of Nursing Eastern Campus

Private Bag X 833

Witsieshoek

9870

06.08.2012

The District Nursing Service Manager

Thabo Mofutsanyana District

Qwa-Qwa

Subject: Request for permission to conduct Research

Dear Sir / Madam

As a lecturer at the Free State School of Nursing, I am presently studying for M. Cur Degree in Psychiatric Nursing Science at the North West University, Potchefstroom campus. I hereby request permission to conduct research on: **Exploring community based interventions for mentally ill patients to improve quality of care** in Thabo Mofutsanyana District specifically in Maluti-A-Phofung municipality. The following areas of Maluti-A-Phofung are identified for utilization as follows: Kestell: Kopanong clinic, Harrismith: Lesedi clinic and Qwa-Qwa: Boiketlo clinic and Phuthaditjhaba clinic. The clinics have been identified because in all of them Mental Health Services are rendered. Two clinics have been identified in Qwq-Qwa because it is a bigger area in Maluti-A-Phofung municipality with many clinics. Other places of data collection will be determined by referrals through snowball sampling to other mental health caregivers in the above mentioned areas.

The following are the objectives of the study:

- To explore and describe current community-based interventions for mentally ill patients in the rural community which contributes to their quality of care.
- To explore and describe suggestions by nurses and other health caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of life.

Professional nurses and other health caregivers who are responsible for management of mentally ill patients are going to be interviewed. Ethical principles will be considered.

The research will be done under the supervision of experts in Psychiatric Nursing Science and Nursing Research at the School of Nursing Science, Potchefstroom Campus of the North West.

Attached kindly find the permission letter to conduct research in Thabo Mofutsanyana District, approved by the Head of the Department of Health in the Free State. The research has ethical clearance as a sub-study within the RISE project (Strengthening the resilience of health caregivers and risk groups, Koen and Du Plessis, reference number NWU-0036-11-51). The period which I plan to collect data is August 2012.

Hoping that my application will reach your favourable consideration and the response at your earliest convenience will be appreciated.

Thank you.

Yours faithfully

L.M.Mamabolo

Supervisor: Prof M.P Koen

Co-Supervisor: Dr E. Du Plessis

APPENDIX E: PERMISSION TO CONDUCT RESEARCH FROMDISTRICT HEALTH MANAGER

health
Department of Health
FREE STATE PROVINCE

16 August 2012

To: Mrs Mamabolo

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I wish to acknowledge receipt of your letter and the letter of permission from the HOD, Dr Kabane.

You are welcomed to come and conduct your research as mentioned in the letter of the HOD and that you inform the District Manager about your presence.

Thank you

SR Sibeko
District Manager
Thabo Mofutsanyana Health District

Mrs RS Sibeko ♦ General Manager – Thabo Mofutsanyana Health District ♦ Private Bag X824, 9870 ♦ Tel: 058 713 0515 Fax 058 713 0318 email DlaminMG@FShealth.co.za ♦ Room32,Ombudman Building, Mampoi Street

APPENDIX F: WRITTEN INFORMATION TO PARTICIPANTS

INFORMATION TO PARTICIPANTS AND INFORMED CONSENT

Information to participation in the following research:

Exploring community based nursing interventions for mentally ill patients to improve quality of care.

Madam/Sir

A.PURPOSE AND BACKGROUND

As a lecture at the Free State School of Nursing, Mrs L.M. Mamabolo is studying M Cur (Psychiatric Nursing Science) degree at the North West University, Potchefstroom Campus. One of the requirements is that she must conduct research. The research has ethical clearance as a sub-study within the RISE project (Strengthening the resilience of health caregivers and risk groups, Koen and Du Plessis, reference number NWU-0036-11-SI).

The title of this research is: **"Exploring community-based nursing interventions for the mentally ill patients to improve quality of care"** and the objectives are as follows:

- To explore and describe the current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life.
- To explore and describe the suggestions by the nurses and health caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of life.

You are being are being requested to participate because I am looking for the professional nurses and other community caregivers who are directly involved with the care of mentally ill patients to respond to a few questions. I am doing this in a number of areas in Maluti-A-Phofung, and after combining all people's answers I hope to learn more about the community-based interventions that are rendered to mentally ill patients in order to improve their quality of life which will help me make useful recommendations to the relevant authorities and organizations.

B. PROCEDURE

Should you be willing to participate the following will occur:

- The study will be conducted at the time that will be determined by you according to your availability.
- You will participate in one session only which will last around 20 minutes to one hour however you can be requested to participate again if there can be a need.

- I will be asking you a few questions and request that you are as open and honest as possible in answering these questions.
- The semi- structured interview will be conducted where you will be guided on the questions which will be based on the research topic.
- The conversation will be recorded on an audio recorder to ensure that I have the whole information, which will be kept confidential and the audio recorder will be kept in a safe place after transcribing has been done.
- The setting will be at a convenient place where there will be tranquillity.
-

C. VOLUNTARY PARTICIPATION

Please understand that your participation is voluntary However I will appreciate if you do share your thoughts with me. If you choose not to participate you will not be affected in any way whatsoever. If you agree to participate you may stop at any time and discontinue your participation. If you refuse to participate or withdraw at any stage, there will be no penalties and you will not be prejudiced in any way.

D. RISKS / DISCOMFORTS

No risks or discomforts are anticipated during the semi-structured interviews. If I ask you a question which makes you feel sad or upset we can stop and talk about it or if you need to speak with anyone after I have left a professional person can be reached at the following telephone numbers: 058 718 3378.

E. CONFIDENTIALITY

All individual information will be remaining confidential. I will not be recording your name anywhere and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information.

F. BENEFITS

There will be no direct benefit to you for participating in this study. However your participation will assist the researcher to formulate guidelines on how to improve quality care for the patients who are mentally ill.

G. COSTS

There will be no costs to as a result of participating in this study.

H. PAYMENTS

No payments will be made to you for participating or sharing of information in this study.

I. CONSENT

You will be given a copy of this consent to keep.

Regards

Mamabolo

L.M. Mamabolo

07. 09. 2012

DATE:

SUPERVISOR: Prof M.P Koen

6/9/12

DATE:

CO-SUPERVISOR: Dr E. Du Plessis

5 Sept. 2012

DATE:

PARTICIPANT:

DATE:

APPENDIX G:

WRITTEN INFORMED CONSENT TO PARTCIPATE IN THE RESEARCH

CONSENT

I ---------- hereby agree to participate in research regarding: **Exploring community-based nursing interventions for mentally ill patients to improve quality of care**.

I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

The purpose of the study has been explained to me, and I understand what is expected of my participation. I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise in this interview.

I understand that this consent form will not be linked to any document, and that my answers will remain confidential.

I ----------understand that, if at all possible, feedback will be given to my community on the results of the completed research.

_____ _____

Signature of participant Date

Additional consent to audio recording:

In addition to the above, I ---------- hereby agree to the audio recording of this interview for the purposes of data capture. I understand that no personally identifying information or recording concerning me will be released in any form. I understand that these recordings will be kept securely in a locked environment and will be destroyed or erased once data captured and analysis is complete.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

APPENDIX H: INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

- What are current community-based interventions for mentally ill patients in a rural community which may contribute to their quality of life?
- How do nurses and other health caregivers suggest these community-based interventions can be utilized to support mentally ill patients in a rural community to improve quality of life?

APPENDIX I: TRANSCRIPT OF SEMI STRUCTURED INTERVIEW

Transcript 9th
R: Researcher
P: Participant

Reflective notes and observations	Transcript	Code
The participant is relaxed and spontaneous from the beginning. Quiet at first but spontaneous thereafter. Participant phone rings and it was switched off. The participant laughs as	R: What are the current community-based interventions for the mentally ill patients in this area? P: Ja, the mentally ill patients normally come on monthly basis to the clinic for their treatment depending on who gets what. What is expected is like they come on monthly basis to get Largactile, Seranace, whatever the treatment might be. So the expectation is that they must come on monthly basis even though it is not easy for the mentally ill patients to do that.. R: Now besides giving the treatment is there any other intervention that the professional nurses, who are responsible for caring for the mentally ill patients rendering? P: Yes Madam, there are those projects that we need to do as part of rehabilitation to our patients. However as we are talking now all the clinics are having shortage of professional nurses. There is no time even for simple home visit. When the patient defaults the treatment it becomes difficult for the nurses to trace the patient in the villages. There are those who stay without treatment for a period of three to four months because there is no time for the professional nurses to go out of the clinics due to pressure of work as I have indicated earlier on. R: Now that you are saying that there is a lot of pressure of work in the	

he says this.	clinic, can you tell me more about the services that are rendered by the staff members who are directly involved with the care of the mentally ill patients. P: Eh one they need to check on the scripts of the patients, because the mentally ill patient is a chronic patient to start with. Every person who is on chronic treatment must be reviewed in six months' time. At some stage it is not possible because eh here at the clinic we are having a visiting doctor who is here for referrals from about three clinics. During the visits the mandate is that she should consult about fifteen patients. There are patients with different illnesses for an example she sees the diabetic patients, hypertensive patients and epileptic patients, that is everybody who is sick or having minor ailments. So these patients are referred fro different clinic to see this one doctor here at the clinic. Therefore the doctor patient's ratio is problematic. The community members in this area are too many for one doctor. R: As I'm listening to you, you are saying that even though you as a mental health coordinator in this clinic you are also responsible for consulting patients with other illnesses and not concentrating only on mentally ill patients. P: Yes I am the coordinator of the mental health care services however each and every patient who needs help must be assisted in whatever manner or according to the specific needs. It can be a woman in labor, an antenatal client, and patients with high blood pressure who is for daily blood pressure checking the referrals to the doctor all these should be attended by professional nurses. It is a lot of work	

The participant points at his left fingers with a pen. The participant laughs again as he says this.	now there is no time for the mental health care coordinator to concentrate on the mentally ill patients alone and also gives a problem when it comes to tracing the defaulters. There is absolutely no time to do the home visits. R: So in other words it means that there is absolutely no mechanism that is put in place to trace the defaulters in this clinic. P: Yes in short I can say there is no mechanism in place to trace those patients because eh earlier that is in the nineties there used to be a mental health roving team. The team was called the community psychiatric team and this was the team that was responsible to do home visits and trace the defaulters. They would normally move around to different clinics to identify the statistics for the defaulters and would get the names of the patients and their files with their addresses. Thereafter they would get into different villages and make sure that the patients get their treatment. Therefore the defaulter rate was reduced by then. R: Are there any other interventions that you can perhaps think about. P: Yes I personally think that that was a very good strategy. If we can have psychiatric community teams in different local areas at least one in each area because the number of defaulters is not that high if looked in terms of areas. If I can make an example one can discover that only two patients in one area default treatment in a week. So in one week the team can manage to cover a certain area of the village in four days as they will be looking for fewer patients in each area. At the end of the week each patient who defaulted for that week in	

	particular will have been traced and the treatment will be given. So I think we really need to have the tracing mechanism in place so the only effective one is for us to go back to community psychiatric team. R: According to your opinion how do these current interventions work for the mentally ill patients? P: Eh the current mechanisms according to me are not working or effective at all. We have been in the different psychiatric institutions, be it a District hospital. Regional or Psychiatric complex, therefore experience has told us that a psychiatric patient cannot be handled by different people. They sort of have trust in one person or professional nurse that they are used to because if they are treated by somebody who they are not used to they become very difficult as they believe that the person does not know anything about their treatment. The mechanism that we are using right now is that we must utilize the community home-based care givers to attend to the patients in their homes, according to my opinion this is totally not good at all. Even if a person can be a nurse if the psychiatric patient sees that person for the first time, they totally refuse to take any instruction or treatment from that person, so it becomes worse for the community home-based care giver to take treatment for the patient home or to instruct the patient to go to the clinic. I think it must be the responsibility of nurses to do the home visits and to trace the defaulters. Maybe with the reengineering program this will be reviewed I really do not know. R: As I am listening to what you are saying at this clinic you are utilizing	

	the community home-based care givers to support the mentally ill patients at their home, how is this helping? P: Eh personally I do not see this helping at any rate. Just to site an example there are patients who even if they come to the clinic for follow up treatment, if they are attended to by somebody else besides the one that they are used to they flatly refuse treatment. It is worse when the patient has relapsed the other professional nurses cannot go next to them or to administer treatment, they refuse. They actually tell whoever is handling them that I will only be attended to by so and so not you therefore I do not want your injection. Now let us imagine if the patient refuses to be given treatment by the professional person what about the community home-based care giver. It becomes worse and it does not work. If they see the person for the first time they are not having confidence in that person. So I the present mechanisms that are in place right now do not work. Those patients who usually default their treatment are very stubborn. On certain occasions I forced to do the home visits using my own car as I was informed about the patients who are having crisis in the community. I also got a backup from the police services to manage to handle those patients. In such cases I will have to carry with me the injection so that I can give it to that particular patient wherever the patient will be. R: Now that you are mentioning few challenging that you are experiencing during the process of caring for the mentally ill patients in the community, tell me more about what is happening in the clinic when you, as the	

There is a knock at the door. The clerk that was referred by the sister to the participant actually entered in the room. She was actually coming to call the participant. The participant had to stop responding to the question as the person could not understand the nonverbal communication that was displayed by the participant to show that he is engaged in an interview. He then had to respond verbally and tell her that he is still busy and there is recording that is taking place. .	coordinator for mental health in this clinic, are not around. P: As I have indicated before some of our patients are very cooperative so they do not give problems. There are those who cannot just accept treatment from any other person that they are not used to. Sometimes even if they submit to the treatment by the person who is not used to attending to them, they are not afraid to tell that person that they do not trust him/her. R: In such cases what happens? P: Eh usually they do submit their selves to treatment and when I meet them they will also tell me that when I was away they were treated by other people and they are really not quite pleased. Now what about the one who is aggressive at home who defaulted treatment and relapsed? It does not work. R: Besides the patients that are refusing to get treatment from the people they are not used to, what are the other challenges that you are experiencing during the process of caring for the mentally ill patients? P: Eh the other challenges include the issue of monthly social grants for the patients. But such patients are found roaming around in the shopping mall looking for food in the dust binds. I think that these are some of the crucial challenges. Because that person is getting a social grant. So what we need to do as community members is to take good care of this person. But the thing is the relatives are only interested in collecting money from the pay point and thereafter they do not care whether the patient had anything to eat, has he taken a bath or how is he dressing. That is no longer their business after receiving the	

	money. Some patients default for about six months, the relatives will only bring them to the clinic when they know that they have to renew their social grant that will be the only time when they bring them to the clinic. R: What do you think should be done in order to improve the quality of care for the mentally ill patients? P: One. I think we should have as many psychiatrists as possible if I start from the top to the bottom. The reason being there is a new patient who comes to the clinic for the first time and is being reported to be sleeping away from home and being violent and destroying the property. One will assess that patient and refers him/her to the District hospital where one is expecting that the patient will be observed for twenty for seventy two hours. Surprisingly after two hours such patients are discharged back home and continuing with the behavior. In the District hospital the patients are assessed by the medical doctors and not the psychiatrist. The family members will come back to the clinic reporting that they have been to the hospital and the patient was not admitted and he is continuing with the violence behavior. Therefore there is a need for an increase in the number of psychiatrist because they can show more concern to the mentally ill patients. But if the patient is taken to the Regional hospital, because of the presence of the psychiatrist, something will be done towards the proper management of the patient; the patient will be assessed properly, even to an extent of being hospitalized if there is a need. All the district hospitals are utilizing the medical doctors who are not interested in mentally ill patients.	

	R: So am I right to say that this is the reason why you are suggesting that there should be an increase in the number of the psychiatrists? P: I do not know how far the department of health can go with this. According to my opinion the Tuba model works so well because the doctors from there are all specialists e.g. if a doctor is trained on gynecological matters then that doctor concentrates only on that and make no mistake their performance is so excellent. If I had the powers I would make a suggestion to our government that the nurses who are having an experience in psychiatric nursing science to be trained for some few years on this field. This would make a difference because it will not be necessary for such people to go for training for seven years. It does not help for a person to be trained in all the disciplined and at the end they master none of these because whatever one does is just doing whatever for the sake of doing it. If the situation could be changed where people go specifically for mental health training that could improve the situation. They can be distributed all over to the District hospitals. They can continuously consult the specialist at a higher level if they meet the challenges unlike what is happening right now where the patient is in the hospital for two hours and is discharged without any improvement. R: Besides the issue of mental health specialists is there any other issue that you can suggest that can lead to the improvement of the quality of care of the mentally ill patients? P: yes I think when it comes to other problems in the clinic for an example, every program is having the indicators	

	to evaluate the performance on monthly basis but with mental health there is absolutely nothing fro the National, Provincial up to the Local levels of care. So I think mental health services should also be given the attention they deserve right from the National level. R: Do you perhaps have anything to add? P: Eh I think the important aspects are that we should get a roving team that will be very good for the mental health care users. The other thing is that we see a lot of mentally ill patients on the streets that their relatives are not known. Some even come from far areas because they are mentally ill. If such patients are taken by nurses they are assed and are taken to the hospital, maybe let us says that they get institutionalized. Then the treatment is prescribed where after a long run the patient becomes mentally sound. Now it becomes a challenge if the patient should be discharged. The patient will not stay in the hospital for the rest of his life as we are also talking about deinstitutionalization of the mentally ill patients. We know that the hospital is not a hostel to start with. Therefore we need to have homes where the mentally ill patients can be placed just like old age homes that we are having around here in our area. If the mentally ill patient does not have anywhere to go after he has been discharged fro the hospital then such a patient should be placed in the home for the mentally ill patients. Immediately the patient is discharged from the street after a month that patient will be back into the institution. Those are the most crucial challenges that need to be attended to. However some of the mentally ill	

	patients are still having their families that they are staying with but if someone has been declared as mentally ill then that person can no longer enjoy her/his rights in the family. The other issue is about the social grant that is received by the mentally ill patients. The relatives just enjoy using the grants to their benefit instead of using it towards the interest of the patient. They only attend to the patient when they go for the payment of the grant on the other days they actually do not care about the basic needs of the patients. So that is the other reason for my suggesting that there should be the homes for the mentally ill patients. The social workers can be used since the department of health is now liaising with other departments. If the members of the community observe that the patient is receiving a grant but does not have proper care the report should be given to the social worker, be investigated ad the social worker will have to make a decision for the patient to be placed in the home. R: Now that you are talking about the homes for the mentally ill patients how do you suggest these should work? P: Eh I think if the government can assist with the residential areas for the mentally ill patients the nurses should take the responsibility. The community members need to be informed about the mentally ill patients and mental illness. This can be done during the days when mental awareness is celebrated as we did in July. So in such cases the community members are invited to hear about the metal illness. And the behavior of people who are suffering mental illness conditions. That one can be	

	done but the most important one is about the residential areas for the mentally ill patients. R: How should those places be utilized and for how long can the patient be expected to stay in such? P: Eh, eh I think it can work on both short and long term periods. If it happens that the mentally ill patient is not well cared for at home then that patients should be taken to the home together with the social grant she/he receives. For those family members who are still prepared to stay with their relative who is mentally ill, but are working and having a problem of living the patient alone when they are at work, can also take their patients to the home and in the afternoons the patient goes back home.	

APPENDIX J: FIELD NOTES

Field notes

Data collection was done in the clinics, church, police station as well as in the offices of the no-governmental institutions. Permission to access these settings was secured from District Health Service Manager of the area. The clinic local area managers were also approached and they gave the clinic managers about t he visits by the researcher to their clinics. When the researcher arrives at the clinics the first person to talk with was the sister in charge of the clinic who would organize a mental health nursing service s coordinator to talk with the researcher and secure an appointment. With the other participants, policeman, traditional healer, religious healer and members of the non-governmental organizations, the appointments were secured by the researcher herself after receiving information from the professional nurses. Most of the interviews were done after one to two weeks after securing the appointments. The appropriate time to start wit h the interview was in the afternoon starting from fourteen (14) hours or fifteen hours and during the working days. Patient's records in the clinics were also looked into, that is two in each clinic. In all the interviews the researcher used the structured interview where she had the interview schedule. Two voice recorders were used. The researcher observed her no-verbal communication throughout the interview that is maintaining an open posture and leaning forward when sitting, eye contact was also maintained.

Participant 1

Descriptive notes

The professional nurse who is also a mental health nursing service coordinator was approached; verbal as well as written information pertaining to the study was given. She was also requested to ask questions for clarity. The professional nurse responded positively and gave the verbal permission to participate in the interview initially and on

the day of the interview a written permission was given where a consent form was signed. The professional nurse was on duty at the clinic where she works and in full uniform during the interview. She showed interest to participate in the interview and she also maintained eye contact wit h the interviewer.

Reflective notes

The professional nurse was relaxed and spontaneous when answering the questions from the beginning of the interview to the end. At the time for the interview the clinic was still having many patients waiting even though it was in the afternoon. She showed concentration and was actually thinking prior to answering each question. She did not have a problem in understanding the questions that were asked and seems to be interested in the work that she does, that is being a mental health nursing service coordinator. She also displayed a positive attitude towards the mentally ill patients and willingness to improve their quality of care. She gave much of the information that she has with regard to the community- interventions of the mentally ill patients. She indicated that she is not only rendering services to the mentally ill patient but also rendering services to other patients who come to the clinic and only have the clinic for mentally ill patients once a week on Fridays. She suggested that there is a need for training more professional nurses on mental health nursing science.

Demographic notes

The interview was conducted in a clinic where the interviewee works and in the visiting doctor's room as the other consultation rooms were still busy. There were many patients who were still waiting for consultation. There was a bit of noise even though the door was closed because the room is next to the patient's waiting area however the noise did not disturb the interview and the voice recording. The environment was conducive to interview as the temperature was warm. There was an electricity power failure in the clinic which has been reported to have occurred in the morning. There was a big table in the room with a lot of boxes containing treatment on top however

means were made such that the table does not form a barrier between the interviewer and the interviewee as they could sit facing each other. Two voice recorders were used to record the interview. Extra batteries were available and the digital one was fully charged and therefore electricity power failure did not pose a negative impact.

Participant 2

Descriptive notes

The professional nurse who is also a mental health nursing service coordinator was approached and verbal as well as written information was given she was also requested to ask questions for clarity. The professional nurse responded positively and gave the verbal permission to participate in the interview initially and on the day of the interview a written permission was given where a consent form was signed. The professional nurse was on duty at the clinic where she works and in full uniform during the interview. She showed interest to participate in the interview and she also maintained eye contact with the interviewer. She reported that was just from a meeting and the researcher found her already waiting for the interview and having prepared the room to be utilized.

Reflective notes

The professional nurse showed much interest to partake in the interview and as a mental health services coordinator she was answering the questions with confidence. She seemed relaxed andgiving a lot of information though examples. She did not experience any problem with understanding of the questions and was spontaneous from the beginning of t he interview. She demonstrated acceptance of the mentally ill patients as she was talking.

Demographic notes

The interview was held in the clinic where the interviewee works and the visiting doctor's consultation room was prepared. The room temperature was conducive to the interview. There was a small table in the room and an examination couch. The chairs were placed in such a way that the interviewer and the interviewee were in a position to see one another and without a barrier in-between. The room was quiet and enhanced privacy. There were very few patients, about two who were in the waiting area wafting for consultation and they were attended to by other professional nurses. The door was closed even though there was somebody who was unaware that there were interviews in place that opened and closed the door but once. This did not cause any disturbances to the interview and voice recordings. The extra batteries for the voice recorder were available and the digital one was fully charged. The computer was available and in good working condition for connecting the universal serial bus cable to charge the second voice recorder.

Participant 3

Descriptive notes

The participant is a professional nurse who is not a mental health nursing services coordinator. She was approached a week before to secure an appointment date for the interview. She gave a verbal agreement to participate in the interview and a written consent was signed on the actual date of the interview. Verbal and written information with regard to the aspects of the interview was given on the first meeting. The important aspects of the interview were reiterated again on the actual date of the interview and the participant was offered an opportunity to ask questions for clarity. Permission for switching on the voice recorders was also granted by the participant.

Reflective notes

The participant was too nervous in the beginning of the interview to an extent that she requested the interviewer to switch off the voice recorders for a brief period. The interviewer listened to the request and also talked about the situation with the interviewee. She indicated that she was not involved that much in the care of the mentally ill patients in the clinic and only relieves when the mental health nursing service coordinator is not on duty and admitted to being nervous. After a short discussion she agreed to continue with the interview. She was also offered few minute to relax and to be at ease. There after she started to relax and to be spontaneous and gained confidence when answering the questions.

Demographic notes

The interview was held in the visiting doctor's consultation room at the clinic where there was a small table and an examination couch. The room was spacious and allowed the chairs to be placed in such a way that the interviewer and the interviewee are facing each other and with no barrier in between. The room temperature was comfortable even though it was on a rainy day. There were only two patients in the waiting area who were attended to by other professional nurses. The cleaner had already started with their work as it was late in the afternoon. However the room was private and free from the noise as the door was closed. The participant's phone rang once and was switched off immediately without leading to a disturbance during the interview.

Participant 4

Descriptive notes

The participant is employed under the South African Police Services and he is also responsible for assisting during the crisis interventions when the mentally ill patient becomes violent in the community. When the researcher secured an appointment for the

interview, he was not around however one of his colleges promised to give him the report. Written information was leftbehind for him to read through. After three days the researcher went to check as to whether he did receive the information and on arrival the interviewee was ready for participation. The important aspects were reiterated and he was requested to ask questions for clarity. He was requested to sign a consent form and a permission to switch on the voice recorder was granted. Two voice recorders were used.

Reflective notes

The interviewee showed a lot of interest during the discussions and was also indicating that one of his siblings has also been diagnosed as mentally ill. He was relaxed and answering the questions with confidence as he used to take part during crisis interventions for mentally ill patients in the community most of his responses were based on experience and willingness to support the mentally ill patients in the community. His argument was based on the fact that most of the time the mentally ill patient becomes aggressive towards his family members who stay with him or her and not other people.

Demographic data

The interview was held in a small office at the police station. There was a big table that reduced the space. The interviewee and the interviewer were each sitting on either side of table because there was no other way of maneuvering the table. The door was closed and the room was private. There seemed to be a lot of disturbances as there were police vans hooting outside now and then. Other staff members were making a lot of noise in the room next door and this lead to a minor disturbance of the interview. Somebody who was also not aware of the interviews in progress opened and closed the door. The room temperature was comfortable.

Participant 5

Descriptive notes

The participant is a priest and also a religious healer. On the day of securing an appointment he was not at home and was reported to have attended a church service in another place. Written information was left behind for him to read. Telephonic follow up was made so as to determine as to whether he was interested to participate in the interview. A verbal agreementwas given telephonically and thedate was secured. On the day of the interview he was busy as he indicated that he was seeing groups of church members. When the interviewer arrived the first group was already attended to and gone. He was therefore waiting for the second group to come. The important aspects of the Interview were reiterated so as to enhance his understanding. A written permission was given. He also allowed the interviewer to use the voice recorders during the interview session.

Reflective notes

He seemed to be interested as a result he responded to the explanation of the important aspects even before the first question could be asked. He was relaxed and spontaneousthroughout the interview session. His wife was also present but not saying anything she was just nodding her head as the husband was talking. He requested that the recorded interview should be played to him so that he could here what he said. After playing the voice recorder he indicated that he was satisfied with whatever has been discussed.

Demographic notes

The interview was held in the dining room at the home of the interviewee which is also a church mission. The interviewer and the interviewee were sitting each on the sofa facing one another. There was a coffee table in-between the sofas where the two voice

recorders were placed. The room temperature was comfortable. There was a disturbing noise from the other room as other members of the family were watching a television. The disturbing noise was also from the opening and closing of the door next to the dining room. There were patients who were walking in the yards. There are some wards in which the patients are admitted for treatment.

Participant 6

Descriptive notes

The participant belongs to a non-governmental institution which is responsible for the mentally ill patients more especially substance induced mental illness. The interviewer secured an appointment a week before and the participant indicated that h e would love to be the one who is interviewed. He then gave the date on which he would be on duty. Verbal and written information was given and the participant also gave verbal permission to partake in the interview. Written permission was given on the actual date of the interview and a written consent was given. The important aspects of the study were reiterated to the participant before commencing with the interview. Permission was also granted by the participant to recordthe interview.

Reflective notes

The participant demonstrated interest in the interview. He is in-charge of the organization. He was relaxed and spontaneous when responding to the questions. He was just waiting for the interview to be completed so that he could attend to some activities of his work. He also displayed eagerness to be developed and acquire knowledge that he can utilize to assist the mentally ill patients in the community.

Demographic notes

The interview was held in one of the participant's offices. The participant scribbled some important points to remember after he received verbal and written information about the interview and was also referring the notes when some of the questions were asked.

There was a big table in the office however it did not hinder the sitting between the interviewer and the interviewee as they could still sit facing one another. The two voice recorders were put on the table. There were no disturbances from the other office even though there were no doors in-between the two offices. The only disturbance that was encountered was when the participant's cell phone rang however he switched it off. The room temperature was comfortable. The building for the offices looked a bit dilapidated.

Participant 7

Descriptive notes

The participant is a manager in a non-governmental organization. The organization also takes care for the mentally ill patients. His work keeps him very busy and away from the institution most of the time. When the appointment was secured he was not in however written information with regard to the study was left behind for him to read. He was later contacted telephonically to confirm the date of the interview. He consented to participate. However on the said date of the interview he was not in and had to reschedule another date telephonically. Still on the very date he was busy with his office work which seemed very urgent to attend to and therefore requested the interviewer to wait for him. The interview started an hour after the researcher arrived at the institution. He apologized for the delay. The important aspects of the interview were reiterated and a consent form was signed. Permission for recording the interview was also granted.

Reflective notes

The participant showed dedication to his work and willingness to partake I n the study because he verbalized that he could not allocate another person for the interview lest the person could not be interested. He was relaxed and spontaneous during the Interview session. He was relaxed and spontaneous during the interview session. His emphasis was on collaboration of the different sectors in order to support the mentally ill patients in the community.

Demographic notes

The interview was held in a small office in the organization where the participant is working. The office is situated at the entrance of the building and it looked neat and well organized. There was a big table with the compute r and the printer on, and this further reduced the space. Because of the office arrangement the table formed a barrier between the interviewer and the interviewee as there could be no other way to place the chairs. The two voice recorders were thus placed on the table. The room temperature was comfortable. There was some noise coming from the patients who were sitting next to the office even though the door was closed for privacy.

Participant 8

Descriptive notes

The participant is a traditional healer who also takes part in the care of mentally ill patients in the community. He is also a chairperson in the traditional healer's forum who is also representing the traditional healers in the mental health care forum in this area. He also stated that he admits the mentally ill patients at his home during the acute stages for treatment. The appointment was scheduled telephonically for the first interaction and both the interviewer and the interviewee met at the community hall where the traditional healers were having their forum meeting. The written information was given to the participant. The researcher was also requested to introduce herself to the members and to state the purpose of her visit. Verbal permission was granted and the members agreed that their chairperson should be the one to be interviewed.

Reflective notes

The interviewee seemed to be interested during the session. He arrived on time as the interview was held at the clinic which is next to his home. He was also excited by the fact that on the day of the interview his wife gave birth to a baby boy and he was looking forward to see the child for the first time after the session. He was spontaneous, relaxed and free during the interview session from the beginning up to the end.

Demographic notes

Arrangements were made through the professional nurse in-charge of the clinic to have the interview conducted with the participant in the clinic. One of the consultation rooms was utilized. In this consultation room there was an examination coach and the chairs were placed in such a way that the interviewer and the participant are facing one another without a barrier in-between. The room temperature was comfortable. The consultation room door was closed for privacy and to control the noise. There were many patients who were sitting in the waiting room and they were consulted by the professional nurses in the clinic. There was no disturbance experienced as the consultation room is situated away from the waiting rooms.

Participant 9

Descriptive notes

The participant is a professional nurse who is also a mental health care services coordinator in the clinic. He is experienced in mental health nursing as he worked for a long period in the mobile clinic team for mental health nursing. The appointment was scheduled telephonically and the information was also given telephonically. The participant agreed to participate in the interview and he indicated that he was available at any time in any activity pertaining to mental health care. The written information was given to the interviewee on the day of the interview and

he was given sometime to go through the information letter and to ask questions if there were any. He then consented to the interview.

Reflective notes

The participant is very passionate to matters related to mental health care nursing. He verbalized interest to work with the mentally ill patients and he is also eager to advance his studies in mental health nursing. He was also laughing at times when he was responding to some of the questions and this indicated passion and commitment in mental health nursing. He was relaxed and answering questions spontaneously during the interview.

Demographic notes

The interview session was held in the clinic where the participant is working and in one of the consultation rooms. The room door was closed for privacy and also to control the noise. The room was spacious, the participant and the interviewer were squarely facing one another. There was no barrier in-between. The room temperature was comfortable. The participant's cell phone rang and was switched off immediately. The clerk entered the room and was not aware that the interviews are in process and she talked to the participant who had to respond to her verbally as she was not moving out and waiting for the response. She left the room after the participant indicated that he was still busy with the interview and this was being recorded.

Participant 10

Descriptive note

The participant is a working in a no-governmental organization which deals with supporting the mentally ill patients in the community. The appointment for the first meeting with the researcher was secured telephonically through the mental health services coordinator of the clinic where the organization is based and. The participant

was also contacted telephonically and received the information about the study. The permission was granted and a date for the interview was agreed upon. On the day of the interview the participant attended a meeting in the morning at the same clinic. after the meeting he had to weight for the interview and thus the interviewer found him on time. He requested that he should be in a company of one of his colleague for support. Reiteration of the aspects of the interview was done and he was also given an opportunity to ask questions for clarity. A written consent was signed prior the interview.

Reflective notes

The participant is a young man who shows interest in supporting the mentally ill patients. He was also answering thequestions with confidence. He had some notes written after he receive information about the study and he indicated that he wrote down in order to remind himself the important responses that he does not want to forget. The interviewee also verbalized that if the members of the organization can be trained on how to support the mentally ill patients they could deliver more than they are presently doing. He also indicated that if they could be given a place to work from together with necessary equipments and not be based in the clinic because sometime it becomes difficult for them to work when all the rooms are occupied.

Demographic notes

The interview was held at the clinic where the organization is based. The mobile house room was utilized as it was the only space available. There were many patients at the clinic who were attended to by the professional nurses. In the mobile houseroom there was only one patient. It was a rainy and a cold day the heating system was switched on. Privacy was maintained and there was no noise as the door was closed. In the room there was an examination couch three chairs were arranged and the interviewer sat facing the interviewee squarely. The interviewee's colleague was sitting a distance away. The two voice recorders were switched on with the permission of the participant. The interview went wellwithout disturbances.

Documents

Documents were also usedas part of data collection strategies. The focus was on written information that may assist on the exploration of the community-based interventions for mentally ill patients to improve quality of care. The patient's records in the clinics were primary sources that could support the phenomenon that is investigated. Purposive or accidental sampling was used to select the patients records. These records were readily available in the clinics as the mentally ill patients are not allowed to take their records home. Therefore the mental health nursing service coordinator was requested to hand in two patients records to the researcher. One institution could not avail the patient's records. The records served to corroborate the evidence from the data collected from the professional nurses.

APPENDIX K: WORK PROTOCOL FOR DATA ANALYSIS

WORK PROTOCOL FOR DATA ANALYSIS

Dear

INDEPENDENT CO-CODER FOR RESEARCH

As a lecturer at the Free State School of Nursing, I am presently studying M. Cur degree in Psychiatric Nursing Science at North West University, Potchefstroom campus. One of the requirements is that I conduct research. The title of the research is: **Exploring community based nursing interventions for mentally ill patients to improve quality of care** in Thabo Mofutsanyana District.

The following are the objectives of the study:

- To explore and describe current community-based interventions for the mentally ill patients in a rural community which contribute to their quality of care.

- To explore and describe suggestions by nurses and other caregivers about the utilization of community-based interventions to support mentally ill patients in a rural community to improve quality of life.

The interview is conducted by the researcher and the interview schedule is as follows:

- What are the current community-based interventions for the mentally ill patients in a rural community which may contribute to quality of care?

- How do nurses and other caregivers suggest these community-based interventions can be utilized to support the mentally ill patients in a rural community to improve quality of life?

Your role in the analyzing of the transcripts and the field notes of the interviews with the professional nurses and other community caregivers as selected according to he criteria for this research. The analysis of the transcripts and the interviews is done according to the guidelines as described by (Nieuwenhuis, 2011: 106).

- Each transcript is divided into three columns, with the transcript in the centre, coding in the right hand side and reflective notes in the left hand side.

- The transcript is read through so as to get the sense of the whole and whilst reading the transcript the questions of the study are kept in mind.
- The themes, words and phrases as stated by the participants are written on the riht hand side.
- Consideration of how many people are using a specific word or phrase as part of their answers to the questions and how many share the same understanding of the concept is done.
- Themes that emerge from the responses are written on the right hand side of the margin of the transcript.
- The identified themes are grouped into main categories, subcategories and further categories.
- The researcher eliminates the redundancies in the themes that are not specified and clarify or elaborates the meanings of the remaining themes by relating to each other and the whole.
- Towards the end of the analysis the concrete data is formulated in scientific terminology. A consensus meeting is arranged for discussion at a suitable date and time.

Your participation as a co-coder in this research is highly appreciated.
Regards

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L.M. Mamabolo Supervisor: Prof. M.P Koen

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Co-Supervisor: Dr E. Du Plessis