

# **Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting**

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Mini-dissertation submitted in partial fulfilment of the requirements for the degree Master of Nursing Science with Psychiatric community nursing at the North-West University

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Examination: March 2021  
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# DECLARATION / CODE OF CONDUCT

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*(Draft 1, 2018.09.07)*

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SIGNED on this day

at the

Campus of the NWU.

Student name and surname

Student number

23639059

Student signature

A handwritten signature in black ink, consisting of a series of loops and strokes, written over a horizontal line.

## DEDICATION

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“It is better to die for an idea that will live,  
than to live for an idea that will die”

Steve Biko



- Firstly, I would like to thank God of Mount Zion.
- Prof. Sehularo Leepile for encouraging me to register for the Master's Degree in Psychiatric Nursing.
- My supervisor Doctor Belinda Scrooby and co-supervisor Prof. Emmerentia du Plessis for being patient with and guiding me well throughout.
- Mr and Mrs Mokgaola for great assistance and guidance.
- My life partner Moeng Mpheng, for always encouraging me to strive harder.
- My colleagues Nkhutlelang O., Mthembu M.M., Mntambo C.M., Mchunu L., and Qwesha N.H. for the motivational and educational support they gave me.
- My Mother Motsaatsie Judith Sibalala for always keeping me in her prayers.
- My godmother Dikhutsahalo Lamentation Mahura for guiding me well.
- My son Morena Montshi for being my motivation.
- My two sisters and brother (Gaone Charlotte Sibalala, Mmathapelo Isobel Sibalala, and James Boikanyo) for supporting me throughout.
- The Department of Health and the Mahikeng sub-district manager for granting me permission to conduct the study.
- All healthcare providers who made my study possible.

## ABSTRACT

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There is a high number of recurring readmissions of mental health care users (MHCUs) which has raised concern related to factors that hinder comprehensive care also related to who and what is needed to provide comprehensive mental health care. This is also a concern in the community setting of Mahikeng sub-district of the North West Province (NWP), South Africa (SA). Comprehensive care is seen as fulfilling the maximum quality of care through developing community- and home-based care that focuses on early detection, follow-up care, rehabilitation, and promoting available social support services, promotion of general health, and continuous updates on mental health. Comprehensive care can be fully reached when there is full collaboration with mental health and non-mental health practitioners.

The aim of this study was to explore and describe the perceptions of healthcare providers of providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA. The objectives were to explore and describe their perceptions regarding 1) factors that hinder providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA, 2) healthcare providers who are needed to implement comprehensive care in the community setting of Mahikeng sub-district of the NWP, SA; and 3) what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

An explorative, descriptive, and contextual qualitative research design was followed in order to allow healthcare providers to share their perceptions regarding factors hindering comprehensive care in the community setting of Mahikeng sub-district of the NWP, SA. Purposive sampling was used to identify participants who meet the selection criteria. The sample size was determined by data saturation, which was reached after 20 telephonic semi-structured individual interviews with healthcare providers. Telephonic semi-structured individual interviews were utilised to gather data after written approval from the Health Research Ethics Committee (HREC) of the North-West University, the North West Provincial Department of Health (DoH), and the Mahikeng sub-district manager (Primary Health Care Manager) was obtained. The sub-district manager who is the gatekeeper then, informed facility managers who acted as mediators about the research study and data collection process. The researcher was then given the authority of being in contact with mediators and obtained informed consent from the healthcare providers who were the research participants. The co-coder and the researcher analysed the data independently.

The findings of this study included four (4) main themes, with sub-themes. The main themes were: theme 1: healthcare providers' understanding of comprehensive care to MHCUs; theme 2: factors hindering comprehensive care to MHCUs; theme 3: stakeholders needed for providing comprehensive care to MHCUs; and theme 4: suggestions for improving comprehensive care to MHCUs.

Conclusions were drawn, namely that improved mental health service is possible through involving/hiring more general health care and mental healthcare providers, enriching the community with knowledge, ensuring availability of treatment, more mental health training for healthcare providers, and ensuring lowered or no factors that hinder comprehensive care.

Recommendations were formulated for nursing education, nursing research, and nursing practice from the findings, literature, and conclusions of the study.

**Keywords:** community mental health, comprehensive care, healthcare providers, mental health care users, psychiatric nursing

## LIST OF ABBREVIATIONS

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<b>CHC:</b>	Community Health Centre
<b>Covid-19:</b>	Coronavirus Disease 2019
<b>DoH:</b>	Department of Health
<b>EMRS:</b>	Emergency Medical Response Service
<b>HIV:</b>	Human Immunodeficiency Virus
<b>HREC:</b>	Health Research Ethics Committee
<b>HST:</b>	Health System Trust
<b>MDT:</b>	Multidisciplinary Team
<b>MHA:</b>	Mental Health Atlas
<b>MHCU:</b>	Mental Health Care User
<b>MNS:</b>	Mental Neurological Substance use
<b>MSE:</b>	Mental Status Examination
<b>NuMIQ:</b>	Quality in Nursing and Midwifery Research focus area
<b>NWP:</b>	North West Province
<b>PRIME-SA:</b>	The Programme for Improving Mental Health Care in South Africa
<b>RN:</b>	Registered Nurse
<b>SA:</b>	South Africa
<b>SANC:</b>	South African Nursing Council
<b>WHO:</b>	World Health Organisation

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# CHAPTER 1:

## OVERVIEW OF THE STUDY

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### 1.1 INTRODUCTION

The high number of recurring readmissions of MHCUs is raising concern about mental health care services. Contributing factors may be the lack of community-based service provision and its inability to assist the MHCUs (Hendricks, 2018:2). It is further supported that although there is access to mental health care in the community setting, it is still lacking in terms of quality and adequate care (Marais & Petersen, 2015:2; Petersen *et al.*, 2016:29). According to De Kock and Pillay (2016:2), comprehensive approaches are indeed necessary to ensure adequate mental health care services to MHCUs. This is a major concern, as the provision of comprehensive care is emphasised and prescribed in the South African Mental Health Care Act (Act 17 of 2002; Maritz, 2010:61).

Comprehensive care, in this case, is mental health care that attends to the biological, psychological, intellectual, social, environmental, physical and economic needs of the MHCUs (Hendricks, 2018:10; Marais & Petersen, 2015:19-20). Comprehensive care is aimed at fulfilling the following: developing community and home-based care that focuses on rehabilitation, providing care that emphasises early detection, providing follow-up care, and promoting available social support services (Marais & Petersen, 2015:2-3; Maritz, 2010:61). According to Hendricks (2018:2), for the MHCUs to receive comprehensive care, their care should be associated with assessment, screening, counselling, outpatient treatment, emergency help 24 hours a day, and referral to appropriate services to satisfy all their health needs. Comprehensive care is based on quality assurance, advocacy, rights protection, capacity, and management development, which further encourage appropriate, useful, and patient-centred care (Marais & Petersen, 2015:2-3; Maritz, 2010:61).

Comprehensive care services are mainly about the needs of the MHCUs (Aburquergue-Sendin *et al.*, 2018:293-298). Comprehensive care is guided by protocols and standards that emphasise quality assurance, advocacy, and rights protection, leading to mental health user-centred care (Marais & Petersen, 2015:1-2; Maritz, 2010:61). Other comprehensive mental health care services include the provision of guidance to develop MHCU-centred services, provision of treatment, which include psychosocial interventions, and appropriate feedback on available services (Acharya *et al.*, 2017:4).

In the following few sections, the researcher provides the background to the study, problem statement, aim and objectives, and the methodology. Measures to ensure trustworthiness as well as ethical considerations are also discussed.

## **1.2 BACKGROUND TO THE STUDY**

Many factors are hindering comprehensive care to MHCUs, such as a lack of mental health resources at the community level related to the promotion of mental health recovery (Maritz, 2010:61; Petersen *et al.*, 2016:29). Comprehensive care in this regard means 1) ensuring quality services; 2) protection of rights; 3) promoting available social services with the use of protocols and standards that emphasise quality assurance and advocacy; 4) early detection and rehabilitation; and 5) encouraging appropriate patient-centred care; therefore, fulfilling adequate care (Marais & Petersen, 2015:7-8; Maritz, 2010:61).

Healthcare providers state some challenges to providing comprehensive care, including lack of time, poor communication with specialists, and fragmented care (Loeb *et al.*, 2016:2; Marais & Petersen, 2015:2-3). However, healthcare providers further stated that comprehensive care is needed in the health system for care coordination, preventing hospitalisations, and building good patient rapport, as poor access to mental health care services is also stated to be a negative contributing factor to the provision of comprehensive mental health care (Loeb *et al.*, 2016:9). According to Albuquerque-Sendin *et al.* (2018:293); and Marais and Petersen, (2015:9), health providers caring for MHCUs need extensive training, dedication, and motivation that aim at comprehensive care.

Maritz (2010:61) highlights barriers impacting negatively on maximum care and quality follow-up care, i.e., inadequate service provision related to resource availability which includes human resources, time, and infrastructure. Stigma is one of the most identified barriers related to mental health, low insight, and lack of treatment compliance of MHCUs (Haugen *et al.*, 2017:218-219; Marais & Petersen, 2015:1). Other barriers are related to support systems and the attitudes of the MHCUs, how they feel and react regarding the type of treatment and care they receive, as well as their family members' attitudes (Maritz, 2010:61). It is further supported that mental health still has barriers in relation to mental health care services, lack of resources, stigma, and comorbidity (Tristiana *et al.*, 2018:63-64). In this regard, there seems to be a high level of unmet needs related to follow-up care and follow through by mental health care services in SA (Marais & Petersen, 2015:19; Maritz, 2010:61).

This is alarming, considering that due to the nature of mental disorders, MHCUs' performance often becomes diminished, as is evident in physical functioning, behavioural regulation, and

recurring mental symptoms, leading their self-esteem and self-efficacy to be compromised (Chan *et al.*, 2018:126). Schneider *et al.* (2016:154) further state that many of those affected by the mental disorder are more likely to experience financial stress, live in inadequate housing, have low levels of productivity, and suffer from malnutrition. It is highly touching as the main reason behind the predisposing factors of disability and premature death is mental health conditions (Schneider *et al.*, 2016:154).

As much as 70% of MHCUs default from treatment immediately after their first or second visit of receiving treatment in the community due to the abovementioned issues, but also due to not receiving the quality care they require, a lack of services, and being demotivated (Corrigan *et al.*, 2014:40). MHCUs are therefore experiencing major challenges, which leads to relapse, being hospitalised, and reduced value of life (Velligan *et al.*, 2017:449). Non-adherence to medication treatment, poor insight, substance use, negative attitudes towards psychotropic medication, medication side-effects, and cognitive impairments are some of the reasons why MHCUs relapse (Velligan *et al.*, 2017:449). Another reason seems to be relapsing due to not having enough income to reach health care services (Corrigan *et al.*, 2014:40). Schneider *et al.* (2016:154) are also concerned about the high prevalence of poverty among the mentally ill. All this seems to be leading to a lack of treatment adherence.

Primary care services for MHCUs are thus faced with various challenges affecting the comprehensive delivery of care (Marais & Petersen, 2015:2; Maritz, 2010:61), including mental illness stigma (Chan *et al.*, 2018:126; Corrigan *et al.*, 2014:37). The experience of stigma leads MHCUs not to attend follow-up treatment because of feeling judged, and family members feel inhibited to express how they feel about the mental state and other related issues of their family members (Chan *et al.*, 2018:126; Marais & Petersen, 2015:11-12). Therefore, there is an urgent need for comprehensive service delivery to MHCUs in the community setting. The Mental Health Atlas (MHA, 2014:13) discusses components necessary for comprehensive service delivery to MHCUs, such as financial resources, human resources, capacity building, stakeholder involvement, service availability, service continuity, and social support. According to the World Health Organisation (WHO, 2012:1), mental health care development and service provision showed a lack of appropriate mental health services and attention, and that leads government and development actors to be active in developing strategies and programmes.

Such programmes include education, employment, health, social protection, and poverty reduction policies. The WHO report, through the Mental Health Gap Action Programme, states that international priorities include developing comprehensive policies and strategies to promote mental health, prevent mental disorders, ensure early identification, and provide care and support, treatment, and recovery (WHO, 2012:2). Comprehensive mental health care services

should include assessment of vulnerabilities, protection, promotion of comprehensive mental health care services, and respect for MHCU rights protection, accessible and affordable mental health care services, and the development of competent, sensitive, adequate human resources for the provision of comprehensive mental health care services (Marais & Petersen, 2015:7-9; WHO, 2012:3-4). Provision of comprehensive care furthermore includes psychosocial interventions, medication, promotion of physical health care needs, policies to promote mental health and prevent mental disorders, health education, schooling, housing, participation in income-generation programmes, and community and family involvement in caring for the MHCUs (WHO, 2012:3-4).

In SA, a policy framework supporting the integration of such comprehensive mental health care into primary health care is in development (Marais & Petersen, 2015:7-8; Schneider *et al.*, 2016:153; Van Rensburg & Fourie, 2016:8). Challenges in community settings still include low prioritisation and stigmatisation of mental health, weak managerial and planning capacity to develop and implement mental health care plans, poor pre-service training of generalists in mental health care, poor service delivery, poor infrastructure, and an insufficient mental health budget (Marais & Petersen, 2015:21). Bear in mind that Schneider *et al.* (2016:154) also state that about 75% of MHCUs do not receive mental health service/care in SA, because of a lack of service delivery. This challenge is aggravated by the dual burden that across the nine (9) South African provinces, about 43% of people living with human immunodeficiency virus (HIV) present with a mental disorder, which further complicates treatment adherence and compliance, e.g., the amount of medication these MHCUs have to take (Schneider *et al.*, 2016:154). Schneider *et al.* (2016:153) also state that policy and practice for improving services rendered should be combined and implemented for the improvement of health care services related to mental, neurological, and substance use (MNS) disorders. Hence the urgent need for the provision of comprehensive mental health care in the community setting.

To render comprehensive mental health care in a community setting, the involvement of multi-disciplinary team (MDT) members is crucial. Schneider *et al.* (2016:154) acknowledge the need for a well-functioning MDT for a comprehensive rendering of mental health care. Furthermore, Marais and Petersen, (2015:9) and Smith (2014:18) agree that human resources are important and that the necessary human resources for mental health care include MDT members such as nurses, medical doctors, psychiatrists, psychologists, social workers, and occupational therapists. These mental health care professionals are mostly placed in hospitals, and they are less available in community settings (Thorncroft *et al.*, 2014:279). These authors further support the fact that the limited availability of mental health care practitioners seems to be a major problem in many countries and that the presence of these MDT members could be very

beneficial in providing effective primary health care to MHCUs in community settings (Thorncroft *et al.*, 2014:279). Less-than-ideal mental health care services to MHCUs is certainly also a reality in SA. In spite of the well-known national slogan, “there is no health without mental health”, mental health still remains a problem in the South African context (Schneider *et al.*, 2016:153). Vision, commitment, allocation of resources, oversight, including support given to all provinces in SA, are highly needed in the implementation of comprehensive mental health care services (Schneider *et al.*, 2016:153). In the NWP particularly, comprehensive mental health care services seem to be unavailable (Marais & Petersen, 2015:1). There is a limited number of mental health care professionals available, such as registered nurses with advanced training in psychiatric nursing (De Kock & Pillay, 2016:5).

Marais and Petersen, (2015:6-11) found that in some community settings in the NWP where mental health care services are provided, there is a lack of resources including medication, incomplete assessment of MHCUs, and a lack of correct records. These problems contribute negatively to comprehensive mental health care services to the MHCUs. Marais and Petersen, (2015:6-11) also stated that MHCUs and health caregivers complained of the standard of care and attention given to mental health, as MHCUs are regarded the same as the general population in the health care setting, while they have special needs. Caregivers together with their MHCUs’ family members also raised their concerns regarding problems that hinder comprehensive care, namely (Marais & Petersen, 2015:6-11):

- Improper communication
- Lack of continuity of care due to staff turnover
- Long waiting times
- A desire expressed for specialised services in the form of special clinics and dedicated staff
- A need for more staff
- A particular need for doctors to be involved in their treatment

Due to the lack of comprehensive services in the NWP, as in other provinces, the majority of MHCUs are being readmitted after discharge. Hence it is necessary for comprehensive mental health care services to be introduced, implemented, and continued in the community setting, as Albuquerque-Sendin *et al.* (2018:293-294) also support the fact that there is a high need for

improving mental health care facilities and services where MHCUs receive their treatment and for ensuring comprehensive mental health care services through quality care.

### **1.3 PROBLEM STATEMENT**

MHCUs in the community setting relapse despite the provision of primary health care services (Petersen *et al.*, 2016:29). Even though MHCUs have some access to treatment at the community level, there are not enough resources to promote their mental health (Petersen *et al.*, 2016:29). This problem negatively impacts MHCUs and their families (Hou *et al.*, 2014:5). A possible contributing factor is that comprehensive mental health care is not provided (Acharya *et al.*, 2017:1). Mental health care in community settings still shows a problem and challenges are still faced indicated by lack of dedicated mental health staff, deficiency of allocated funding, and poor accountability for quality service delivery (Ellie, 2020:2). Most registered nurses in community setting facilities do not have a nursing qualification in psychiatric nursing or a speciality in mental health care and are still being expected to work with MHCUs (Ellie, 2020:2).

Comprehensive mental health care is seen as the ideal and is described as community and home-based care that focuses on early detection, follow-up care, rehabilitation, and promoting available social support services (Maritz, 2010:61). It also involves the use of protocols and standards that emphasise quality assurance, advocacy, rights protection, as well as capacity and management development; leading to patient-centred care (Maritz, 2010:61). The South African National Mental Health Policy Framework and Strategic Plan 2013-2020 (Department of Health [DoH], 2013) states that mental health was aimed and intended to be integrated into all aspects of general health care (Madikizela, 2017:2). The Programme for Improving Mental Health Care in South Africa (PRIME-SA) has implemented projects to uplift and upgrade mental health care in SA in facilitation of integration and task-sharing (Madikizela, 2017:2). Comprehensive mental health care ideally requires the provision of both psychosocial interventions and medication, the promotion of physical health, policies to promote mental health care and prevent mental disorders, health education, adequate schooling and housing, income-generation programmes, as well as community and family involvement in caring for MHCUs (WHO, 2012:3-4).

The reality is, however, that in many communities such as the NWP, including the Mahikeng sub-district, the provision of mental health care services does not seem to be a priority. Mental health care mainly focuses on providing medication, e.g., the primary reason MHCUs visit primary health care clinics after being discharged from the hospital is to collect treatment. In addition, there is a huge gap in communication between the psychiatric hospital and community health centres (CHC) in terms of follow-up of MHCUs (Loch, 2014:137). According to Loch

(2014:137), after mental health admissions and possible setbacks after discharge, there is unsatisfactory care which leads to negative outcomes e.g., relapse of MHCUs. Regardless of the PRIME-SA for integrating mental health care services into the community setting, there's still a major challenge as healthcare providers in the community setting still show negative attitudes and perceptions and other negative concerns towards mental health, which makes it difficult for MHCUs to receive proper care (Madikizela, 2017:2).

Looking at related research, a study conducted by Corrigan *et al.* (2014:37) regarding MHCUs not honouring follow-up appointments determined that this mainly happened because of negative judgements attached to mental illness. Due to such issues, approximately 70% of MHCUs default from mental health check-ups and treatment after the first or second appointment (Corrigan *et al.*, 2014:37). Furthermore, a study conducted by Velligan *et al.* (2017:449) found that factors related to relapse include defaulting treatment, poor insight, substance abuse, cognitive impairments, and medication side effects. Maritz (2010:61) shares barriers impacting negatively on maximum care and quality follow-up care, namely inadequate service provision related to resource availability which includes human resources, time, and inadequate infrastructure. Other barriers are related to support systems and the attitudes of the MHCUs as well as of their family members (Maritz, 2010:61). Hendricks (2018:2-4) shares that MHCUs do not receive adequate mental health services due to lack of appropriate service provision in community settings, lack of training and knowledge of healthcare providers, negative attitudes, and poor understanding of mental illness. Although much research has been conducted on this topic, no research could be found on the perceptions of healthcare providers themselves on comprehensive care delivery to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA. Healthcare providers are in a position to improve mental health care in community settings to bring such health care services closer to the ideal of comprehensive care (Schneider *et al.*, 2016:154).

Comprehensive care in the community to MHCUs is vital as MHCUs require attention from several and specific MDTs to be in a good state of mental health. This, however, seems to be ideal, and the reality is that often there are not enough MDT members with the necessary skills in the community setting to ensure this care to MHCUs (Yesuku-Udechuku *et al.*, 2015:268). There may be several barriers in community settings that prevent the provision of comprehensive mental health care that we are not aware of yet.

There was thus a need to explore and describe healthcare providers' perceptions of providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA. The researcher argued that such research will increase knowledge and understanding

regarding how mental health care services can be improved to contribute to MHCUs living a higher quality of life in a community setting.

#### **1.4 RESEARCH QUESTION**

The research question is an important step in research, as it narrows down the research topic (Doody & Bailey, 2016:19). It is important to select a good research question as it guides the choice of methodology, methods, sample, sample size, data collection instruments, and data analysis techniques (Doody & Bailey, 2016:19). In this research study, the research question was the following:

- What are the perceptions of healthcare providers regarding comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA?

#### **1.5 RESEARCH AIM AND OBJECTIVES**

The research aim was to explore and describe the perceptions of healthcare providers providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA, to gain new insights on how to improve these services in this specific context. The objectives of the research study were the following:

- To explore and describe the perceptions of healthcare providers regarding factors that hinder providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA;
- To explore and describe the perceptions of healthcare providers who are needed to implement comprehensive care in the community setting of Mahikeng sub-district of the NWP, SA; and
- To explore and describe the perceptions of healthcare providers on what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

#### **1.6 PARADIGMATIC PERSPECTIVE**

The paradigmatic perspective is a collection of rationally connected ideas and suggestions that give a theoretical perspective that leads the researcher in a specific research direction (Pretorius *et al.*, 2016:176), and is discussed below.

## **1.6.1 Meta-theoretical assumptions**

The meta-theoretical assumptions for this research study are based on the researcher's own opinion and observation regarding man and world, including Ray's theory of bureaucratic caring (Coffman, 2013:121-122). The assumptions regarding nursing, person, health, and environment are described below:

### **1.6.1.1 Nursing**

According to Ray's theory of bureaucratic caring (Coffman, 2013:121) nursing is defined as holistic, rational, spiritual, and ethical caring that needs the good intentions and aim of an individual and others including the whole community, organisational, and bureaucratic cultures. This definition is in line with the principle that MHCUs should be cared for comprehensively in the community setting, taking all their needs into consideration and considering their cultural and spiritual beliefs.

### **1.6.1.2 Person**

The researcher agrees with Ray's theory of bureaucratic caring that a person is a spiritual and cultural being, created by God, the Mystery of Being, and they engage co-creatively in human organisational and transcultural relationships to find meaning and value (Coffman, 2013:121). In this study, person refers to MHCUs and healthcare providers (MDT members) who need comprehensive care in a community setting for development, implementation, facilitation and maintenance of proper provision of mental health care services.

### **1.6.1.3 Health**

Ray's theory of bureaucratic caring views health as a state of complete physical and psychological well-being for individuals, families, and communities as a whole (Coffman, 2013:122). People construct their reality of health in terms of biology, mental patterns, characteristics of their image of the body, mind, and soul, ethnicity, and family structures of society and community (political, economic, legal, and technological), and experiences of caring that give meaning to lives in complex ways. The focus of this study was on the provision of comprehensive care to MHCUs in a community setting in order that their health is improved.

### **1.6.1.4 Environment**

Ray's theory of bureaucratic caring explains environment as a complex spiritual, ethical, ecological, and cultural phenomenon (Coffman, 2013:122). The environment consists of symbolic systems and patterns of meanings which are transmitted historically and are

maintained through caring values, attitudes, and communication. Nursing practice in environments embodies the elements of the structure and spiritual and ethical patterns of meaning. Environment in this study specifically refers to community settings, both the community health care centres and the community where the MHCUs receive mental health care and treatment.

## **1.6.2 Theoretical assumptions**

The theoretical assumptions of this study include the central theoretical argument as well as the conceptual definitions of the major concepts applicable to this study.

### **1.6.2.1 Central theoretical argument**

By exploring and describing the perceptions of healthcare providers of providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA, including perceptions on factors hindering comprehensive care to MHCUs, who are needed to implement comprehensive care to MHCUs and what can be done to improve comprehensive care for MHCUs, insight will be gained. Through gaining this insight, recommendations can then be made regarding providing comprehensive care and limiting hospital re-admissions of MHCUs living in the community setting of Mahikeng sub-district of the NWP, SA.

### **1.6.2.2 Definition of concepts**

The following concepts were prominent in this research:

- MHCUs

MHCUs as described in the Mental Health Act, No. 17 of 2002 (South Africa, 2002) as individuals receiving care and treatment from mental health care facilities. In this research study, MHCUs refer to all individuals who seek mental health treatment, including newly mentally diagnosed patients and known mentally ill/psychiatric patients in the community setting of Mahikeng sub-district of the NWP, SA.

- Comprehensive care

Comprehensive means 'complete' or 'full', aimed at including all details, items, facts, information that may be concerned for something to be achieved fully and thoroughly (Oxford Advanced Learner's Dictionary, 2010:296). Care is defined as attention or thought given to a matter which needs proper handling to avoid doing wrong or harm, i.e., what an individual may need for their health or protection (Oxford Advanced Learner's Dictionary, 2010:212).

Comprehensive care means fulfilling maximum quality of care through developing community and home-based care that focuses on early detection, follow-up care, rehabilitation, and promoting available social support services (Maritz, 2010:61). It also involves the use of protocols and standards that emphasise quality assurance, advocacy, rights protection, as well as capacity and management development; leading to patient-centred care (Maritz, 2010:61).

In this research study, comprehensive care therefore means quality care and treating MHCUs in the community setting of Mahikeng sub-district of the NWP, SA comprehensively by implementing and practising proper and needed care on a daily basis, which includes rehabilitation, early detection of illness, follow-up care, social support services, advocacy, assessment, health education, and receiving medication.

- Perceptions

The Oxford Advanced Learner's Dictionary (2010:1087) defines perception as the way one notices things, mostly with senses and also by the ability to understand the true nature of something, meaning the reasoning, thinking, and viewpoint: simply, insight. In this study, perceptions refer to the meaning, thoughts, and viewpoints of healthcare providers regarding comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

- Community setting

According to Smith *et al.* (2012:2) community setting is a level of care where integrated, easy-to-access health care services are provided by healthcare providers who are accountable and who develop a continuous therapeutic relationship with health care users.

In this research study, a community setting means the setting where the MHCUs receive mental health care services, live, and work; specifically, in the community setting of Mahikeng sub-district of the NWP, SA.

- Healthcare providers

Healthcare providers refer to a person/individual who provides health care services (South Africa Mental Health Care Act 17, 2002:5). In this research study, healthcare providers refer to all individuals who provide treatment, including diagnosing psychiatric conditions and providing care to mentally ill/psychiatric patients in the community setting of Mahikeng sub-district of the NWP, SA.

- Contextual  
Contextual refer to the specific area or place where data will be collected (Brink *et al.*, 2016:59).

### **1.6.3 Methodological assumptions**

The research model of Botes (1995:6) was used for guiding the methodological assumptions of this study as it is specifically developed for nursing research such as this research exploring and describing the perceptions of healthcare providers' regarding factors hindering comprehensive care for MHCUs in a community setting. The Botes model guides researchers to conduct research in a systematic, scientific manner, within the context of nursing. The context of nursing is described on three levels in the Botes model (Botes, 1995:6), and its application in this research is discussed below.

The first level indicates nursing practice as a potential source of research problems. The researcher who is a Registered Nurse registered with the South African Nursing Council (SANC), recognised the problem of MHCUs who mostly relapse and go back to hospital for re-admission. Based on this observation, the researcher gained interest in exploring and describing healthcare providers' perceptions regarding providing comprehensive care to MHCUs in a community setting, in order to better the provision of comprehensive mental health care.

The second level represents nursing research. The researcher agrees that nursing research should be conducted in a systematic manner, following the research process. Principles of rigour and ethics should be and were adhered to, in order to ensure trustworthiness. The researcher engaged in this research process in order to address the research problem that was identified from the nursing practice. Based on the outcomes of this research, recommendations could be formulated to assist in providing comprehensive care in the community setting and limiting hospital re-admissions of MHCUs.

The third level consists of the paradigmatic perspective of the researcher. The researcher's paradigmatic perspective guided her view of nursing, man, health, and environment as applicable to this research, as well as on relevant methods of knowledge generation and thus formed the framework within which research decisions were made. The paradigmatic perspective of this study consists of meta-theoretical, theoretical, and methodological assumptions, and was discussed in detail in section 1.6.

## **1.7 RESEARCH METHODOLOGY**

In this chapter, the research design and method will be discussed briefly and a detailed description will follow in Chapter 2.

### **1.7.1 Study design and method**

An explorative, descriptive, and contextual qualitative research design was deemed appropriate in this research study because it enabled the researcher to explore and describe the perceptions of healthcare providers regarding providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA (Bradshaw *et al.*, 2017:1-2; Brink *et al.*, 2016:120; Colorafi & Evans, 2016:24; Creswell, 2014:4; Flick, 2018:8; Holloway & Galvin, 2016:3-4; Klopper, 2008:68; McAlpine, 2016:40; Polit & Beck, 2017:666; Silverman, 2016:3).

The research method will briefly be described with attention given to the population, sampling, data collection, data analysis, and literature integration.

### **1.7.2 Population, sampling technique, and sample size**

Population, sampling technique and sampling size for this study will be discussed. This includes how research participants were selected and events from which the actual information was drawn and this was discussed under population and sampling (Brink *et al.*, 2016:130-131).

#### **1.7.2.1 Population**

Population is the individuals to whom the researcher is interested in who have required knowledge and experience regarding research (Brink *et al.*, 2016:131; Holloway & Gavin, 2016:143; Polit & Beck, 2017:365).

In this research, the study population was mental health care providers working in the Mahikeng sub-district in five (5) CHCs and four (4) primary care clinics for a period of more than two (2) years. They were included as the population as they are the professionals who work with MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

There were no numbers available regarding the specific healthcare providers in the Mahikeng sub-district, but the numbers available for the district within which this sub-district falls indicated that at the time of the study the following healthcare providers were working in the district: community health workers = 2354, nursing assistants = 564, enrolled nurses = 198, registered nurses = 1120, medical practitioners = 161, pharmacists = 64, dental practitioners = 16,

occupational therapists = 8, physiotherapists = 15, and speech and audiologists = 1 (Health System Trust (HST), 2019:715).

In this research study population included mental healthcare providers like one medical doctor and nineteen (19) registered nurses. Due to Covid-19 restrictions, not all of these healthcare providers were available at the community setting at the time the study was conducted. Consequently, only registered nurses and a medical practitioner could be involved in the study (see Chapter 2 for more detail).

### **1.7.2.2 Sampling and sampling technique**

In this research study, purposive sampling was used. Purposive sampling means selecting specific people who will take part as participants in a research study (Brink *et al.*, 2016:141; Holloway & Galvin, 2016:143; Lawrence *et al.*, 2015:1-2; Nyumba *et al.*, 2018:23; Polit & Beck, 2017:368). For this research study, potential participants were chosen and selected based on the researchers' judgement regarding their knowledge and experience, and on how informative participants are based on the research topic (Moser & Korstjens, 2018:10). This sampling technique was utilised to select healthcare providers who complied with the selection criteria, and who voluntarily participated and signed a consent form. The selection criteria are listed in Chapter 2.

### **1.7.2.3 Sample size**

The sample size was determined by data saturation (Brink *et al.*, 2016:141-144; Fusch & Ness, 2015:1407; Gentles *et al.*, 2015:1782-1783; Holloway & Galvin, 2016:152; Polit & Beck, 2017: 702). Data saturation was reached after 20 telephonic semi-structured individual interviews with healthcare providers working with MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

## **1.7.3 Data collection**

The role of the researcher, physical environment, the method of data collection, as well as the recruitment of participants will be discussed in this section.

### **1.7.3.1 Role of the researcher**

Before data collection, scientific clearance was obtained from the Quality in Nursing and Midwifery (NuMIQ; see Appendix A) review committee and ethical approval was also obtained from the North-West University's Health Research Ethics Committee (HREC; reference number NWU-00323-20-A1; see Appendix B). Thereafter written legal authorisation was obtained from

the North West Provincial Department of Health (see Appendices C and D), and the Mahikeng sub-district manager (Primary Health Care Manager; see Appendices E and F) of the health facilities where the researcher collected the data. The researcher then continued with the recruitment of participants, as explained in section 1.7.3.2.

### **1.7.3.2 Recruitment of participants**

The researcher planned to obtain permission and recruit participants through face-to-face meetings and distributing hard copies of recruitment material and informed consent documentation. However, due to Covid-19 restrictions she had to adjust to using a telephonic approach. Through this approach, she obtained consent from the North-West Provincial Department of Health and the Mahikeng sub-district manager who is a gatekeeper. The gatekeeper shared through email to all mediators regarding the research study that the researcher will need to do in the Mahikeng sub-district and researcher was included in the email so she can gain access to the community.

The researcher then contacted the mediators and discussed the purpose of the researcher study, informed consent to conduct study and to gain access to staff members, and the inclusion and exclusion criteria. The mediators shared contacts of the potential research participants with the researcher. Then, after gaining consent, the researcher distributed recruitment material a week-two weeks before collection of data through WhatsApp to every potential participant, who were selected by operational manager of every CHCs or Clinic in the Mahikeng sub-district (see Appendix G). During this process, the researcher informed the healthcare providers about the inclusion and exclusion criteria through telephone calls after distribution through WhatsApp, so that healthcare providers who were eligible to be part of the research study could consider to participate.

Mediators then shared potential participants cell-numbers with the researcher, after gaining access to healthcare providers who were eligible as chosen/selected by operational managers to be part of the research study, the researcher shared with them the stamped and signed informed consent through assistance of the mediators who printed the forms and placed them in the plastic folder, while sanitizing hands throughout and then the researcher explained the purpose and measures included in the consent form to potential participants through telephone calls. After this explanation and discussion, the healthcare providers indicated whether they were interested or not. The researcher guided the mediators on how to handle consent forms after printing i.e. to sanitize hands and put consent form in a plastic folder for four (four). After signing of the informed consent, the mediators scanned the consent forms and sent to the researcher, placed the original copies in a plastic folder and inside a box. Initially the interviews

would have been done through focus group interviews, but then the Covid-19 pandemic struck and the researcher's approach had to change to telephonic semi-structured individual interviews (see Chapter 2 for more detail).

### **1.7.3.3 Data collection method**

Before amendment of the data collection method, the researcher's initial strategy was to conduct focus group interviews from nine (9) facility in the community setting of Mahikeng sub-district of the NWP, SA, but all of that had to change due to the Covid-19 pandemic restrictions.

The strategy regarding the data collection method had to be amended to the following data collection method: telephonic semi-structured individual interviews. In line with Emans (2019:20), the researcher used telephonic semi-structured individual interviews as it allowed the researcher to use probing questions in order to guide the participant (interviewee) into finding the most relevant answers. This was the method of data collection in this study as it provided a wide range of information (see Chapter 2 for more detail).

### **1.7.3.4 Physical environment**

The interviews were conducted through telephonic semi-structured individual interviews. The researcher and participants were thus in different settings during data collection. The telephonic semi-structured individual interviews were conducted at a time that was conducive and convenient for both the researcher and the participants of the study. However, participants were given a chance to be comfortable and to ensure a closed-up private room to maintain privacy, confidentiality, and comfort. An hour before the interview, the researcher called the research participant and reminded him/her of the research interview, and reminded the research participant to be in a quiet and closed or, if possible, locked room to avoid disturbance during the research interview. A few minutes before the interviews, the researcher called the research participants to check that they are comfortable and ready to start with the interview.

### **1.7.3.5 Field notes**

During data collection, the researcher documented all required contextual information as part of the field notes during the individual semi-structured interviews (Brink *et al.*, 2016:59-60; Phillippi & Lauderdale, 2018:381). The researcher considered the field notes as her own private, personal thoughts, ideas, and queries regarding the research interviews and responses (Brink *et al.*, 2016:159; Phillippi & Lauderdale, 2018:381). As the interview was conducted telephonically, the researcher ensured that for every participant, "jotting down" was done, in order to remind herself of the participants' responses (Phillippi & Lauderdale, 2018:381). The

researcher ensured that she took note of the weather/season, date of collection of data, etc. (Phillippi & Lauderdale, 2018:383) as some participants would complain of weather e.g., rain and how it would disturb the interview.

Directly after the interview, the researcher made field notes on what happened during the interview, namely methodological, descriptive, and personal notes (Brink *et al.*, 2016:159). These notes were written on paper, including non-verbal cues, and were read in conjunction with the transcripts during data analysis.

#### **1.7.4 Data analysis**

Audio-recordings of the telephonic semi-structured individual interviews with the healthcare providers were transcribed verbatim. The transcription of recordings included laughter, notes about pauses, and emphasis (Holloway & Wheeler, 2002:116). A transcriber was involved to transcribe the data, namely an independent person with experience in transcribing audio-recordings of research interviews. This process generated 20-30 pages of written dialogue per interview, and the researcher then read it while listening to the recording (Sutton & Austin, 2015:227-228). The transcripts were then also analysed by a co-coder (See Appendix: L) following Tesch's (Creswell, 2014:196; Theron, 2015:7) coding process. This process is discussed in more detail in Chapter 2.

#### **1.7.5 Literature integration**

Literature was obtained through literature searches on the articles, books, and theses available from the Ferdinand Postma Library of the North-West University, Potchefstroom Campus and Mahikeng Campus as well as the internet. This literature was used to embed the findings of the research in existing literature, adding to the trustworthiness of the study. The literature integration forms part of the discussion of the findings in Chapter 3.

### **1.8 MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness or rigour of the research study is about the degree of confidence in data, interpretation, and methods used for ensuring the quality of the research study (Connelly, 2016:435). According to Brink *et al.* (2016:126), Connelly (2016:435) and Cope (2014:89), measures to ensure trustworthiness in qualitative research include credibility, dependability, confirmability, transferability, and authenticity. Rigour in qualitative studies is of importance as it validates integrity in research findings because qualitative data is made up of interpretative methods which aim to explore, understand, and explain people's experiences through non-numerical data, which in turn make an impact on health practice or policy development (Brink *et*

*al.*, 2016:126; Hadi & Closs, 2016:641; Polit & Beck, 2017:787). The researcher's understanding of the measures to ensure trustworthiness are outlined briefly below, while the application of these measures are discussed in Chapter 2.

### **1.8.1 Credibility**

Credibility is also known as confidence in the truthfulness of the findings of the study as the most important elements of the study (Brink *et al.*, 2016:172; Connelly, 2016:435).

Techniques to ensure credibility included prolonged engagement over phone calls, member checking, exploring explanations, iterate questioning of data, audit trial. The study will be examined by internal and external examiners and published in the form of a mini-dissertation and a research article. More details will be discussed under 2.9.1.

### **1.8.2 Dependability**

The stability of research data over time and over the conditions of the research data is known as dependability (Brink *et al.*, 2016:172-173; Connelly, 2016:438; Cope, 2014:89).

In this research study thick description of the research was done, the research study was peer examined and a co-coder was included during data analysis. More details will be discussed under 2.9.2.

### **1.8.3 Confirmability**

Confirmability is the neutrality or the degree of consistency of findings and the degree to which the information could be repeated (Brink *et al.*, 2016:173; Connelly, 2016:435; Cope, 2014:89).

In this research study member checking, sharing detailed description of the research process, data collection through telephonic semi-structured individual interviews using audio-recorders and writing field notes was done. More details will be discussed in 2.9.3.

### **1.8.4 Transferability**

Transferability is the manner in which findings are useful to individuals in other settings, and differs from other aspects of research in that readers merely determine how applicable the findings are to their situation (Brink *et al.*, 2016:173; Connelly, 2016:435; Cope, 2014:89).

This research study is contextual as collection of data took place where the challenge or problem is experienced. More details will be discussed under 2.9.4.

### **1.8.5 Authenticity**

According to Brink *et al.* (2016:172) and Cope (2014:89), authenticity speaks of the ability and extent to which the researcher expresses the feelings and emotions of the participants' experiences in a faithful manner without sugar-coating anything.

In this research study, telephonic semi-structured individual interviews were transcribed verbatim and analysed according to specific data analysis steps, and also involving a co-coder.

## **1.9 ETHICAL CONSIDERATIONS**

Ethical issues specific to qualitative research were related to informed consent, anonymity, confidentiality, data generation, treatment, publication, and the participant-researcher relationship (Streubert & Carpenter, 2011:60). The principle of beneficence was protected at all times and therefore participants were not harmed, and in cases where the research had potential to cause psychological trauma, follow-up counselling and referrals would have been made. In addition, participation was voluntary. Streubert and Carpenter (2011:60-65) further share that participants should be treated with dignity and respect at all times and the principle of justice should always be a priority, too. The application of these principles, as well as additional ethical considerations, are discussed in detail in Chapter 2.

## **1.10 CHAPTER OUTLINE**

This mini-dissertation on exploring the perceptions of healthcare providers regarding providing comprehensive care to MHCUs in a community setting is divided as follows:

Chapter 1: Overview of the study

Chapter 2: Research design and method

Chapter 3: Findings and literature integration

Chapter 4: Conclusions, limitations, and recommendations

## **1.11 CHAPTER SUMMARY**

This chapter comprised an overview of this study which includes the introduction, background and problem statement, research question, research aim and objective, paradigmatic perspectives as well as a short description of the research design and method that was followed

in this study. The division of chapters were outlined. A detailed description of the research design and method is given in the following chapter.

## **CHAPTER 2:**

### **RESEARCH DESIGN AND METHOD**

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#### **2.1 INTRODUCTION**

In the previous chapter, the introduction, background and problem statement, research question, research purpose and paradigmatic perspective as well as a brief description of the research design and method were discussed. This chapter comprises a detailed description of the research design and method followed in this study.

#### **2.2 RESEARCH DESIGN**

According to Creswell (2014:4), the research design is the significant plan of the research study, following the research problem (Brink *et al.*, 2016:96; Holloway & Gavin, 2016:3). The research problem directs the type of research design to be followed, as the aim of the research design is to properly align the pursuit of a research goal with practical considerations and limitations (Mouton & Marais, cited by Klopper, 2008:68). Mouton and Marais, cited by Klopper (2008:68), define research design as a set of guidelines and instructions used to address a specific research problem.

An explorative, descriptive, and contextual qualitative research design was used in this research study because it enabled the researcher to explore and describe the perceptions of healthcare providers regarding providing comprehensive care, including their perceptions on factors that hinder providing comprehensive care to MHCUs, perceptions of who are needed to implement comprehensive care, and perceptions of what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA (Bradshaw *et al.*, 2017:1-2; Brink *et al.*, 2016:59; Colorafi & Evans, 2016:24; Creswell, 2014:4; Flick, 2018:8; Holloway & Galvin, 2016:3-4; Klopper, 2008:68; Polit & Beck, 2017:666; Silverman, 2016:3).

Qualitative research is said to be a form of social inquiry that is based on the way people make sense of their experiences and the world they live in (Brink *et al.*, 2016:11; Flick, 2018-8). Qualitative research aims to explore human behaviour, feelings, and experiences and what lies at the core (Brink *et al.*, 2016:11; Flick, 2018:8). The researcher described, analysed, and interpreted the findings of the research (Holloway & Galvin, 2016:3-4). Qualitative research is about understanding others' experiences (Silverman, 2016:3). Qualitative research methods view the researcher's communication, research participants, and their environment as modes of knowledge, and researchers become part of the research process and try to understand participants' knowledge and practices (Brink *et al.*, 2016:11; Flick, 2018:8; Polit & Beck,

2017:666-667). Semi-structured individual interviews are aimed at providing a flexible technique for researchers (Kallio *et al.*, 2016:2955-2958). Semi-structured individual interviews are mainly utilised when the research benefits from an open setting and also when more useful information is needed from research participants (Kallio *et al.*, 2016:2955-2960). According to Guest *et al.* (2006) cited by Fusch and Ness (2015:1409) six (6) participants can be used during semi-structured individual interviews; however, in this research study, data collection was determined by data saturation. The purpose of qualitative research in this research was to provide strong evidence regarding the research problem investigated (Brink *et al.*, 2016:97).

Explorative designs were used because the researcher needed to have insight on what is occurring on a particular topic on which no information has been found, in order to find out the gap, needs, or goals for a particular population (McAlpine, 2016:40). Telephonic semi-structured individual interviews were used in exploring certain phenomena (McAlpine, 2016:40). The purpose of explorative designs in this study was to explore the perceptions of healthcare providers regarding comprehensive care, including their perceptions of factors that hinder providing comprehensive care to MHCUs, perceptions of who are needed to implement comprehensive care, and the perceptions of healthcare providers on what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

Descriptive designs are mostly concerned with collecting data to identify or justify current problems in practice, to make judgements, or to determine what others do in related practice (Brink *et al.*, 2016:113; Bradshaw *et al.*, 2017:1-2), as in this case. Descriptive designs aim to find out more and understand a phenomenon, process, or the perspective and views of the people involved (Brink *et al.*, 2016:113; Bradshaw *et al.*, 2017:1). Qualitative descriptive studies are moreover relevant to the health science environment as they provide a space to describe factual responses regarding questions of how people feel about certain issues, reasons regarding issues or why they use specific services or functions of certain services, and factors that facilitate or hinder use (Brink *et al.*, 2016:113; Karen & Browynne, 2016:16). The purpose of descriptive research in this study was to describe the perceptions of healthcare providers providing comprehensive care, including their perceptions of factors that hinder providing comprehensive care to MHCUs, perceptions of who are needed to implement comprehensive care, and the perceptions of healthcare providers on what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

This was also a contextual study as data collection was done where the problem or challenge was found/experienced. Contextual studies are considered when data collected is only valid in a

specific context (Brink *et al.*, 2016:59; Klopper, 2008:68). A study which focuses on specific events in natural settings, giving the researcher a chance to familiarise him/herself and understand meanings of experiences, is said to be a contextual research study (Brink *et al.*, 2016:59; Zhou, 2010:310). In this study, the context was in the community setting of Mahikeng sub-district of the NWP, SA. According to Health System Trust (HST, 2019:715), the Mahikeng sub-district has 40 ward-based outreach teams, 27 clinics, four (4) community health centres (CHCs), one (1) district hospital, one (1) central/tertiary hospital, and one (1) private hospital. There were no numbers available regarding the specific healthcare providers in the Mahikeng sub-district, but the numbers available for the district within which this sub-district falls indicated that at the time of the study the following healthcare providers were working in the district: community health workers = 2354, nursing assistants = 564, enrolled nurses = 198, registered nurses = 1120, medical practitioners = 161, pharmacists = 64, dental practitioners = 16, occupational therapists = 8, physiotherapists = 15, and speech and audiologists = 1 (HST, 2019:715). Healthcare providers meeting the criteria for this study worked in the community setting of Mahikeng sub-district of the NWP, SA and provided care to MHCUs in a community setting.

### **2.3 POPULATION**

Population in research means a group of individuals who are of interest and who meet the criteria of the research study (Brink *et al.*, 2016:120; Brink *et al.*, 2012:131; Creswell, 2014:4; Flick, 2018:8; Holloway & Gavin, 2016:143; McAlpine, 2016:40; Polit & Beck, 2017:365; Silverman, 2016:3). This abovementioned sub-district was chosen as it is part of the NWP where a lack of comprehensive service delivery due to lack of communication, improper service delivery, lack of service continuity due to staff turnover, long waiting times, particular need for specialised doctors, lack of full assessment, poor records, need for more staff, and lack of mental health medication were reported (Marais & Petersen, 2015:7-8). Conducting research in this sub-district allowed the researcher to explore and describe the perceptions of healthcare providers regarding comprehensive care to MHCUs in a part of this identified province.

In this research, the study population was healthcare providers working in the said setting, in five (5) CHCs, and four (4) primary care clinics as they are the professionals who work with MHCUs in the community. Healthcare providers in this research study included psychiatrists, medical doctors, social workers, registered nurses (RNs), and psychologists. In the said setting, normally one (1) doctor is assigned to about three (3) - four (4) community health centres and psychologists and social workers rotate in clinics on specified days, excluding Saturdays and Sundays. However, at the time of the study, due to Covid-19 restrictions, these healthcare

providers were placed minimally in community settings. The RNs were still permanently placed at each CHC and primary care clinic. For more information on the inclusion and exclusion criteria, see section 2.4.1.

## **2.4 SAMPLING**

Sampling refers to the manner of selecting a particular group of people for successful interview (Brink *et al.*, 2016:130; Creswell, 2014:79-80). Brink *et al.* (2012:132) define sampling as the process of choosing certain individuals from a population to gather information on a phenomenon in a way that represents the population of interest. The sampling technique and sample size are discussed.

### **2.4.1 Sampling technique**

In this research study, purposive sampling was used. Purposive sampling was considered to be the most appropriate for this study as the researcher is familiar with the population from which the sample was selected and was thus able to select specific people who would be the most appropriate to take part in the research study (Brink *et al.*, 2016:141; Holloway & Wheeler, 2002:138; Lawrence *et al.*, 2015:1-2; Nyumba *et al.*, 2018:23; Polit & Beck, 2017:368). Purposive sampling was used because it allowed the researcher to choose specific individuals from a population to gather information on a said phenomenon in a way that represents the population of interest which the researcher will be focusing on, as it is used for the identification and selection of information-rich cases in qualitative research studies (Brink *et al.*, 2016:141; Lawrence *et al.*, 2015:1-2).

Purposive sampling is furthermore recommended in studies where interviews are considered, as such discussions depend on the ability and capacity of the most relevant participants to share relevant and appropriate information (Brink *et al.*, 2016:141; Holloway & Galvin, 2017:143; Lawrence *et al.*, 2015:1-2; Nyumba *et al.*, 2018:23; Polit & Beck, 2017:368). In this research study, purposive sampling was used to select healthcare providers who met the criteria of selection, and who agreed to participate in this study. For this research study, potential participants were chosen or selected based on the researchers' judgement regarding their knowledge and experience (Moser & Kortjens, 2018:10).

The following inclusion and exclusion criteria were applicable to this study.

#### **Inclusion criteria:**

Participants who were:

- Multidisciplinary team (MDT) members who have experience in working with MHCUs in a community setting in the North West Province.
- Members of the MDT, including psychiatrists, medical doctors, psychologists, speech therapists, occupational therapists, pharmacists, social workers, and RNs.
- MDT members with two (2) years or more experience working in a community setting because they have experience working with MHCUs and are therefore seen as information-rich persons regarding providing care to MHCUs in a community setting.
- MDT members who were willing to participate in the study.
- MDT members who were able to communicate and express their perceptions comfortably in English, as the preferred and practiced language in the workplace in health care settings. Members were included if they expressed themselves in another language, granted that the language was understood by the researcher.

Healthcare providers in the inclusion criteria were considered because they came in direct contact with the MHCUs for review, consultations, examination, and they have experience in providing care to the MHCUs and understand the needs of MHCUs.

Due to Covid-19 and its restrictions, the researcher only managed to conduct research interviews with nineteen (19) RNs as they mostly work in the community setting and are always available at the CHC and clinics, and only one (1) medical practitioner. Other members of the MDT were not allowed to be in the community as they work at the hospitals, and only come to the community for relief or monitoring of patients for only a few hours on a weekly basis.

**Exclusion criteria:**

In this research study, the following individuals were excluded because although they form part of the health care team, they work under supervision of the healthcare providers mentioned under the inclusion criteria.

- Enrolled nursing assistants
- Enrolled nurses
- Community service nurses
- Student nurses

- Medical assistants
- Students of the other professions

#### **2.4.2 Sample size**

The sample size was determined by data saturation after interviews with twenty (20) participants. Data saturation occurs when no additional information is obtained during data collection and when themes that emerge keep repeating (Brink *et al.*, 2016:141-144; Fusch & Ness, 2015:1407; Gentles *et al.*, 2015:1782-1783; Holloway & Galvin, 2016:152; Polit & Beck, 2017:702). According to Fusch and Ness (2015:1407), data saturation is reached when new information is no longer obtained from the research participants, which makes no further coding necessary; in other words, there is no additional information to add to topics or sub-topics. During data collection, telephonic semi-structured individual interviews were mainly utilised because the research benefited from an open setting and because rich information was needed from research participants (Kallio *et al.*, 2016:2959-2960).

According to Fusch and Ness (2015:1409), depending on the sample size of the population, data saturation can be reached by conducting interviews from as little as six (6) interviews, and that only when no new data, no new themes, no new coding, and the ability to replicate the study emerge. When the researcher reaches a point of no new data, it is most likely to reach point of no new themes, meaning data saturation has been reached (Fusch & Ness, 2015:1409). In this study, data saturation was reached after conducting 20 telephonic semi-structured individual interviews.

### **2.5 RECRUITMENT OF PARTICIPANTS AND OBTAINING INFORMED CONSENT**

Before recruitment and data collection, scientific clearance was obtained from the Quality in Nursing and Midwifery (NuMIQ) review committee (see Annexure A) and ethical approval was also obtained from the North-West University's Health Research Ethics Committee (HREC; reference number NWU-00323-20-A1; see Appendix B). Thereafter, written legal authorisation was obtained from the North West Provincial Department of Health (see Appendices C and D), and the Mahikeng gatekeeper (Primary Health Care Manager; see Appendices E and F) of the health facilities where the researcher collected the data.

The recruitment procedure was carried out with the assistance of the gatekeeper of the relevant sub-district (Mahikeng sub-district). The district manager acted as the gatekeeper and is also known as the Primary Health Care Manager. The gatekeeper gave the researcher the authority

to conduct research at the chosen district and issued letters of authority for said health facilities to allow the researcher to gain access to healthcare providers and the health facilities.

The gatekeeper shared through email to all mediators regarding the research study that the researcher will need to do in the Mahikeng sub-district and the researcher was included in the email so she can gain access to the community. The researcher made arrangements professionally through email and calls with the mediators, who are leaders known as operational managers in clinics and CHCs. The researcher then contacted the mediators and discussed the purpose of the research study, informed consent to conduct study and to gain access to staff members, and the inclusion and exclusion criteria. The mediators shared contacts of the potential research participants with the researcher.

The mediator of every clinic or CHC identified potential participants, based on the inclusion and exclusion criteria, and all potential participants were informed by the mediators that they had a right to choose whether they want to participate in the study or not, to avoid coercion. The mediators identified potential research participants at the sub-district facilities by informing participants about the research study through word of mouth and the researcher shared recruitment material via WhatsApp and explained through telephone calls to avoid violating Covid-19 restriction regulations (see Appendix G with title Recruitment material: "Invitation to participate in the research study"). Participants were also informed that no penalty or prejudicial treatment will be given to them if they decide not to participate in the research study. Participants were informed about their right to withdraw from the research study if they do not feel comfortable and to withhold information if they do not want to share. Participants were also informed about their right to seek clarification regarding the purpose and aim of the research study.

Prior to the informed consent, through communicating with the mediators, the researcher sent the "inclusion and exclusion criteria" via email to them so that they could familiarise themselves with it and later fully discuss it to clarify questions. This ensured that the mediators understood fully who they should invite for informed consent to avoid misunderstandings. Participants in this research study gave conditional informed consent verbally, then later on arrangements were made for signing of informed consent.

After the inclusion criteria were fully understood by respective mediators, an "informed consent form" (see Appendix H), together with a document with title "Section A: Demographic details and definition of concepts" (see Appendix I) were sent via email, a date and time to address misunderstandings were set, and through telephonic contact, matters were addressed.

Due to the fact that most of the population were not comfortable with the use of emails and have limited connectivity and experience in using smart phones, as Mahikeng sub-district is a rural area, the mediators then printed out the “informed consent form” which were paid for by the researcher and “Section A: Demographic details and definition of concepts” (see Appendix I) for all potential participants.

Consent forms were signed, with the assistance of and in the presence of the mediator, one (1) or two (2) weeks after the recruitment of the potential participants with the mediator in order to provide them with adequate time to make a decision without being coerced to do so. This allowed enough time for research participants to decide whether they would like to participate in the research study. During this time, the document with title “Section A: Demographic details and definition of concepts” (see Appendix I) was also given to the participants that have signed the informed consent form.

The demographic details forms were printed four days before issuing to potential participants and were placed in plastic bags, and strict order was given regarding hand sanitizing and given to participants to fill in their details such as cell phone numbers to be contacted on for interview appointment preparation and for conducting the interviews. The form was also used for indication of gender, home language, number of working years and for indication of “responsibilities towards the MHCUs”.

The mediators were guided by the researcher regarding assurance of handling the consent forms, the researcher asked that after printing the consent forms should be in plastic pockets for about a week. On the day of signing the informed consent, the researcher called potential participants per CHC or Clinic.

The researcher then made arrangements with the mediators on how the signed “informed consent form” and document with title “Section A: Demographic details” would be scanned and sent back to the researcher via email as contact with participants was not allowed according to Covid-19 regulations (Güner *et al.*, 2020:571-576). The researcher then after four (4) days collected the signed informed consent forms while they were put in plastic folders and put in a box to avoid potential spread of Covid-19.

## **2.6 DATA COLLECTION**

The data collection method, communication skills used during telephonic semi-structured individual interviews as explained by Farooq and De Villiers (2017:3) and Emans (2019:17-26) as well as the role of the researcher will be discussed in this section.

Data collection consists of the use of information to understand and explain the phenomenon (Bradshaw *et al.*, 2017:4). In this study, it was initially planned that focus group interviews would be used as data collection method. However, due to Covid-19 restrictions, this data collection method had to be amended and data collection was done by means of telephonic semi-structured individual interviews. Semi-structured individual interviews aim at providing a flexible data collection technique for researchers (Brink *et al.*, 2016:158; DeJonckheere & Vaughn, 2019:1). Semi-structured individual interviews were mainly utilised as the research benefited from an open-ended approach, and also because the researcher needed rich information from research participants (Brink *et al.*, 2016:158; DeJonckheere & Vaughn, 2019:1-2). For this research study, data was collected from 20 participants, although 8-12 participants can be used during semi-structured individual interviews (Brink *et al.*, 2016:158; DeJonckheere & Vaughn, 2019:1).

The researcher used telephonic interviews due to the Covid-19 pandemic, for protection of self and the participants. Furthermore, Farooq and De Villiers (2017:3) state that participants tend to participate more freely in telephonic interviews as compared to face-to-face interviews, and it also reduces bias and increments anonymity as the interviewee and interviewer cannot see each other.

The data collection method included a short demographic information questionnaire (section A; already completed by participants who gave informed consent) and the semi-structured interview schedule (section B; see Appendix I).

In section A, the following demographic information was asked:

- Current occupation
- Institution
- Gender
- Home language
- Years working in community setting with MHCU
- Role and responsibilities towards the MHCU

Section B consisted of an interview schedule of five (5) questions that allowed the researcher to explore and describe perceptions of participants on providing comprehensive care to MHCUs in the community setting, and the following are the questions that were asked:

- In your view, what does comprehensive mental health care entail?
- In your opinion, what factors hinder comprehensive care to MHCUs in the community setting? (Why?) (Motivate)
- Who do you think is needed to provide comprehensive care in the community setting? (Why?) (Motivate)
- What do you think can be done to improve comprehensive care among MHCUs in the community setting? (Why?) (Motivate)
- Any other comments on comprehensive care to MHCUs

Prior to data collection, the researcher called the participant at least one (1) or two (2) hours before the interview to check if the participant was still ready and free for the set appointment. The researcher informed and discussed with the participant the importance of being in a conducive, private room away from noise, to avoid being disturbed during the interview. The researcher also notified the participant that if they had extra phones, the phone should be on silent to avoid disturbance due to incoming calls or text messages. The participant was also made aware of the importance of ensuring that they were comfortable and in a private space in order to limit interruptions to the minimum during the course of the interview.

During the telephonic semi-structured individual interviews, the researcher again introduced herself to the participant, then checked together with the participant if indeed the participant met the requirements of being part of the research interview i.e., two (2) years' experience, registered with the correct professional body (e.g., SANC), and a member of the MDT. The researcher again made the participant aware of his/her right of voluntary participation and that he/she could withdraw or stop the interview at any time without being penalised in any way. The participant was also made aware again of the time the interview would take, which was 30 minutes to an hour, and that the interview would be a telephonic semi-structured individual interview and consisted of five (5) questions. Before asking the questions, the researcher asked for the participant's verbal permission to audio-record, and then the interview began. The telephonic semi-structured individual interviews were audio-recorded by the researcher to allow transcribing and analysis of data after data collection.

During data collection, to encourage participants to express themselves freely, the researcher followed communication skills as described by Emans (2019:17-26) in the publication "Interviewing: Theory, techniques and training" which describes types of cognitions in research such as feeling (e.g., level of anxiety), knowledge and instructions. Some participants got

anxious during the interview because of answering a certain question and the researcher always took that into consideration. Knowledge is related to this study because participants answered questions in a form of sharing knowledge to close the gap to a said phenomenon (e.g., anything known about the said regulations/information on a said setting). Instructions of the interview included how the interview was followed, i.e., introduction and conclusion, location of interview, use of audio recorder, prepared questions of the interview, allowing free flowing during the interview, and avoiding interruptions in-between.

The researcher used semi-structured interviews during November 2020 to December 2020 as it allowed the researcher to probe questions in order to drive the participant (interviewee) into finding the most relevant answers (Brink *et al.*, 2016:158; Emans, 2019:20). The researcher maintained a neutral attitude throughout the interview and all personal behaviour, values, and opinions of the researcher were on the background (Emans, 2019:20). Anonymity and the use of an audio-recorder were transparent to the participants' knowledge and privacy and confidentiality was made clear to the participant (Brink *et al.*, 2016:37; Emans, 2019:23-24). Emans (2019:25-26) made the researcher aware of: how to assess participants' responses and behaviour: participants were chosen according to their purpose of expertise, i.e., according to the interests of the researcher; and that questions to all participants should be the same and be formulated to allow free flowing and a formal format of the research data.

During and after data collection, the researcher documented all required contextual information as part of field notes (Phillippi & Lauderdale, 2018:381). The researcher considered the field notes as her own private, personal thoughts, ideas, and queries regarding the research interviews and responses (Phillippi & Lauderdale, 2018:381). As the interview was telephonic, the researcher ensured that for every participant, "jotting down" was done, in order to remind herself of participants' responses (Phillippi & Lauderdale, 2018:381). The researcher ensured that she took note of the weather/season, date of collection of data, etc. (Phillippi & Lauderdale, 2018:383) as some participants would complain of weather e.g., rain and how it would disturb the interview. Field notes were organised into methodological, descriptive, and personal notes (see Appendix K). These notes were read in conjunction with the transcripts during data analysis.

## **2.7 DATA ANALYSIS**

The audio-recordings were transcribed *verbatim*. The transcription of recordings included laughter, notes about pauses, and emphasis (Holloway & Wheeler, 2002:116). A transcriber was involved to transcribe the data, namely an independent person with experience in transcribing audio-recordings of research interviews. Transcribing usually takes an experienced

transcriber eight (8) hours to transcribe one 45-minute audio-recorder interview. This process generated 20-30 pages of written dialogue per interview, and the researcher then read it while listening to the recordings, to check for accuracy and completeness (Sutton & Austin, 2015:227-228).

The researcher then organised the data in an orderly, coherent fashion so that she could discern patterns and relations regarding the data. The qualitative analysis process involved the assimilation and synthesis of narrative non-numeric data that includes reduced themes and categories with the aid of a coding procedure (Brink *et al.*, 2016:177; Brink *et al.*, 2012:57-58), which was shared with an independent co-coder to follow during data analysis.

The following eight (8) steps of Tesch's (Creswell, 2014:196-197; Theron, 2015:7) coding process was applied by the researcher and an independent co-coder:

- The researcher read all transcripts to acquire a sense of the whole data set and wrote down ideas in the margins.
- Secondly, the researcher selected one (1) interview, the shortest and/or most interesting one, and read through it; the concept being to know what it is about and identify similar and meaningful phrases in the transcripts.
- The researcher then completed this task for several transcripts and made a list of topics. Similar topics were grouped together and columns were formed and data was arranged into main/major topics, unique topics, and leftovers.
- The list of topics was made and returned to the data. The topics were abbreviated as codes and the researcher wrote the codes next to the appropriate segments of the text. Then the researcher used this preliminary organising process to gather whether new categories and codes emerged.
- The most descriptive wording was found for the topics and were returned into categories. The researcher continued to try and reduce the total list of categories by grouping together topics that related to each other. Lines were drawn between categories to show interrelationships.
- The researcher then made final decisions on the abbreviations for each category and alphabetised the codes made from the data.
- The researcher then assembled data material belonging to each category in one place and performed a preliminary analysis, focusing on all the data at hand in one category at a

time. The focus was on the content of each category. During this process, the research question was kept in mind in order to discard irrelevant and unneeded data.

- Then the researcher recoded the existing data where needed.

In this research study, an independent co-coder was involved to also analyse the data and after a consensus discussion with the co-coder, the themes were finalised, as discussed in Chapter 3.

## **2.8 LITERATURE INTEGRATION**

After analysing and presenting the data (see Chapter 3), literature was searched in medical journals, PubMed, Medline, Science direct, emerald insight journals, Google Scholar, eBooks, books from the national library and North-West University; Potchefstroom Campus and Mahikeng Campus. Various other resources available were used.

Information gained from the literature assisted and gave the researcher direction regarding how the findings of the research relate to existing literature. The literature integration is presented in Chapter 3.

## **2.9 TRUSTWORTHINESS/RIGOUR**

Trustworthiness or rigour of the research study is about the degree of confidence in data, interpretation, and methods used for ensuring the quality of research study (Brink *et al.*, 2016:171-172; Connelly, 2016:435). According to Brink *et al.* (2016:171-172), Connelly (2016:435), and Cope (2014:89), measures to ensure trustworthiness in qualitative research include credibility, dependability, confirmability, transferability, and authenticity. Rigour in qualitative studies is of importance as it validates integrity in research findings because qualitative data is made up of interpretative methods which aim to explore, understand, and explain people's experiences through non-numerical data, which in turn make an impact on health practice or policy development (Brink *et al.*, 2016:171-172; Hadi & Closs, 2016:641). The measures to ensure trustworthiness in this study are discussed.

### **2.9.1 Credibility**

Credibility is also known as confidence in the truthfulness of the findings of the study as the most important elements of the study (Brink *et al.*, 2016:172; Connelly, 2016:435). According to Brink *et al.* (2016:172) and Cope (2014:89), credibility also refers to the truthfulness of the data and a truthful representation of the views of the participants. Brink *et al.* (2016:172) and

Connelly (2016:435) further state that credibility is interconnected to the internal validity which is related to questions like: “was the study conducted using procedures related to the qualitative approach or was an adequate justification provided for variations?” Techniques that can be used to ensure credibility include prolonged engagement with participants and member-checking (Brink *et al.*, 2016:172; Connelly, 2016:435). Credibility also includes explored explanations, iterative questioning of data, and returning to examine findings several times (Brink *et al.*, 2016:171-172; Connelly, 2016:435).

In this research study, credibility was maintained through prolonged engagement of at least one (1) to two (2) months in the study until data collection reached data saturation. During the interviews, participants were also given enough time to verbalise their perceptions regarding providing comprehensive care to MHCUs in a community setting, and the study will be examined by internal and external examiners and published in the form of a mini-dissertation and a research article.

Some strategies also involved during this engagement included (Brink *et al.*, 2016:172; Connelly, 2016:435):

**Member checking:** In this research study, member checking was used as a way to confirm information participants have given during data collection, to ensure credibility, truthfulness, and accuracy of results in order to avoid the thoughts or agenda of the researcher to cover or cloud the findings negatively. The process of member checking is described under ‘2.9.3 Confirmability’.

**Audit trail:** In this strategy, the researcher explained in detail each aspect of the research process in order to let readers understand thoroughly (Brink *et al.*, 2016:787; Hadi & Closs, 2016:642). The mini-dissertation provides such a detailed discussion of this research.

## **2.9.2 Dependability**

The stability of research data over time and over the conditions of the research data is known as dependability (Brink *et al.*, 2016:172-173; Connelly, 2016:438). According to Brink *et al.* (2016:172-173) and Cope (2014:89), dependability refers to the steadiness of data in similar conditions. Dependability includes the researcher’s notes of all activities that occur during the research study and who to interview and what to observe (Brink *et al.*, 2016:173; Connelly, 2016:435). The study would be considered dependable if the research study findings were to be duplicated with similar participants in similar conditions (Brink *et al.*, 2016:173; Polit & Beck, 2017:787).

In this research study, a thick description of the research is used to ensure the possibility of repeating the study by another researcher in another context, e.g., telephonic semi-structured individual interviews. Dependability in this study was also reached through peer examination and involving a co-coder during data-analysis.

### **2.9.3 Confirmability**

Confirmability is neutrality or the degree of consistency of findings and the degree to which information could be repeated (Brink *et al.*, 2016:173; Connelly, 2016:435; Cope, 2014:89). In this research study, presentation to supervisors and colleagues of research has been made to confirm neutrality and consistency of findings, and the research data was sent to the supervisors several times. A co-coder was also used to avoid bias in the research study, where he checked the information. The researcher kept all records of notes, decisions, and analysis progress, and notes were viewed by colleagues and discussed by peer-debriefing sessions (Brink *et al.*, 2016:172; Connelly, 2016:435). These help to prevent one person's perspective regarding the study and that, in turn, avoids bias.

The researcher conducted member checking with study participants to ensure confirmability (Brink *et al.*, 2016:173; Cope, 2014:89). The researcher called the research participants telephonically and shared the findings while confirming the findings of the data collection. The researcher arranged calls with research participants and explained fully what would be happening during the call. Nine (9) participants agreed to member checking, and they confirmed the findings of the study.

During member checking, the researcher explained to the participants that she will be checking the results found after data analysis has been done and will only need to confirm the findings with them (Birt *et al.*, 2016:1802-1803; Brink *et al.*, 2016:172). Confirmability was also reached through a detailed description of the research process, as well as during data collection through telephonic semi-structured individual interviews using audio-recorders and writing field notes in detail.

### **2.9.4 Transferability**

Transferability is the manner in which findings are useful to individuals in other settings, and differs from other aspects of research in that readers merely determine how applicable the findings are to their situation (Brink *et al.*, 2016:173; Connelly, 2016:435). Transferability refers to findings that can be applied to other settings or groups; this means the findings should have meaning to individuals who are not involved in the study and readers are able to associate the results to their own experiences (Brink *et al.*, 2016:173; Cope, 2014:89). This study is

contextual as data collection took place where the challenge or problem is experienced, which will allow other people who experience the same problem to associate their experiences to this study.

### **2.9.5 Authenticity**

According to Cope (2014:89), authenticity speaks of the ability and extent to which the researcher expresses the feelings and emotions of the participant's experiences in a faithful manner without sugar-coating anything. Through reporting in a descriptive approach (see Chapter 3), the reader was able to convey the participant's experience through the quotes provided.

Authenticity also includes integrity which refers to critical reflection to uphold valid interpretations of the data obtained from the research participants; it is the researcher's decision process and critical appraisal of the evidence and the interpretations thereof (Brink *et al.*, 2016:173; Cope, 2014:90; Polit & Beck, 2017:788). In this research study, the telephonic semi-structured individual interviews were transcribed *verbatim* and analysed according to specific data analysis steps, involving a co-coder.

## **2.10 ETHICAL CONSIDERATIONS**

Ethical concerns in nursing research are prioritised and the perspectives for nursing ethics are maintained to develop ethical behaviour in research (Brink *et al.*, 2016:34; Polit & Beck, 2017:211; Rani & Sharma, 2012:45). The need for ethical guidelines is that the human rights of participants in nursing research must be exercised in ensuring the protection of their safety (Brink *et al.*, 2016:34; Rani & Sharma, 2012:45). Ethical issues specific to qualitative research are related to informed consent, anonymity, confidentiality, data generation, treatment, publication, and participant-researcher relationship (Brink *et al.*, 2016:34; Streubert & Carpenter, 2011:60).

According to Brink *et al.* (2016:34-38) and DoH Ethics in Health Research Guidelines (2015:14), three (3) broad ethical principles was adhered to, as follows:

### **Beneficence and non-maleficence**

Maximised benefits and reduced harm to participants were highly considered, as beneficence prohibits infliction of harm and non-maleficence encourages no harm (Brink *et al.*, 2016:35-36; DoH, 2015:14; Polit & Beck, 2017:211). To ensure this principle, the researcher respected healthcare providers and avoided any discomfort, especially emotional, spiritual, social, legal,

and economical, as the interviews were conducted telephonically. Healthcare providers received full explanations of the research purpose and the definition of concepts in a language they could understand.

Research participants were given opportunities to express how they view what they are involved in, and their interests outweighed the interests of the research. Participants were capable to make their own choices and were treated with respect and given the chance to exercise self-determination.

### **Distributive justice (equality)**

Equality was possessed for all research participants and they received equal benefits from the research study; they were never discriminated against in any form (Brink *et al.*, 2016:36-37; DoH, 2015:14). The participants in this study were selected purposefully, as they were chosen for reasons directly related to the research problem. All discussions with the participants were respected, including those who asked to decline taking part; the researcher didn't force their participation.

### **Respect for persons (dignity and autonomy)**

The researcher respected the participants' right to privacy and confidentiality by keeping their names private and participants were also told that an audio-recorder would be used during data collection. Research participants were given the opportunity to express how they view what they are involved in, and their interests outweighed the interests of the research. Participants were capable to make their own choices, were treated with respect, and were given the chance to exercise self-determination (Brink *et al.*, 2016:35; DoH, 2015:14; Polit & Beck, 2017:211).

The researcher made this principle possible through the following:

- Written legal authorisation was obtained from the North West Provincial Department of Health (see Appendices C and D), and the Gatekeeper (Primary Health Care Manager; see Appendices E and F) of the health facilities where the researcher collected the data.
- Initial ethical approval (involving the initially planned focus group interviews), as well as an amended ethical approval (involving the telephonic semi-structured individual interviews), was obtained from the North-West University's Health Research Ethics Committee (HREC; reference number NWU-00323-20-A1; see Appendix B).
- Informed signed consent forms were completed by the participants as proof of voluntary and informed participation in this study (see Appendix H).

- The researcher took responsibility to fully explain the purpose of the research study to the participants before data collection, which was to explore and describe the perceptions of healthcare providers regarding providing comprehensive care to MHCUs in a community setting, including a definition of concepts as well as what is expected from participants.
- To avoid coercion, participants were fully made aware of their right to participate in this study and were also informed of their right to decline participation in this study without being penalised or punished in any way.

Further application of these principles and ethical considerations are discussed in the following sub-sections.

### **2.10.1 Measures to ensure privacy and anonymity**

According to Brink *et al.* (2012:37), anonymity means 'being nameless', and participants who took part in the research study were told of their right that all information received from them during data collection would remain anonymous. The interviews were conducted in the form of telephonic semi-structured individual interviews, and full confidentiality and anonymity were thus promised to the research participants.

The participants were ensured that their identities would be protected and their privacy and self-worth maintained. Alphabetical codes were used to identify them rather than using their names in the study. During the interview sessions, the participants were informed that the personal information shared would be not available to any person and the participants were informed that the data generated through the telephonic semi-structured individual interviews will be shared anonymously between the participants, researcher, supervisor, co-supervisor, ethics research committee, transcriber, and co-coder, and – in synthesised form – through the mini-dissertation and a research article.

De Chasney (2015:12-13) calls privacy and confidentiality data security. He further states that neutral settings that are safe, convenient, and therapeutic for research participants are conducive for audio-recording the data. He also shares that computers, smartphones, and tablets should be secured through security passwords, especially when transmitting sensitive information. In terms of loss of information or theft, there should be ways to deactivate to avoid unauthorised access of information (De Chasney, 2015:16). These principles were followed, and the (1) informed consent forms and (2) demographic data and transcripts of the telephonic semi-structured individual interviews were taken in separately and kept in different boxes in a locked cupboard in the NuMIQ's director's office, at the North-West University, Potchefstroom Campus.

### **2.10.2 Legal authorisation and goodwill permission**

Legal authorisation and goodwill permission were obtained as described above and in this chapter in the section regarding recruitment and informed consent (see section 2.5).

### **2.10.3 Probable experience of participants**

According to Brink *et al.* (2012:6), one's experience is guided by familiar or functional information which increases or sustains one's knowledge; this is known as the probable experience of participants.

In this research, study participants were likely to feel slightly exposed to share their perceptions telephonically. This risk was limited through providing thorough information about the study, obtaining informed consent, and ensuring that the participants felt ready to start with the interview.

### **2.10.4 Risk and precautions**

According to Brink *et al.* (2012:43), major potential risks that are likely to occur in a research study include physical harm, physical discomfort, fatigue or boredom, psychological or emotional distress, loss of privacy, loss of time, and financial costs.

A possible risk for the researcher and participants was becoming infected with Covid-19 due to contact with one another when gaining initial entry into the community and confirming the signed informed consent forms when face-to-face contact was still permitted with participants. During the gaining of entry to the population, the researcher strictly adhered to health guidelines as set out by Güner *et al.* (2020:571-576), and as required and practised by the CHC and clinic where participants were recruited, namely:

- Social distancing of at least 2 metres.
- Regular hand-washing with a 70% alcohol-based sanitising hand rub
- Wearing an appropriate face mask
- No touching of face
- Screening temperature and completing the screening test before entering the CHC and clinic premises

The researcher furthermore mitigated this risk through conducting telephonic semi-structured individual interviews.

The benefit of the study is that it yielded meaningful recommendations that have the potential to improve comprehensive mental health care services to MHCUs in future. It is clear that the benefits outweigh the risks. This was a minimal-risk study because it didn't involve offensive objects, using human being's body parts or bodies to test something, or any physical harm.

#### **2.10.5 Experience, skills, and competency of the researchers**

The researcher gained experience in research as a group leader while completing the Bachelor of Nursing Sciences at the North-West University Mahikeng Campus, under the supervision of a supervisor and co-supervisor who have both acquired PhD degrees. In this research study, the researcher used this experience and was able to collect data and analyse the data. The supervisors in this study both have extensive experience in providing supervision to master's degree students, specifically in qualitative research.

#### **2.10.6 Data management**

Data captured from the completed data analysis was only shared with the research supervisors, transcriber, and co-coder. They were required to sign confidentiality agreements. The data, provided in complete format, is saved on the researcher's password-protected computer. The documents are password protected. Hard copies will be stored for five years in the researcher's office. After five (5) years, any hard copy datasets as well as the password-protected folder containing the original dataset will be destroyed by the researcher according to the North-West University's rules and regulations for data/record management, i.e., the hard copies will be shredded and the electronic copies will be deleted from the computer files and from the 'recycle bin' on the computer.

#### **2.10.7 Dissemination of results**

After a transparent, detailed analysis of the data, while following good research ethics, the findings of the research are concluded on and findings should be shared (De Chasney, 2015:8). Dissemination includes publishing and presenting the research findings to colleagues, professional peers, and funding organisations and second dissemination includes sharing research findings with people from the community who are directly affected by it such as community members, advisors, lecturers, and professors (De Chasney, 2015:9).

The dissemination of results in this research will be done through presenting information to research colleagues, MDT members, and members of the community after data has been

analysed, and information will be shared through sharing of a hard copy of the results. The participants will be visited at their workplaces and short reports will be shared with them, and verbal presentations will be delivered during their scheduled MDT meetings. A written report will be sent to the NW-DoH, and the research results will be shared at relevant research days. This mini-dissertation will be available at the NWU Library, and a research article is planned.

#### **2.10.8 Monitoring of the research**

The researcher used the approved proposal to conduct the research. The implementation of the research was monitored by the researcher and supervisors through at least monthly meetings, e-mail, and telephonic communication. The researcher adhered to ethical principles as explained in Chapters 1 and 2. No adverse events occurred. The supervisors monitored data analysis by comparing the transcripts of the telephonic semi-structured individual interviews with final codes. Annual progress reports were written to HREC.

#### **2.10.9 Conflict of interest**

The researcher of the proposed study has no personal nor financial influence that may have inappropriately influenced her in undertaking this study.

### **2.11 CHAPTER SUMMARY**

A detailed description of the research design and method followed in this study was given in this chapter. The next chapter will deal with the findings and literature integration on the healthcare providers' perceptions of providing comprehensive care to MHCUs in a community setting.

## **CHAPTER 3:**

### **FINDINGS AND LITERATURE INTEGRATION**

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#### **3.1 INTRODUCTION**

The previous chapter contained a detailed description of the research design and method followed in this study. This chapter consists of a discussion of the realisation of data collection and analysis as well as a description of the findings and literature integration.

#### **3.2 REALISATION OF DATA COLLECTION AND ANALYSIS**

As discussed under Chapters 1 and 2, telephonic semi-structured individual interviews were used to collect data in this study on perceptions of healthcare providers regarding providing comprehensive care to MHCUs in a community setting. Twenty telephonic semi-structured individual interviews were conducted and two (2) audio-recorders were used to record the healthcare providers' perceptions and the recordings were transcribed verbatim. An example of a transcribed interview is provided in Appendix J. Field notes were taken after each interview and are presented in Appendix K.

The participants' demographic data is presented in section 3.3 below. Furthermore, data analysis was done using the eight (8) steps of Tesch's (Creswell, 2014:196; Theron, 2015:7) coding process. After the co-coder and the researcher analysed the data independently, a meeting was scheduled to reach consensus on the themes and sub-themes that emerged from the data. These themes and sub-themes are described in detail in section 3.4.

#### **3.3 DEMOGRAPHIC INFORMATION**

Demographic information of healthcare providers who took part in this research study was obtained from the information they completed in Section A of the interview schedule (see Appendix I). This information includes: home language, gender, occupation, work environment type, number of years of working experience, and the healthcare provider's roles and responsibilities towards the MHCUs.

Most participants described their roles and responsibilities towards MHCUs as assessing Mental Status Examination (MSE), ensuring adherence and compliance of psychiatric medication, to provide moral support, to treat symptoms, consultations, assessment and management of symptoms, dispensing and ensuring availability of psychiatric medication, review of treatment,

provision of mental health education, to provide rehabilitation programmes, referral for six months review or for further management and treatment.

The demographic information is summarised in Table 3.1.

The following demographic data of participants include the type of institution they work in, gender, home language, years of working experience and roles and responsibilities towards the MHCUs, for more detail see table 3.1 below:

**Table 3.1: Demographic data of participants**

No.	Participant	Current occupation	Institution	Gender	Home language	Years of working experience	Roles and responsibilities towards the MHCUs
1.	<b>Participant A</b>	Registered Nurse	CHC	Female	isiZulu	5-6 years	“MSE, possible referral, adherence and compliance.”
2.	<b>Participant B</b>	Registered Nurse	CHC	Female	SePedi	2-3 years	“To provide moral support, to ensure MHCU takes medication, to treat symptoms and refer for further management.”
3.	<b>Participant C</b>	Registered Nurse	CHC	Female	SeTswana	3-4 years	“Providing medication and refer them to Bophelong hospital when it’s their six months review, and encourage them to adhere and comply with their treatment.”
4.	<b>Participant D</b>	Registered Nurse	CHC	Female	isiXhosa	2-3 years	“Dispensing medication. Referral to the doctor for renewal of prescriptions and review and MSE on their visits.”
5.	<b>Participant E</b>	Registered Nurse	CHC	Female	SeTswana	10-15 years	“Comprehensive care according to the challenges as I believe a MHCU has needs like any other people in Maslow’s hierarchy of needs.”
6.	<b>Participant F</b>	Medical practitioner	CHC	Female	SeTswana	8-9 years	“Consultations. Review treatments. Review for possible referral. Repeat prescription.”
7.	<b>Participant G</b>	Registered Nurse	CHC	Female	SeTswana	20-25 years	“Giving of treatment. Mental Status Examination. Referrals for evaluation. Treatment adherence. Psycho-social evaluation.”
8.	<b>Participant H</b>	Registered Nurse	CHC	Female	SeTswana	3-4 years	“We provide patients with treatment, we refer them to hospital for review. Encourage them for compliance.”

No.	Participant	Current occupation	Institution	Gender	Home language	Years of working experience	Roles and responsibilities towards the MHCUs
9.	Participant I	Registered Nurse	CHC	Female	isiZulu	2-3 years	“MHCU are unstable: 1. Usually assess them, 2. Question their diagnosis, 3. Plan then immediate care to stabilise the pt. 4. Manage accordingly, 5. Refer to the highest care as needed. Stable MHCU: 1. Assess with every contact, 2. Issue Rx (usually special packages from BPH/MPH) the MHCU Rx is available in facility stock, 3. Refer for reviews in six months period accordingly, 4. Offer any often care needed despite of mental health also e.g. maternity.”
10.	Participant J	Registered Nurse	CHC	Male	SeTswana	3-4 years	“Provision of mental health care, provision of mental health treatment, rehabilitation programmes.”
11.	Participant K	Registered Nurse	CHC	Female	SeTswana	15-20 years	“Compile monthly stats. Organise awareness campaigns. Ensure availability of treatment. Refer those who are unstable. Trace those who default treatment.”
12.	Participant L	Registered Nurse	CHC	Female	isiXhosa	2-3 years	“To provide care and health education to the MHCU. Providing medical treatment and other therapeutic services to the patient.”
13.	Participant M	Registered Nurse	CHC	Female	SeTswana	3-4 years	“For collection of treatment, review and continuity of care. Refer to the doctor for renewal of prescription.”
14.	Participant N	Registered Nurse	CHC	Female	SeTswana	4-5 years	“Assessment, diagnosis and treatment.”

No.	Participant	Current occupation	Institution	Gender	Home language	Years of working experience	Roles and responsibilities towards the MHCUs
15.	<b>Participant O</b>	Registered Nurse	CHC	Female	SeTswana	2-3 years	“Holistic care, diagnosing of Rx, assisting with referrals for prescriptions renewal. Assessing progress and relapses. Diagnosis of any other health related problems (pregnancy, HIV testing, TB etc.). Non-pharmacological care & therapeutic care. Family related concerns that may affect progress.”
16.	<b>Participant P</b>	Registered Nurse	CHC	Female	English	2-3 years	“Provide health education, rehabilitative and treatment services.”
17.	<b>Participant Q</b>	Registered Nurse	CHC	Female	SeTswana	9-10 years	“Continuity of care-adherence and counselling-and offer treatment. Make sure that scripts are renewed at every six months.”
18.	<b>Participant R</b>	Registered Nurse	CHC	Female	SeTswana	15-20 years	“To assist them, provide treatment and ensure they recover. Health educate the community not stigmatise patients with mental illness. They need care and support from families, community and health care workers. Refer them to the relevant institution e.g. hospital for treatment.”
19.	<b>Participant S</b>	Registered Nurse	Clinic	Female	SeTswana	10-15 years	“Assess patients who are mentally ill, diagnose and treat. Assist in behaviour modification programme. Refer to hospital for review in 6-monthly. Refer newly diagnosed patients to hospital for initiation of treatment. Continue mental health awareness days.”
20.	<b>Participant T</b>	Registered Nurse	CHC	Female	SeTswana	4-5 years	“Diagnosing, assessment, management.”

### 3.4 RESEARCH FINDINGS AND LITERATURE INTEGRATION

The following four (4) major themes were identified:

- Theme 1: Healthcare providers' understanding of comprehensive care to MHCUs
- Theme 2: Factors hindering comprehensive care to MHCUs
- Theme 3: Stakeholders needed for providing comprehensive care to MHCUs
- Theme 4: Suggestions for improving comprehensive care to MHCUs

Table 3.2 represents the above major themes as well as the sub-themes of the perceptions of healthcare providers regarding providing comprehensive care to MHCUs in a community setting.

**Table 3.2: Healthcare providers' perceptions regarding providing comprehensive care to MHCUs in a community setting**

Theme 1	Theme 2	Theme 3	Theme 4
Healthcare providers' understanding of comprehensive care to MHCUs	Factors hindering comprehensive care to MHCUs	Stakeholders needed for providing comprehensive care to MHCUs	Suggestions for improving comprehensive care to MHCUs
<ul style="list-style-type: none"> <li>• Holistic approach to mental health care, treatment, and rehabilitation services</li> <li>• Provision of psychiatric treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of resources:               <ul style="list-style-type: none"> <li>○ Shortage of nursing staff</li> <li>○ Financial constraints</li> <li>○ Lack of psychiatric medication</li> </ul> </li> <li>• Lack of support:               <ul style="list-style-type: none"> <li>○ Lack of family support</li> <li>○ Lack of support from non-nursing staff</li> </ul> </li> <li>• Poor counselling skills</li> <li>• Stigma attached to mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Involvement of family members</li> <li>• Involvement of community members</li> <li>• Involvement of MDT members</li> </ul>	<ul style="list-style-type: none"> <li>• Conducting mental health education</li> <li>• Conducting awareness campaigns</li> <li>• Establishment of support groups</li> <li>• Participating in community enrichment projects</li> <li>• Availability of psychiatric medication</li> <li>• Employment of more health professionals</li> <li>• More in-service training for healthcare providers</li> </ul>

**3.4.1 Theme 1: Healthcare providers’ understanding of comprehensive care to MHCUs**

The first main theme of healthcare providers’ understanding of comprehensive care to MHCUs is indicated in Table 3.2, as well as in Table 3.2.1 below. The first main theme is divided into two (2) sub-themes, as shown in Table 3.2.1 below.

**Table 3.2.1 Healthcare providers’ understanding of comprehensive care to MHCUs**

- Holistic approach to mental health care, treatment, and rehabilitation services
- Provision of psychiatric treatment

**3.4.1.1 Holistic approach to mental health care, treatment, and rehabilitation services**

Participants shared their understanding of comprehensive care to mental health care as a holistic approach and treating an individual as a whole human being, meaning psychologically, clinically, mentally, socially, and also rehabilitating MHCUs. They also perceived comprehensive care as care provided by the MDT members, the community, and the family. Healthcare providers further shared that comprehensive care is ensuring that both non-medical and medical treatment of psychiatric treatment are always available to MHCUs in the community settings.

The inputs of the healthcare providers are indicated by the following transcript quotations:

- It entail a holistic approach towards a mental health user with regard to identifying one, with regards to treating one, with regard to rehabilitating one (Participant A: Female Registered Nurse)
- In my understanding I think it should be taking care of mental health users in community and clinical setting as well in all spheres of life, that’s how I understand it... In all spheres of life meaning there are levels of understanding as well psychologically, clinically, mentally and socially (Participant D: Female Registered Nurse)
- That entails giving the mentally ill patients treatment holistically meaning that we are including the nurses, the community, the psychologist, the psychiatrist and even their family members (Participant G: Female Registered Nurse)

- What I can really say about comprehensive care to mental health users is we must not just look at the mental health we must look at the person in total look at the psychological set up, look at the physical set up, look at other problems that the person might have, look at the social problems the person might have, look at financial problem that the person may face and attend to it (Participant F: Female Medical Practitioner)

Literature also supports that comprehensive care is much broader than just simply caring for MHCUs. According to Mulder *et al.* (2017:2), it has come to attention that mental health disorders and related symptoms have not decreased regardless of continuous mental health treatment provided, hence it is still believed that provision of treatment and rehabilitation services will assist in maintaining comprehensive mental health care services.

Comprehensive care, in this case, is mental health care services that attends to the biological, psychological, social, environmental, and economic needs of the MHCUs (Hendricks, 2018:10). Comprehensive care is aimed at fulfilling the following: developing community and home-based care that focuses on rehabilitation, providing care that emphasises early detection, providing follow-up care, and promoting available social support services (Maritz, 2010:61). According to Hendricks (2018:2), for the MHCUs to receive comprehensive care, their care should be associated with assessment, screening, counselling, outpatient treatment, emergency help 24 hours a day, and referral to appropriate services to satisfy all their health needs. Therefore, comprehensive care is based on quality assurance, advocacy and rights protection, capacity, and management development, which further encourage appropriate, useful, and patient-centred care (Maritz, 2010:61).

In addition, comprehensive health care services are mainly about the MHCUs (Albuquerque-Sendin *et al.*, 2018:293-298). Comprehensive care is guided by protocols and standards that emphasise quality assurance, advocacy, and rights protection, leading to mental health user-centred care (Maritz, 2010:61). Furthermore, other comprehensive mental health care services include the provision of guidance to develop MHCU-centred services, provision of treatment, which includes psychosocial interventions, and appropriate feedback on available services (Acharya *et al.*, 2017:4).

#### **3.4.1.2 Provision of psychiatric treatment**

The participants believe that treatment for MHCUs should be available at all times and support for compliance should be maintained as it assists the MHCUs not to relapse. They further share that not only is it important for the MHCUs, but also for those around the MHCUs because when

they are stable then everyone around them is safe. The following direct quotations support the findings:

- Is giving the patient treatment and also making sure the mental health care user takes the treatment because if she/he doesn't take the treatment there is no use because some of them take the treatment home and you find out that at home they are not taking it (Participant B: Female Registered Nurse)
- In my opinion it means giving all health care to mental health care users by giving medication to them (Participant C: Female Registered Nurse)
- By taking care of the user and making sure he/she comply to the medication and goes to the appointments, the hygiene and other staff if the patient is not doing well the family will also be able to give a report and take them to clinic or doctor (Participant H: Female Registered Nurse)
- "After you have actually assessed the patient and detected the problem, then you'll be treating that patient. The treatment includes both medical and a therapeutic one is actually based on the rehabilitation program" (Participant I: Female Registered Nurse)

In addition to perceptions of participants, the literature states some strong reasons regarding the importance of psychiatric medication regardless of arrears in mental health such as detention. The provision of psychiatric medication assists in stabilising the MHCUs and, in turn, those living with or around MHCUs become protected as the MHCU is in a good mental health state (Edworthy *et al.*, 2016:18).

Research also supports that mental health treatment should meet minimal standards of clinical practice and provision of effective mental health treatment should keep MHCUs stable and cause a reduction in community measures related to relapse or psychological distress and suicide (Mulder *et al.*, 2017:1-2).

It can be concluded that healthcare providers' understanding of comprehensive care to MHCUs regarding a holistic approach to mental health care, treatment, and rehabilitation services and provision of psychiatric treatment has been reached. More information is indicated under section 4.2.1.

### 3.4.2 Theme 2: Factors hindering comprehensive care to MHCUs

This second main theme entails factors hindering comprehensive care to MHCUs indicated in Table 3.2, as well as in Table 3.2.2 below.

This second main theme could be divided into four (4) sub-themes, as shown in Table 3.2.2 below:

**Table 3.2.2 Factors hindering comprehensive care to MHCUs**

- **Lack of resources:**
  - Shortage of nursing staff
  - Financial constraints
  - Lack of psychiatric medication
- **Lack of support:**
  - Lack of family support
  - Lack of support from non-nursing staff
- **Poor counselling skills**
- **Stigma attached to mental illness**

#### 3.4.2.1 Lack of resources: Shortage of nursing staff, financial constraints, and lack of psychiatric medication

Healthcare providers who participated in this study share a concern regarding lack of resources. Mentioned resources that lack under mental health include shortage of nursing staff, financial constraints towards MHCUs and lack of psychiatric medication. Although other resources are maintained, healthcare providers still believe that the above-mentioned resources should be met and maintained for proper delivery of mental health services to MHCUs.

##### 3.4.2.1.1 Shortage of nursing staff

The participants were convinced that one of the major contributing factors which hinder comprehensive care to MHCUs is a shortage of nursing staff and also members of other professions. It makes it difficult for nursing staff to give full attention to MHCUs as they overwork themselves to provide care to all patients in the health facilities. The following direct quotations give examples:

- Because of the shortage itself it sometimes becomes very difficult for us to maintain a list of people that we have in the community and actually make sure that they adhere to compliance half the time we don't have the means we don't have the numbers to go out in the community (Participant A: Female Registered Nurse)
- The first one can be shortage of staff, especially the nursing staff then other health professionals (Participant E: Female Registered Nurse)
- Factors hindering this services are that one aspect I can think of is lot of shortage of staff and some other nurses they are not confident enough (Participant K: Female Registered Nurse)
- I will say it is because of the shortage of staff because if the staff was enough then we will have a chronic person focusing on this and now his prioritization of the patient (Participant K: Female Registered Nurse)

These statements can be supported by literature that limited availability of mental health care providers seems to be a major problem in many countries (Thorncroft *et al.*, 2014:279). There is a limited number of mental health care providers available, such as RNs with advanced training in psychiatric nursing (De Kock & Pillay, 2016:5). Shortage of healthcare providers poses a challenge to mental health care services of MHCUs in community settings (Olfson, 2016:567). Shamsi and Peyravi (2020:1) also support that shortage of nurses is a major problem worldwide. Healthcare providers (nurses) report widespread challenges with obtaining speciality in mental health and that, in turn, compromises service delivery to MHCUs in community settings (Olfson, 2016:562). In addition, constraints and challenges in mental health include shortage of healthcare providers specifically trained in mental health (Kohrt *et al.*, 2018:3). Research reports that nurses experience high levels of stress and burnout due to shortage of nursing staff, as they have to take on work overload to reach satisfactory work requirements (Roets *et al.*, 2018:1-2)

#### 3.4.2.1.2 Financial constraints

One of the contributing factors stated by the participants is that most MHCUs do not honour their return/follow-up dates because they do not have money for transport to come to the health facility, and this statement is confirmed by the following direct quotations from the transcripts:

- Some of the people default because they can't afford to go to (mentioned name of the hospital) for argument sake to fetch medication on a regular monthly basis (Participant A: Female Registered Nurse)
- You might find that they don't have money for transport on the day of the appointment and obviously it's a matter of pitching any other day (Participant F: Female Medical Practitioner)
- Yes, money is also a challenge as they don't have money to go to the clinic and also the hospital for follow-ups because others come after three (3) or four (4) months and tells me sister I did not have money for transport. I think if they were receiving SASSA grant they will not have such problems as the grant is every month and secondly they can drink treatment with food so if there is grant they will be able to buy food (Participant H: Female Registered Nurse)
- I think on the financial most of them rely on SASSA to take part for them to get grants so that they have something financial backup (Participant M: Female Registered Nurse)
- You know in our communities economy is the problem, money is the problem if I do not have money I am going to miss out on my appointment (Participant N: Female Registered Nurse)

Schneider *et al.* (2016:154) state that many of those affected by mental disorders are more likely to experience financial stress, live in inadequate households, have low levels of productivity, and suffer from malnutrition. Another author further supports that financial constraints seem to be one of the challenges in obtaining mental health care services (Olfson, 2016:560).

Furthermore, most unemployed MHCUs are affected by sleep disorders and substance abuse disorders (Ibanez *et al.*, 2016:7). Another reason seems to be relapsing due to not having enough income to reach health services (Corrigan *et al.*, 2014:40). Research shows that MHCUs with low income show increased psychological stress compared to those who earn well (Mulder *et al.*, 2017:1-2). Schneider *et al.* (2016:154) are also concerned about the high prevalence of poverty among the mentally ill.

### 3.4.2.1.3 Lack of psychiatric medication

In the community setting of Mahikeng sub-district, most participants shared that a lack of medication is a major problem as the medication is mostly out of stock from the health care facility pharmacy. The following are the verbal reports of participants regarding lack of psychiatric medication:

- You know our government maybe lack of medication in the facility like for example today I had a mental health care user was suppose maybe to give him diazepam but it was out of stock (Participant B: Female Registered Nurse)
- Shortage of medication because sometimes they come and there is no medication because mostly of their scheduled medication are not kept in the facility (Participant E: Female Registered Nurse)
- It's not like the medicine are there in stock at the clinic all the time they are not there they have to be order it's a procedure (Participant F: Female Medical Practitioner)
- Ok firstly is lack of resources medication I will say lack medication or should I say unavailability of psychiatric medication (Participant C: Female Registered Nurse)
- I think they end up relapsing because of that community point of view we don't have the kind of medication that they use (Participant A: Female Registered Nurse)

The shortage of resources also affects the distribution of psychiatric medication and that leads to a treatment gap of more than 75%; this lack of availability and accessibility of psychiatric medication falls under stated mental health barriers (Sidana, 2018:4). The lack of psychiatric medication falls under constraints under mental health (Kohrt *et al.*, 2018:3). Unmet needs were divided into three major categories, namely: 1) treatments of questionable quality, 2) delays in obtaining treatment, and 3) no treatment available (Koposov *et al.*, 2017:1310). The MHCUs are therefore experiencing major challenges such as unavailability of medication, which leads to relapse, being hospitalised, and reduced value of life (Velligan *et al.*, 2017:449).

Challenges in receiving and adhering to mental health treatment lead MHCUs to have mental health breakdown and relapse, further complicating severe mental illness (Olfson, 2016:575).

### 3.4.2.2 Lack of support

Lack of family support and non-nursing staff in mental health makes it difficult for healthcare providers to provide care towards MHCUs in a community setting. Healthcare providers share that MHCUs who are not supported by their family members or non-nursing staff tend to relapse.

#### 3.4.2.2.1 Lack of family support

Participants shared that most of the MHCUs lack support from their family members as most of them do not honour follow-up/return dates and do not comply with medication, and that leads MHCUs to relapse.

This is supported by the following direct transcript quotations:

- Lack of support by the family at home if the mental health care user does not have enough support from the family at home it will be difficult for them to adhere in their medication (Participant B: Female Registered Nurse)
- Sometimes there is no satisfactory family support maybe that person may need to be almost like adopted maybe have someone that is taking care of them not necessarily a family it can be neighbours just so that there is somebody who is looking after that person (Participant F: Female Medical Practitioner)
- They lack support from their family (Participant G: Female Registered Nurse)

MHCUs are most likely to be in family environments which are characterised by abuse, neglect and poor relationship/companionship, and most of MHCUs who find themselves in these situations attempt suicide as they are in need of parental support and family-based intervention (LeCloux *et al.*, 2016:2597).

#### 3.4.2.2.2 Lack of support from non-nursing staff

According to healthcare providers, having to work alone with a lack of non-nursing staff when dealing with MHCUs who need specialised care and mental health care attention brings exhaustion and lowers morale support. The following quotes supports this finding:

- They highlight the fact that they called the police they have called the Emergency Medical Response Service (EMRS) but none of them are willing to come and assist unless they bring the patient to the clinic and sometimes is actually a serious exercise to the family (Participant A: Female Registered Nurse)
- Like as I was saying that the mental health user must get support from the family and community must elaborate on that (Participant B: Female Registered Nurse)
- O.k. we have access whereby we need social workers but because they are not available at our facility level it becomes very difficult to assist the patient and some problems are caused by social problems (Participant C: Female Registered Nurse)
- We need social workers and Ubuntu neighbourliness like people in the neighbour should be part of the support group like pastors because they are multi-tasking they can even do a job of a social worker or a psychologist they can do that job at a particular time (Participant F: Female Medical Practitioner)
- The South African Police and the EMRS which take long to respond to come and assist the patient when they are called in the community setting I think is because they are not well trained on how to handle a mental health care user in the community (Participant S: Female Registered Nurse)

It is probably not fair or realistic to expect nurses or general medical clinicians to carry more than modest mental health care responsibilities, as it lowers the quality of mental health care (Olfson, 2016:561). After being diagnosed with a mental illness e.g., depression, MHCUs mostly receive only anti-depressants with no other therapy or counselling, even though required (Olfson, 2016:561). Nurses report burnout and stress due to lack of support as they have to extend their duties to domestic and clerical supervisory duties, serving MHCUs' meals, restraining violent MHCUs, and intern administer medication and admissions (Joubert & Bhagwan, 2018:49). Authors further support that nurses complain of stress related to overworking by also attending to administrative duties (Roets *et al.*, 2018:1).

### **3.4.2.3 Poor counselling skills**

Participants reported that they do not have speciality in psychiatry and that their counselling skills are basic and mostly cannot reach the depth of the MHCUs in need of psychological assistance. This statement is supported by the following direct transcript quotations:

- I think the other one is poor counselling skills when it comes to providing care to mental health care users most health care professionals have poor counselling skills (Participant C: Female Registered Nurse)
- So in my point of view and experience were and experience from where I am practicing at the moment, there is no passion for mental health but only for other skills. That's what I mean so if there could be cushioned or a focal psychiatric nurse at the clinic or psychologist that could be better for the patient (Participant D: Female Registered Nurse)
- As a professional nurse I am not inclined of what is mental illness, how to treat and screen users then comprehensive care is hindered (Participant N: Female Registered Nurse)
- Yes because in most cases we are dealing with eeeeh eeh... nurses who doesn't have skills who doesn't understand how to deal with these patients... (Participant R: Female Registered Nurse)
- I think because they are not well trained on how to handle those aggressive or disruptive patients (Participate S: Female Registered Nurse)

Literature supports that poor counselling skills still remain a major problem in the health setting. It is unfortunate that healthcare providers (e.g., nurses) are not adequately or fully trained to address mental health problems because they lack training, capacity building, and skills (Koposov *et al.*, 2017:1309-1310). Healthcare providers state some challenges to providing comprehensive care that include lack of time, poor communication with specialists, and fragmented care (Loeb *et al.*, 2016:2).

Many healthcare providers have little training in mental health care; even when provided with training, healthcare providers tend to lose the motivation for providing mental health services because of not being compensated or getting financial incentives (Olfson, 2016:561-562).

#### **3.4.2.4 Stigma attached to mental illness**

MHCUs in community settings do not have the liberty to live their lives because of how badly they are treated because they suffer from a mental illness. Participants shared that members of the community do not understand mental health; hence, members of the community keep stigmatising people suffering from mental illness. The following direct quotations support the statement:

- If the mental care users are stigmatise obviously they won't take their treatment (Participant B: Female Registered Nurse)
- With mental health care there is sort of a stigma to the condition that the user can experience which is not necessary really (Participant F: Female Registered Nurse)
- Firstly it will be a stigma from the community (Participant D: Female Registered Nurse)
- O.k. there are two factors the first factor the stigmatization like in the community mental health care users are being stigmatized (Participant T: Female Registered Nurse)

Researchers also supports that stigma still remains a major problem for mental health in community settings. Primary care services for MHCUs are thus faced with various challenges affecting the comprehensive delivery of care (Maritz, 2010:61), including mental illness stigma (Chan *et al.*, 2018:126; Corrigan *et al.*, 2014:37). Challenges in community settings are still stigmatisation of mental health (Marais & Petersen, 2015:21). Recent indications are that stigma is still a major problem related to mental health care (Janse van Rensburg, 2018:5).

The experience of stigma leads MHCUs not to attend follow-up treatment because of feeling judged, and family members feel inhibited to express how they feel about the mental state and other related issues of their family members (Chan *et al.*, 2018:126). Most MHCUs do not seek mental health care services due to the stigma attached to mental health (LeCloux *et al.*, 2016:2598). The author further supports that high levels of stigma towards MHCUs from the communities and healthcare providers set a barrier for seeking required mental health care services (Kohrt *et al.*, 2018:2).

Due to the stigma attached to mental health, and many perceptions and attitudes, MHCUs do not receive timely access to mental health care services and that is because of the self-perceived need for treatment, uncertainty about the effectiveness of mental health treatment, and the idea of handling their own problems (Olfson, 2016:560).

According to Mulder *et al.* (2017:2) politicians may be convinced that giving more for mental health services would be best preferable to address fundamental issues of inequality and discrimination.

In conclusion factors hindering comprehensive care to MHCUs have been supported, as resources such as shortage of nursing staff, financial constraints and lack of psychiatric medication have been fully explored. Lack of support including lack of family support and lack of

support from non-nursing staff has been supported. Poor counselling skills and stigma attached to mental illness were also discussed. Conclusion to factors hindering comprehensive care to MHCUs is discussed under 4.2.2.

**3.4.3 Theme 3: Stakeholders needed for providing comprehensive care to MHCUs**

The third main theme entails stakeholders needed for providing comprehensive care to MHCUs indicated in Table 3.2, as well as in Table 3.2.3 below.

This third theme could be divided into three (3) sub-themes, as shown in Table 3.2.3 below:

**Table 3.2.3 Stakeholders needed for providing comprehensive care to MHCUs**

<p>Stakeholders needed for providing comprehensive care to MHCUs:</p> <ul style="list-style-type: none"> <li>• Involvement of family members</li> <li>• Involvement of community members</li> <li>• Involvement of MDT members</li> </ul>
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**3.4.3.1 Involvement of family members**

According to the participants, involving family members in caring for the MHCUs could be very helpful and the MHCUs’ compliance to treatment could improve as MHCUs stay with their family members most of the time. These perceptions regarding involvement of family members are confirmed by the following direct quotations from the transcripts:

<ul style="list-style-type: none"> <li>• Ok like I said the family will be involve in the family level (Participant A: Female Registered Nurse)</li> </ul>
<ul style="list-style-type: none"> <li>• Families must be involved, there is nothing that can be done without families of mental health care users (Participant E: Female Registered Nurse)</li> </ul>
<ul style="list-style-type: none"> <li>• Sometimes there is no satisfactory family support maybe that person may need to be almost like adopted maybe have someone that is taking care of them not necessarily a family it can be neighbours just so that there is somebody who is looking after that person (Participant F: Female Medical Practitioner)</li> </ul>

These findings are supported by literature. Family members are the main source of care for MHCUs, which provides more reason for family involvement to be encouraged and emphasised (Kohrt *et al.*, 2018:8). An increased level of family support mostly results in lower likelihood of mental health care service use, lower levels of depression, less need for mental health care services, and reduced suicidal attempts or mental health breakdown (LeCloux *et al.*, 2016:2597). For maintained provision of care, family-related treatment includes family-based treatment such as attachment-based family therapy (LeCloux *et al.*, 2016:2597).

**3.4.3.2 Involvement of community members**

The participants believe that if members of the community could be part of caring for the MHCUs or promoting mental health, this could help uplift the image and standard of mental health as healthcare providers and members of the community will be working together through involvement of community educational programmes and knowledge sharing of how the community values and principles are governed, and as the MHCUs will also benefit from the support of the members of the community. Benefits that the MHCUs are likely to experience are support, more confidence in associating with others, and reduced stigma from the community setting, as they will be more accepted and community members’ knowledge will be enhanced, too, in relation to mental health. This is supported by the following direct quotations:

- It helps a lot with regard to the family supporting the user and the community in terms of neighbours in the streets (Participant A: Female Registered Nurse)
- I would say to chief and pastors from the rural area (Participant D: Female Registered Nurse)
- Mental health patients are sensitive they need support of the community members in order for them to be strong and adhere to their medication (Participant B: Female Registered Nurse)
- Neighbourhood should be part of the support group like pastors because they are multi-tasking they can even do a job of a social worker or a psychologist they can do that job at a particular time (Participant F: Female Medical Practitioner)

According to Ibanez *et al.* (2016:7), the WHO recommends an integrated community-based mental health system between MHCUs, family involvement, community member’s involvement, and MDT members. The reason for community involvement is that should delivery of primary

care services not be accessible, at least the MHCUs will know where to receive care or help in the community (Kohrt *et al.*, 2018:17). Potential benefits of community involvement are MHCUs with changed behaviour, creating a supportive environment, and better provision of care towards MHCUs from the community members and their family members because they use local cultural idioms leading to more effective mental health support (Kohrt *et al.*, 2018:8).

### 3.4.3.3 Involvement of MDT members

The participants shared that providing care to the MHCUs needs different healthcare providers as MHCUs do not only need medical/treatment care when coming for review but also need psychological, physical, social, and financial assistance when they come to the health facility. These perceptions regarding involvement of MDT members are confirmed by the following direct quotations from the transcripts:

- You know when it comes to a mental health care user I will say multi-disciplinary team they are needed to provide the comprehensive... starting from the psychiatrist, the psychologist, the social workers and even the professional nurse (Participant B: Female Registered Nurse)
- Psychiatrists, psychologist and nurses as well, I think they also fall under healthcare providers who can help the users if I can put like that in short (Participant D: Female Registered Nurse)
- Social worker, psychiatrist who ever is relevant because sometimes the problem is we refer irrelevantly so we refer relevantly so because if we refer irrelevantly I don't think the user will get the right help and medication (Participant E: Female Registered Nurse)
- Ok the medical staff we are definitely needed and then we need social services, occupational therapy because some of the patient are very withdrawn they are not active and they need to be engaged (Participant F: Female Medical Practitioner)

Different authors are in support of having MDT members, and literature supports it accordingly. To render comprehensive mental health care in a community setting, the involvement of the MDT is crucial. Healthcare providers differ in their scope of practice, interests, commitment, confidence and skills and effectiveness in evaluating and treating mental health problems (Olfson, 2016:561). The presence of these MDT members could be very beneficial in providing effective primary health care to MHCUs in community settings (Thornicroft *et al.*, 2014:279).

Schneider *et al.* (2016:154) acknowledge the need for a well-functioning MDT for a comprehensive rendering of mental health care.

Furthermore, Smith (2014:18) agrees that human resources are important and that the necessary human resources for mental health care include MDT members such as nurses, medical doctors, psychiatrists, psychologists, social workers, and occupational therapists. MDT members with the necessary skills are needed in the community setting to ensure this care to MHCUs (Yesuku-Udechuku *et al.*, 2015:268). Mental health disorders are continuing to be treated by psychiatrists and other mental health specialists (Olfson, 2016:562).

In summary of theme stakeholders needed for providing comprehensive care to MHCUs importance of sub-themes which state that involvement of family members, involvement of community members and involvement of MDT members is important in the provision of comprehensive mental health care. Conclusion to this theme has been discussed under 4.2.3.

**3.4.4 Theme 4: Suggestions for improving comprehensive care to MHCUs**

This fourth main theme of suggestions for improving comprehensive care to MHCUs is indicated in Table 3.2, as well as in Table 3.2.4 below.

This fourth main theme could be divided into seven (7) sub-themes, as shown in Table 3.2.4. below:

**Table 3.2.4 Suggestions for improving comprehensive care to MHCUs**

Suggestions for improving comprehensive care to MHCUs:
<ul style="list-style-type: none"><li>• Conducting mental health education</li><li>• Conducting awareness campaigns</li><li>• Establishment of support groups</li><li>• Participating in community enrichment projects</li><li>• Availability of psychiatric medication</li><li>• Employment of more health professionals</li><li>• More in-service training for healthcare providers</li></ul>

#### 3.4.4.1 Conducting mental health education

Most participants believe that conducting mental health education could assist in improving knowledge of people, especially members of the community, on matters related to mental health. These perceptions are confirmed by the following direct quotations from the transcripts:

- Community mental health education with regard to the recent mental illness that are there that arise and that concern us as a community (Participant A: Female Registered Nurse)
- By doing health education at the community health centre every morning with alternative topics because at the health care centre different community members come every day (Participant B: Female Registered Nurse)
- I think the support group formation will come up with the health education because when you put health education so health education with the formation of a support group with the mental health care users including the none health care users who will be the family members and the community members (Participant E: Female Registered Nurse)
- Well to teach the patients how to take the medication and how the medication must be taken and why the medication must be taken properly and why it must be taken on time (Participant F: Female Medical Practitioner)

Mental health education is regarded as an important measure for providing proper non-mental health treatment. Health technologies, including educational procedures and information, are regarded as important to maintain the provision of mental health (Campos *et al.*, 2018:2102). Conducting mental health education is prescribed for all conditions, especially programmes involving families of MHCUs or substance abuse disorders, education on adherence and relapse prevention (Kohrt *et al.*, 2018:10-11).

#### 3.4.4.2 Conducting awareness campaigns

According to the participants, they believe that campaigns regarding mental health could impart knowledge on members of the community and that could assist in doing away with stigma. The quotes below share perceptions of participants in favour of conducting awareness campaigns:

- I think with more guides out there with more road campaigns or shows to actually emphasise the importance of mental health care I think people will understand more (Participant A: Female Registered Nurse)
- I think awareness campaign for our community because when it comes to mental health there is a lot of stigma so if our community can be educated with regards to what is mental health (Participant C: Female Registered Nurse)
- I think awareness about mental health care in our community and health centres (Participant F: Female Medical Practitioner)

Mental health awareness campaigns are also regarded important according to literature. To reach and meet mental health needs of MHCUs, research shows that community practices are required such as intensive, coordinated, and ongoing outreach necessary for the successful care of the MHCUs (Olfson, 2016:573). A study found that most individuals do not seek mental health assistance due to lack of awareness about the illness, religious beliefs, lack of family support, financial support, financial constraints, family dynamics, family tolerance about symptoms, lack of insight about illness, family resilience, or community beliefs regarding mental illnesses (Sidana, 2018:4). The author further supports creating awareness about mental health issues through information, education and communication, promotion, and prevention of mental illnesses; also, reaching community doorsteps of MHCUs will assist in spreading more details regarding mental health in the communities (Sidana, 2018:4-5). Conducting awareness campaigns includes interventions to decrease stigma, mental prevention programmes targeting members of the community, addressing emotional and psychological support, and mental health education and awareness (Kohrt *et al.*, 2018:10). Fortunately, there is some improvement in reporting mental health symptoms due to greater public awareness of common mental health disorders (Mulder *et al.*, 2017:2).

#### **3.4.4.3 Establishment of support groups**

Most participants believe that there is a need for support groups in the community setting, as that will show a sense of caring to the MHCUs and that they are not alone. The following transcripts give direct quotes:

- I wish people can actually take it a fact that support groups are there to support them, to teach them, to help their knowledge (Participant A: Female Registered Nurse)
- I will just give one more support group maybe, what do you call that when people go to church and speak to the pastor give a support (Participant D: Female Registered Nurse)
- I think the support group formation will come up with the health education because when you put health education so health education with the formation of a support group with the mental health care users including the none health care users who will be the family members and the community members (Participant E: Female Registered Nurse)
- Because at support group they will be motivating each other, supporting and encouraging each other and how to care for each other. And also their family members (Participant G: Female Registered Nurse)

In support of these perceptions, support groups are highly accentuated/recommended in literature. Coping with psychological distress is a common focus of group interventions as it includes cognitive-behavioural approaches and relaxation techniques (Reiser *et al.*, 2016:118). Research further supports that MHCUs with severe or moderate mental health problems may need rehabilitation or support in their interactions (Olfson, 2016:573). Support groups may be useful within mental health recovery especially if it includes spirituality (Forrester-Jones *et al.*, 2018:384). In another study, respondents shared the positive benefits of support groups in how it assisted them in handling stress, promoting mental health, self-care, and improved work performance (Kahn *et al.*, 2016:164).

#### **3.4.4.4 Participating in community enrichment projects**

To rehabilitate the MHCUs, the participants believe that extramural activities should be put in place at the community setting to allow MHCUs to refresh their minds and keep themselves busy. Here is a direct quote from the transcripts to support this perception:

- They must do something in the community like playing soccer or doing certain chores like removing the grass, gardening and other stuff (Participant B: Female Registered Nurse)
- I think that they are important because mental health doesn't involve us, it have its medication on its own it also needs activities that will keep the users busy and also help them to be able to deal with their problems because not every mental illness requires medication. Alone some activities that will assist the patient to deal with their problems (Participant C: Female Registered Nurse)
- Up to know we don't have anything in the community it's only the referral system to do for now. But we could have had something like rehabilitation centres where we can send them, where they can feel free and know that they are accepted.

Literature supports the importance of community enrichment projects. According to Talmage and Knopf (2017:7-10), community enrichment is said to be inclusive, meaning it is regarded a community outcome that results from methods of inclusion that use diversity as a resource and inclusion of all individuals and groups who were never included before (integration of all members in the community). Community enrichment is a leading process to community development aimed at positively enhancing the community through activities (sports), events, structures, and community functions, with the purpose of exploring new cultures, meeting new people (mentorship, friendship, and social interactions), learning new things, and experiencing new things (Talmage & Knopf, 2017:20-21). The following programmes and activities are necessary for ensuring community enrichment: family activities, social and independent living, skills training, medication adherence support groups, dealing with stigma, employment opportunities / income generation e.g., gardening projects, self-help groups and life skills programmes, which lead to reduced social exclusion (Kohrt *et al.*, 2018:11).

#### **3.4.4.5 Availability of psychiatric medication**

Participants believe the availability of medication in health care facilities could make the smooth running of care possible because MHCUs will not need to be sent to hospital for collection of treatment, and a reduction in relapse of MHCUs will be a positive outcome. Below are the direct quotes from the transcripts supporting this perception:

- Government need to put measures into place to make sure that medication to mental health care users is always available (Participant A: Female Registered Nurse)
- So you must make sure that even at home the patient takes treatment (Participant B: Female Registered Nurse)
- Resources that's going to meet the Mental Health Care Users' needs such as availability of medication (Participant C: Female Registered Nurse)

Caring for MHCUs in a community setting, healthcare providers aimed to prescribe a growing number and various mental health service provisions, in order to treat MHCUs with different mental health conditions (Olfson, 2016:559). Studies highlighted the need for improving accessibility of treatment for MHCUs, particularly in rural areas or where MHCUs need transport, as health facilities are far (Kohrt *et al.*, 2018:6). Policy planners and mental health professionals must work on the following strategies: ensuring availability of affordable and appropriate medication at public mental health facilities located in the community, for reduction of the treatment gap and MHCUs' satisfaction with treatment and treatment continuity (Sidana, 2018:4-5). Increased availability and ease of prescribed psychiatric medication mean positive provision of mental health services (Olfson, 2016:567). Psychiatric medication was delivered to assist MHCUs to stay stable and to function better (Kohrt *et al.*, 2018:12).

#### **3.4.4.6 Employment of more health professionals**

Having enough and properly trained healthcare providers could uplift the standard of mental health in the community level and MHCUs could get the needed mental health attention they need. Following are the direct quotes from the transcripts:

- Firstly is to employ health care professionals who are well trained when it comes to mental health (Participant C: Female Registered Nurse)
- I think more than anything I wish we have more nursing staff so that all nurses that are on duty will have commitment to special need of mental health care users (Participant A: Female Registered Nurse)
- Well lack of personnel is a serious problem because maybe that's where it involves HR because it actually need more personnel being hired to balance out (Participant F: Female Medical Practitioner)

Employment of more health professionals is not only important to research participants in this study, but also to authors of different literature. Expanding employment and involvement of healthcare providers in the provision of mental health care services in the community setting enhances the delivery of evidence-based mental health care services to MHCUs (Olfson, 2016:567). More healthcare providers in the health care services will allow better service delivery through increased outreach programmes, increased provision of mental health education, increased promotion of adherence monitoring, and improved documentation as delegation of staff will be enough (Kohrt et al., 2018:12-13). The reason for employing more healthcare providers is for better provision of mental health care services to assist with challenges in mental health (Olfson, 2016:561). The employment of more health professionals and an increased number of health care students in colleges would improve care in the community settings (Shamsi & Peyravi, 2020:1-7). Employment of more health care professionals will eradicate the shortage of healthcare providers and will increase future hope of a maintained number of healthcare providers (Shamsi & Peyravi, 2020:1-7). More health care providers deliver a vital and growing proportion of frontline service to MHCUs in the community settings (Olfson, 2016:560).

**3.4.4.7 More in-service training for healthcare providers**

Participants have a strong belief that in-service training for healthcare providers could assist in upgrading their knowledge of mental health care and how to care better for the MHCUs. Provided below are the direct quotes from the transcripts supporting these perceptions regarding more in-service training:

- There should be more in-service training when it comes to mental health care I know we have done psych but we need training I believe there is new information coming every day (Participant C: Female Registered Nurse)
- I think the psychiatrist should train the nurses and also the basic training like I said (Participant D: Female Registered Nurse)
- With the training I am not 100% sure but it can be done because when you do something you wait for the outcome because with one year training and with four year course with the mental health module is a very short time so with training maybe it can improve I believe it can work only when the person is determine (Participant E: Female Registered Nurse)

- But I don't think they get holistic care because some of the personnel are not trained there really do need re-training on psychiatric patient. How to evaluate them and so on (Participant G: Female Registered Nurse)
- Nurses will also be trained for the care of this patients especially those ones that are not trained for psychiatric nursing they will get a chance to be trained and they will have skills to take care and treat the mental health users, so there will be no gaps to start with on the care of mental users that's what I think (Participant J: Male Registered Nurse)
- The one that I was for the community, for the facility I think continues in-service training and proper coordination of the program (Participant T: Female Registered Nurse)

More in-service training and formalised educational opportunities under mental health for healthcare providers could upgrade the standard of service provision because knowledge is indeed the way to success, and literature supports that, too. According to Albuquerque-Sendin *et al.* (2018:293), health providers caring for MHCUs need extensive training, dedication, and motivation that aim at comprehensive care. Challenges in community settings still include low prioritisation, poor planning, and poor pre-service training of generalists in mental health care and poor service delivery (Marais & Petersen, 2015:21).

To stop/minimise healthcare providers' distress, more training about mental health could be promoted through health technologies in order to promote care to the MHCUs (Campos *et al.*, 2018:2101). Hendricks (2018:2-4) shares that MHCUs do not receive adequate mental health services due to lack of appropriate service provision in community settings, lack of training and knowledge of healthcare providers, negative attitudes, and poor understanding of mental illness. Authors believe that in order to provide adequate care, nurses require specialised psychiatric nursing knowledge and skills when caring for MHCUs (Joubert & Bhagwan, 2018:49).

It can be summarised from direct quotation and literature that suggestions for improving comprehensive care to MHCUs have reached consensus under sub-themes conducting mental health education, conducting awareness campaigns, the establishment of support groups, participating in community enrichment projects, availability of psychiatric medication, employment of more health professionals and more in-service training for healthcare providers. The conclusion of the sub-theme is further discussed under 4.2.4.

### **3.5 CHAPTER SUMMARY**

The findings of this study on describing and exploring healthcare providers' perceptions regarding comprehensive care to MHCUs in a community setting, data analysis, as well as literature integration were discussed in this chapter. From direct quotations from the transcripts, the findings were enriched as verbalised by the participants. In the next chapter, the researcher discusses the conclusions, limitations, and recommendations of the study with specific reference to nursing education, nursing research, and nursing practice.

## **CHAPTER 4:**

# **CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS**

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### **4.1 INTRODUCTION**

In the previous chapter, the realisation of data collection and data analysis, including results description and literature integration, was discussed. The findings were fully discussed, supported by direct quotations from the transcripts. In the following chapter, the conclusions, limitations, and recommendations of the study will be made with specific reference to nursing education and nursing research including nursing practice.

### **4.2 CONCLUSION OF THE STUDY**

From data analysis, four (4) major themes were identified after 20 telephonic semi-structured individual interviews with healthcare providers as discussed in Chapter 3. Conclusions on these four (4) major themes will be discussed separately. These conclusions provide meaning on the participants' perceptions regarding comprehensive care to MHCUs in a community setting, and address the gap highlighted in the problem statement of this study (see Chapter 1, section 1.3).

#### **4.2.1 Conclusion regarding healthcare providers' understanding of comprehensive care to MHCUs**

Participants shared that the provision of comprehensive care to MHCUs should be considered to be whole and not leaving any aspects related to care out. Speaking of all aspects, the participants mentioned that MHCUs should be cared for mentally/psychologically, physically, clinically, and socially, and treatment/medication should always be provided.

#### **4.2.2 Conclusion regarding factors hindering comprehensive care to MHCUs**

From the findings of this research study and literature confirmation, it is clear that many factors are a challenge when it comes to mental health care provision. Most health facilities are challenged by similar factors which make it difficult for mental health care provision to be maintained. Among other factors, the shortage of nursing staff and lack of support from non-nursing staff compromises the care to MHCUs, as they cannot receive comprehensive care. Lack of family support also deteriorates the proper care that these MHCUs should be receiving because once they receive medication from the community health centre and go back home, most of the family members do not care to assist or even remind them to take their medication accordingly. This also affects their follow-up dates as some are not mentally stable to keep

record of most important treatment measure such as return dates for review. Lack of psychiatric medication in community health centres seems to be the most common factor, and when the medication is out of stock, these MHCUs should be referred to the hospital to collect medication. Most MHCUs relapse from medication because they do not have money to go to CHCs for treatment or to go to hospital for the collection of medication. Stigma regarding mental health poses a big risk to these MHCUs because of its attachment to mental health, which leads to lack of support and consideration towards the MHCUs. Poor counselling skills also affect provision of care to MHCUs negatively. This is mainly caused by a lack of knowledge or a lack of trained personnel with adequate skills in mental health, and that compromises adequate counselling of MHCUs and leads to compromised service delivery under mental health.

#### **4.2.3 Conclusions regarding stakeholders needed for providing comprehensive care to MHCUs**

For comprehensive mental health care to be reached, several stakeholders could be considered and that could uplift a positive outcome for mental health as supported by the research findings and literature confirmation. To close the gap in mental health care provision, all aspects of support to care should be considered; for example, family should be involved, community members, and all members of the MDT should take part in providing care to the MHCUs. If provision of care is considered from the community setting to the CHC, nothing will be missed and the MHCUs will receive comprehensive care without any compromise.

#### **4.2.4 Conclusion regarding suggestions for improving comprehensive care to MHCUs**

Suggestions for improving comprehensive care to MHCUs are conducting mental health education, awareness campaigns, support group establishment, community enrichment projects, availability of psychiatric medication, employment of health professionals, and more in-service training for healthcare providers. By following the abovementioned suggestions, mental health care provision could improve and upgrade mental health care services.

### **4.3 EVALUATION OF THE STUDY**

Mental health care provision seems to be a very distinct and broad type of discipline. Other than other existing health needs, mental health seems to need more attention as it is most demanding/challenging. From the community setting to the CHCs/facilities, nothing should be left out, in order for the MHCUs to receive complete care. Comprehensive mental health care needs a holistic approach in care, treatment, and rehabilitation services; enough healthcare providers including members of the MDT are therefore needed. Comprehensive mental health

care needs members of the community and family members of the MHCUs to be involved in provision so that continuity of care can be maintained to avoid MHCUs relapse.

The research aim and objectives for this study were to:

- Explore and describe the perceptions of healthcare providers regarding factors that hinder providing comprehensive care to MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.
- To explore and describe the perceptions of healthcare providers who are needed to implement comprehensive care in the community setting of Mahikeng sub-district of the NWP, SA.
- To explore and describe the perceptions of healthcare providers on what can be done to improve comprehensive care for MHCUs in the community setting of Mahikeng sub-district of the NWP, SA.

Based on these findings and conclusions, it can be concluded that the aim and objectives of the study were met and the central theoretical argument is supported. Recommendations for nursing education, research, and practice could be formulated (see section 4.5 below).

#### **4.4 LIMITATIONS OF THE STUDY**

The limitations identified by the researcher of this study are discussed below:

- The inclusion criteria were all members of the MDT, but because of the Covid-19 pandemic, psychologists, social workers, psychiatrists, etc. could not be found in the community setting (CHC) and clinics as they were only based at the hospital setting to avoid moving around; therefore, only RNs and one (1) medical doctor took part during data collection.
- Covid-19 itself was a major challenge for data collection, as the researcher had to change the data collection method from focus group interviews to telephonic semi-structured individual interviews.

#### **4.5 RECOMMENDATIONS FOR NURSING EDUCATION, NURSING RESEARCH, AND NURSING PRACTICE**

From the findings, literature, and conclusions of this study as discussed above, recommendations for nursing education, nursing research, and nursing practice are discussed below.

#### **4.5.1 Recommendations for nursing education**

- Nursing education should aim to improve the knowledge and insight of healthcare providers through promoting workshops, training, and advanced diplomas or degrees for all healthcare providers who meet the requirements, in order for comprehensive mental health care to be reached.
- Training should be offered to nurses on mental health strategies related to promotion through mental health campaigns, community outreach programmes, and also through school visits as mental health affects everyone, even from a young age.
- Training should be offered to nurses regarding provision of primary, secondary, and tertiary care to MHCUs, their families, and the community through all phases of mental illness, including integration into the community, thereby involving the prevention of mental illness, promotion of mental health care and treatment to rehabilitation.
- Nurses should receive more training on the role of advocacy in the care, treatment, and rehabilitation of the MHCUs and how to collaboratively work with / involve other MDT members.
- Training of MDT members in relation to working in the community setting should be provided.
- Workshops should be presented to nurses and MDT members regarding the establishment of therapeutic relationships with MHCUs, their family members, and the community at large because of their lack of skills in handling MHCUs who have mental breakdowns, leading to nurses tending to be afraid of MHCUs.
- Short courses should be offered on population risk identification related to mental health problems through engaging the self into the community, for early detection and early mental health interventions in communities.

#### **4.5.2 Recommendations for nursing research**

From the findings of this research study on exploring and describing healthcare providers' perceptions regarding providing comprehensive care to MHCUs in a community setting, further research is needed. Research is mainly and specifically recommended in the following areas:

- More research should be done on which educational activities are needed to improve comprehensive care in a community setting.

- Research should also be done on the positive impact among MHCUs who receive comprehensive care in a community setting.
- More research should be done to explore the insight of community members, caretakers, and family members regarding insight into mental health.
- Research should be done on compliance and adherence to psychiatric medication, including measures which hinder service delivery related to psychiatric medication.
- More research should be done on factors which lead to shortage of nurses and factors which enhance nursing retention.

#### **4.5.3 Recommendations for nursing practice**

From the research findings on exploring and describing healthcare providers' perceptions regarding providing comprehensive care to MHCUs in a community setting, recommendations will be given for nursing practice and these are outlined below:

- Continuous mental health education should be encouraged when dealing with MHCUs.
- Prevention programmes which will include three (3) levels of prevention should be promoted: primary, secondary, and tertiary programmes.
- Healthcare providers should maintain mental health awareness campaigns to keep mental health information open to everyone.
- Mental health co-ordinators should keep all healthcare providers in line with upcoming programmes on mental health and should support relevant stakeholders in promoting comprehensive mental health care in community setting.
- Mental health care sectors should strive to work together with non-government organisations and other government departments for the promotion of comprehensive mental health care through workshops, campaigns, and mental health education.
- Advanced mental health nurses should facilitate mental health workshops, as that will promote knowledge especially to recently qualified nurses.
- The development and maintenance of support groups for MHCUs should be available, and the evaluation of the experiences of role players who develop a support group should be conducted.

- Psychiatric medication should be more available in the health care facilities.
- Employment of more health professionals should be promoted in mental health settings to ensure full coverage of comprehensive care towards the MHCUs and to avoid shortage of staff members.
- Community enrichment projects should be developed and maintained, and participation of healthcare providers should be encouraged including members of the community and the MHCUs.
- During provision of care in the health facilities, involvement of and support from the MDT members, family members, and community should be encouraged during provision of care to the MHCUs.
- More and enough mental health environments/infrastructures, buildings, facilities, or places where MHCUs receive care, treatment, or rehabilitation assistance, diagnostic or therapeutic interventions, or other health services, and health facilities such as community health and rehabilitation centres, clinics, general hospitals, and psychiatric hospitals should be made available in the nursing practice to allow better mental health care service delivery.
- Increased employment of nurses in the community setting could assist with the shortage of nursing staff.
- More support for nursing staff is needed through the recognition of nurse's roles, an improved working environment, the provision of professional independency, flexible working schedules, improvement of facility structures, and improved salaries, as this could work as a motivation for nurses to do better work in caring for the MHCUs.

#### **4.6 CONCLUDING REMARKS**

The aim and objectives of this study were reached through exploring and describing perceptions of healthcare providers regarding providing comprehensive care to MHCUs in a community setting in Mahikeng sub-district, NWP. Through exploring and describing healthcare providers' perceptions, knowledge and insight was gained on what/who is needed to provide comprehensive care and factors were highlighted which hinder comprehensive care among MHCUs in a community setting.

The findings and conclusions of this study indicated that improvement is needed in mental health care in general and all relevant aspects to improve comprehensive care among MHCUs in a community setting should be given full attention.

Recommendations for nursing education, nursing research, and nursing practice were made. These recommendations are likely to improve comprehensive care to MHCUs in a community setting.

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# APPENDIX A:

## NUMIQ APPROVAL



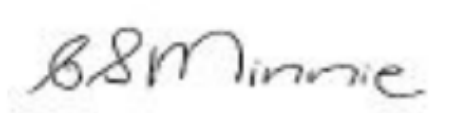
### Scientific Committee Approval for a research Application Research Using Human Participants

Scientific Committee Information			
Name of the scientific committee	NuMIQ Potchefstroom	Discipline(s)	Nursing
Research Entity	NuMIQ	Contact Person for the committee	Prof Karin Minnie
Faculty	Health Sciences	E-mail address for the committee contact person	Karin.Minnie@nwu.ac.za

Title of the study:	<b>Healthcare providers' perceptions on comprehensive care to mental health care users in a community setting</b>		
Researchers involved in the study:	Mrs Ontlotlile Sibalala Dr Belinda Scooby Prof Emmerentia du Plessis		
Potential risk level for human participants:	No risk	<input type="checkbox"/>	Motivate: This is a low-risk study because it doesn't involve offensive objects, using human being's body parts or bodies to test something or any physical harm.
	Minimal risk	<input checked="" type="checkbox"/>	
	Medium risk	<input type="checkbox"/>	
	High risk	<input type="checkbox"/>	
Potential risk level for children and incapacitated adults:	No risk	<input checked="" type="checkbox"/>	Motivate: No children and incapacitated adults used as participants, only multiprofessional team members
	No more than minimal risk of harm	<input type="checkbox"/>	
	Greater than minimal risk with the prospect of direct benefit	<input type="checkbox"/>	
	Greater than minimal risk with no direct benefit	<input type="checkbox"/>	
Recommendation for the REC:	Review by the research ethics committee required	<input checked="" type="checkbox"/>	Motivate: Human participants are going to be used.
Any additional comments	Motivate: <a href="#">Click here to enter any additional comments</a>		

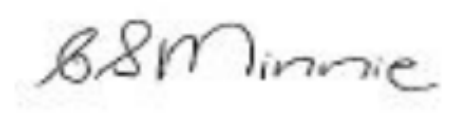
<b>Chairperson of the committee</b>	Prof Karin Minnie
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<p>Committee members present during the review</p> <p>(NB, please ensure no conflict of interest)</p>	<p>Prof W Lubbe  Dr A du Preez  Dr A van Wyk  Dr E Bornman  Mr F Watson  Ms V Neethling</p>
<p>Date of review</p>	<p>2019/10/14</p>



Signature of Chairperson

Date: [Click here to enter a date.](#)



Signature of Research Director

Date: [Click here to enter a date.](#)

*Form developed by Prof Minnie Greeff, 1 March 2017*  
*Form updated by Prof Minnie Greeff, 31 January 2019*  
*Form updated by Prof Minnie Greeff, 8 May 2019*

Original details: (2329522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.6 Forms\9.1.5.6\_SC Approval\_Human Participants.docm  
18 June 2019  
File Reference: 9.1.5.6

# APPENDIX B: PERMISSION FROM THE ETHICS COMMITTEE OF THE NORTH-WEST UNIVERSITY

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**Health Sciences Ethics Office for Research,  
Training and Support**

**North-West University Health Research Ethics  
Committee (NWU-HREC)**  
Tel: 018 299-1206  
Email: [Ethics-HRECAppl@nwu.ac.za](mailto:Ethics-HRECAppl@nwu.ac.za)

15 June 2020

To whom it may concern

## **APPROVAL OF THE RESEARCH STUDY FROM THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES**

**Ethics number: NWU-00323-20-S1**

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC).

**Study title: Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting**

**Study leader/supervisor: Dr B Scrooby**

**Student: OI Sibalala - 23639059**

**Application type: Single study**

**Risk level: Minimal**

You are kindly informed that this application was reviewed at the meeting of the North-West University Health Research Ethics Committee (NWU-HREC), Faculty of Health Sciences, North-West University, held on 11/03/2020. Following review of the application, it has been decided that the study is approved. Approval in this letter means that **final ethics approval** was indeed granted for the **research methodology and the ethical aspects** of this study and that the NWU-HREC has **no further ethical concerns** relating to the research ethics process, except for the outstanding documentation indicated below, which must be provided to the NWU-HREC by the researcher. It is important to mention that this letter indicates that there are no further ethical concerns that exist, regarding the execution of the research. A final ethics letter will be issued upon the receipt of the following documentation:

- a. A copy of the permission letter from you as the provincial Department of Health, indicating that the study can proceed.

The mentioned document, as indicated above, should be submitted to [Ethics-HRECProcess@nwu.ac.za](mailto:Ethics-HRECProcess@nwu.ac.za) by the researcher, for review before the ethics approval certificate can be provided. This approval is provided for a year, after which continuation of the study is dependent on receipt of an annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation for another year.

If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at [Ethics-HRECAppl@nwu.ac.za](mailto:Ethics-HRECAppl@nwu.ac.za).

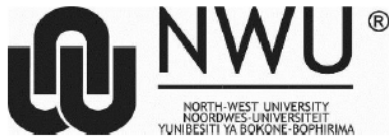
Yours sincerely

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Chairperson: NWU-HREC

Current details: (25239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.3 Letters Templates\9.1.5.3.6\_Gatekeepers\_Letter\_HREC.docm  
30 April 2018

File reference: 9.1.5.3.6



Dr B Scrooby  
Nursing sciences  
NuMIQ

Private Bag X6001, Potchefstroom  
South Africa 2520

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

**Health Sciences Ethics Office for Research,  
Training and Support**

**North-West University Health Research Ethics  
Committee (NWU-HREC)**  
Tel: 018-285 2291  
Email: [Wayne.Towers@nwu.ac.za](mailto:Wayne.Towers@nwu.ac.za)

25 October 2020

Dear Dr Scrooby

## **APPROVAL OF YOUR AMENDMENT REQUEST BY THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES**

**Ethics number: NWU-00323-20-A1**

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC) secretariat.

**Study title: Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting**

**Study leader/Researcher: Dr B Scrooby**

**Student: OI Sibalala - 23639059**

You are kindly informed that your amendment request (Changes to the data collection strategy due to the COVID-19 pandemic) to the aforementioned project has been approved. Any future amendments to the proposal or other associated documentation must be submitted to the NWU-HREC, Faculty of Health Sciences, North-West University, prior to implementing these changes. These requests should be electronically submitted to [Ethics-HRECApply@nwu.ac.za](mailto:Ethics-HRECApply@nwu.ac.za), for review BEFORE approval can be provided, with a cover letter with a specific subject title indicating, "Amendment request: NWU-XXXXX-XX-XX". The letter should include the title of the approved study, the names of the researchers involved, the nature of the amendment/s being made (indicating what changes have been made as well as where they have been made), which documents have been attached and any further explanation to clarify the amendment request being submitted. The amendments made should be indicated in **yellow highlight** in the amended documents. The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating that it is an amendment request e.g. "Amendment request: NWU-XXXXX-XX-XX". This e-mail should indicate the nature of the amendment. This submission will be handled via the expedited process.

**Please note:** Due to the nature of the study i.e. (telephonic semi-structured interviews with the multidisciplinary team members that assist in the treatment of mental health care users in a public health facility), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study except that the researcher must ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at [Ethics-HRECApply@nwu.ac.za](mailto:Ethics-HRECApply@nwu.ac.za).

Yours sincerely

Digitally signed by  
Prof Petra Bester  
Date: 2020.10.26  
12:04:16 +02'00'

Chairperson: NWU-HREC

Current details: (23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.3 Letters Templates\9.1.5.4.1\_Approval\_Letter\_Amend\_Req\_HREC.docm  
30 April 2018

## APPENDIX C: REQUEST TO THE NORTH-WEST PROVINCIAL DEPARTMENT OF HEALTH TO CONDUCT RESEARCH

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178e Masamane Village

Tshidilamolomo

Mafikeng

2745

Department of Health

Dear Sir/Madam

I am Ontlotile Innocentia Sibalala, a Professional Nurse at Unit 9 Community Health Centre.

South African Nursing Council number: 16074122

I am studying Master in Psychiatry with North West University, Potchefstroom Campus

Student number: 23639059

I need a goodwill letter for application of Health Research Ethics Committee

Research topic: **Healthcare providers' perceptions on comprehensive care to mental health care users  
in a community setting**

Research supervisor: Dr Scrooby Belinda

Belinda.Scrooby@nwu.ac.za

Research co-supervisor: Prof Emmerentia Du Plessis

Emmerentia.duplessis@nwu.ac.za

Researcher: Sibalala Ontlotile Innocentia

sibalalaontlotile@gmail.com

0784995633

Kind regards,

Sibalala Ontlotile Innocentia

# APPENDIX D: PERMISSION FROM THE NORTH-WEST PROVINCIAL DEPARTMENT OF HEALTH TO CONDUCT RESEARCH



## POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. O. I. Sibalala  
North West University

Physical Address : 3087 Joe Slovo Street  
(Work/ Institution) : Unit 9 CHC  
Mmabatho , 2790

Subject : Research Approval Letter – Healthcare providers' of providing comprehensive care to mental health care users in a community setting.


This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards,

  
Ms. T.P. Tshilwanambi  
Acting Director: PPRM&E

22 June 2020  
Date

SIBALALA O.I.   
Researcher

22/06/2020  
Date

  
Healthy Living for All

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## APPENDIX E: REQUEST TO THE MAHIKENG SUB-DISTRICT MANAGER “GATEKEEPER” (PRIMARY HEALTH CARE MANAGER)

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Private bag x8001, Potchefstroom  
South Africa 2320  
Tel: 018 289 111/2222

School of Nursing  
Science  
Tel: 0764995633  
Fax: 018 299 1827  
Email: sibalalaontfotile@gmail.com

**Department of Health: Mafikeng sub-district**

**Primary Healthcare Manager**

178e Masamane Village

Tshidilamolomo

Mafikeng

2745

23 June 2020

Dear Mr MN Motlhabane

### **Request to conduct a research study in the Mafikeng Sub-district of North West Province**

I am Ontfotile Innocentia Sibalala, a Professional Nurse at Unit 9 Community Health Centre, South African Nursing Council number: 16074122. I am currently studying my Master's in Psychiatric Nursing Science with the North-West University (NWU), student number: 23639059.

The study is aimed at exploring and describing healthcare providers' perceptions of factors hindering comprehensive care to Mental Health Care Users (MHCU) in a community setting in the North West Province (NWP). Such research will increase knowledge and understanding regarding how mental healthcare services can be improved to contribute to MHCU living a higher quality of life in a community setting.

This study will be conducted in the Mafikeng Sub-district in the North West Province during July-December 2020 where participants are currently employed and will involve multidisciplinary team members who have experience in working with MHCU.

We plan to collect data by means of focus group interviews to explore and describe the perceptions of healthcare providers of comprehensive care, factors that hinder comprehensive care to MHCU in the community setting, who are needed to implement comprehensive care in the community setting, and what can be done to improve comprehensive care for MHCUs in the community setting.

Ethical clearance is granted by the NWJ Health Research Ethics Committee (HREC) (Clearance no. NWU-00323-20-S1) and the NWDoH.

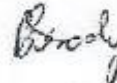
I kindly request a written permission to conduct the study in the Mafikeng Sub-district in the North West Province. May I request that the written permission be emailed to the following address: [sibalelaontlile@gmail.com](mailto:sibalelaontlile@gmail.com).

Your positive consideration will be highly appreciated.

Yours sincerely



Sibalela Ontlile Innocentia  
Master's student



Dr Belinda Scrooby  
Supervisor

## APPENDIX F: PERMISSION FROM THE MAHIKENG SUB-DISTRICT MANAGER “GATEKEEPER” (PRIMARY HEALTH CARE MANAGER)

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**health**  
Department of  
Health  
North West Province  
REPUBLIC OF SOUTH AFRICA

1<sup>st</sup> Floor, NWDoH New  
Office Park  
C/O Sekake & First St  
Industrial Site  
MAHIKENG, 2745  
Private Bag X127  
MMABA HQ, 2735

Tel: 0719; 861 4817  
Email:  
Mahl@nw.gov.za



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### OFFICE OF THE PHC MANAGER - MAHIKENG SUB DISTRICT

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**TO : MS O.I. SIBALALA**

**CC : ALL ASSISTANT MANAGER NURSING – PHC  
ALL OPERATIONAL MANAGER NURSING – PHC**

**FROM : MR M.N. MOTLHABANE  
PHC MANAGER**

**SUBJECT : APPROVAL TO CONDUCT RESEARCH IN VARIOUS CLINICS  
WITHIN MAHIKENG SUB DISTRICT**

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This communiqué serves to inform you that your request has been approved.

Permission has been granted by Director: Policy, Planning, Research, Monitoring and Evaluation.

Please note that relevant managers will be informed.

Mr. M.N. Motlhabane  
PHC Manager

26/06/2020  
Date



Healthy Living for All

# APPENDIX G: RECRUITMENT MATERIAL “INVITATION TO PARTICIPATE IN THE RESEARCH STUDY”



**INVITATION**

Healthcare providers' perceptions on comprehensive care to mental health care users in a community setting

**WOULD THIS STUDY BE A GOOD FIT FOR ME**

This study might be a good fit for you if:

- You are a healthcare provide/professional registered with HPCSA or SANC;
- Are working in the community setting (Community Health Centre or Clinic)
- Members of the multidisciplinary team (MDT), including psychiatrists, medical doctors, psychologists, speech therapists, occupational therapists, pharmacists, social workers, and registered nurses.
- MDT members have two (2) years or more experience working in a community setting because they have experience working with MHCU and are therefore seen as information-rich persons regarding factors hindering comprehensive services to MHCU in a community setting.

**WHAT WOULD HAPPEN IF I TOOK PART IN THE STUDY**

- Confidentiality and privacy will be taken as priority
- Consent forms will be signed and followed accordingly
- You will be able to share knowledge regarding perceptions on comprehensive care to mental health care users in a community setting

**BENEFITS OF THE STUDY**

- Study participants are likely to gain more knowledge about necessary services for comprehensive mental health services.
- Participants will also be able to learn other strategies on how to care for their mental health care users.

**DATA COLLECTION METHOD**

Research participants will be involved in once off telephonic individual semi-structured interviews.

**DECLINE TO PARTICIPATE/PRIVACY**

- You are free to decline to participate in the research and no penalty will be imposed on you.
- Your personal details will at no point be made available to anyone that is not part of the research team.

**RESEARCH DATE: 2020**



**THE RESEARCHER**

Sibalala Ontlottle Innocentia

A registered professional nurse with the South African Nursing Council (SANC)

Graduated Bachelor of Nursing Science, North West University Mafikeng Campus.

Currently: Psychiatry Master Degree, North West University, Potchefstroom Campus.

**CONTACT DDETAILS**

Sibalala Ontlottle Innocentia

E-mail: [sibalaontlottle@gmail.com](mailto:sibalaontlottle@gmail.com)

Cell: 0784995633

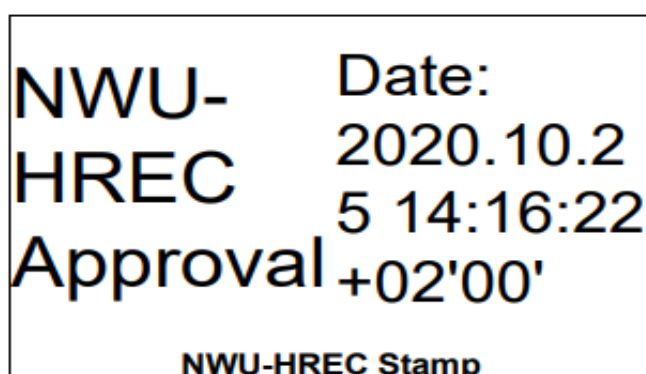
**FUNDING:** This research is partially funded by self and bursary received.

# APPENDIX H: WRITTEN, STAMPED INFORMED CONSENT BY MEMBERS OF THE HEALTHCARE PROVIDERS' TO PARTICIPATE IN THE RESEARCH

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Private Bag X1290, Potchefstroom  
South Africa 2520  
Tel: +2718 299-1111/2222  
Fax: +2718 299-4910  
Web: <http://www.nwu.ac.za>



## INFORMED CONSENT DOCUMENTATION FOR Healthcare providers being interviewed

**TITLE OF THE RESEARCH STUDY:** Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting

**ETHICS REFERENCE NUMBER:** NWU-00323-20-A1

**PRINCIPAL INVESTIGATOR:** Dr Belinda Scrooby

**POST GRADUATE STUDENT:** Sibalala Ontlotile Innocentia

**ADDRESS:** School of Nursing Science, Private Bag X6001, Potchefstroom, 2520

**CONTACT NUMBER:** 078 499 5633

You are being invited to take part in a **research study** that forms part of my Master's degree of Nursing Science in Psychiatric Nursing Science.

Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in

any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00323-20-A1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

#### **What is this research study all about?**

- *The purpose of this study is to conduct a qualitative explorative and descriptive study aimed at exploring and describing healthcare providers' perceptions of factors hindering comprehensive care to Mental Health Care Users in a community setting in the North West Province. Such research will increase knowledge and understanding regarding how mental healthcare services can be improved to contribute to MHCUs living a higher quality of life in a community setting.*
- *This study will be conducted in the sub-district in the North West Province during 2020 where participants are currently employed and will involve multidisciplinary team members who have experience in working with MHCUs.*
- *We plan to collect data by means of telephonic semi-structured individual interviews to explore and describe the perceptions of healthcare providers of comprehensive care, factors that hinder comprehensive care to MHCUs in the community setting, who are needed to implement comprehensive care in the community setting, and what can be done to improve comprehensive care for MHCUs in the community setting.*

#### **Why have you been invited to participate?**

- *You have been invited to be part of this research because you are multidisciplinary team members, including psychiatrists, medical doctors, psychologists, speech therapists, occupational therapists, pharmacists, social workers, and registered nurses who have two years or more experience in working with MHCUs in a community setting in the North West Province.*
- *You also fit the research because you come in direct contact with the MHCUs for review, consultations, examination and have experience in providing care to the MHCUs and understand the needs of a MHCU.*
- *You will only be able to participate in this research if you are willing to do so and provide voluntary, written informed consent.*
- *You will be expected to communicate and express your perceptions comfortably in English, as the preferred common language in the workplace in healthcare settings. You will not be excluded if you do express yourself in another language, granted that the language is understood by the research team.*
- *You will not be able to take part in this research if you have to work under supervision of the healthcare providers mentioned above.*

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**What will be expected of you?**

- *You will be expected to sign this consent form in the presence of the facility manager.*
- *You will be expected to complete a document with title "Section A: Demographic details" and read definitions of concepts that will be used during the semi-structured individual interview.*
- *Data collection will be done through a telephonic semi-structured individual interview.*
- *You will be expected to answer/give comments on the following questions:*
  - *In your view, what does comprehensive mental healthcare entail?*
  - *In your opinion, what factors hinder comprehensive care to Mental Health Care Users (MHCU) in the community setting? (WHY?) (Motivate)*
  - *Who do you think is needed to provide comprehensive care in the community setting? (WHY?) (Motivate)*
  - *What do you think can be done to improve comprehensive care among MHCU in the community setting? (WHY?) (Motivate)*
  - *Any other comments on comprehensive care to MHCUs*
- *The interview will be audio recorded to ensure accurate transcribing of the interviews.*

**Will you gain anything from taking part in this research?**

- *There are no direct gains for you if you take part in this study, but the other gains of the study will be to gain more knowledge about necessary services for comprehensive mental healthcare services, participants will be able to learn other strategies on how to care for their MHCUs, and participants will also be made aware of how mental healthcare services are lacking in the community setting.*

**Are there risks involved in you taking part in this research and what will be done to prevent them? No there are no direct risks in this study.**

- *The risks to you in this study are low. There may be slight physical/emotional discomfort or fatigue, but no more than what you will experience during a typical meeting of about 90 minutes.*
- *There are more gains for you in joining this study than there are risks.*

**How will we protect your confidentiality and who will see your findings?**

- *Anonymity of your findings will be protected by the use of codes during interviews and transcribing of the interviews. Only the researcher, supervisor, co-supervisor and ethics research committee, transcriber and the co-coder will be able to look at the findings. Your original semi-structured interviews during data analysis will be kept under lock and key in a separate cupboard from the consent forms. After data analysis, all the documents, including copies, will be locked in the NuMIQ Director's office for a period of 5 years before they are being permanently destroyed through a shredding machine.*

**What will happen with the findings or samples?**

- *The findings of this study will only be used for this study through recommendations after data collection and data analysis.*

**How will you know about the results of this research?**

- *We will give you the results of this research when the study is completed and are written up in a mini-dissertation as well as the publishing of one article in an accredited journal by 2021.*
- *You will be informed of the findings by 2021 when you will be visited at your workplaces and short reports will be shared with you, and verbal presentations will be delivered during your scheduled MDT meetings.*
- *A written report will be sent to the North West Department of Health, and the research results will be shared at relevant research days.*

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

- *This study is self-funded by the student.*
- *No you will not be paid to take part in the study.*

***There will thus be no costs involved for you, if you do take part in this study.***

**Is there anything else that you should know or do?**

- You can contact Sibalala Ontlotile Innocentia at 078 499 5633 if you have any further questions or have any problems.
- You can also contact the NWU-Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or [carolien.vanzyl@nwu.ac.za](mailto:carolien.vanzyl@nwu.ac.za) if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

**Declaration by participant**

By signing below, I ..... agree to take part in the research study titled: **Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting.**

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.
- I also give my consent that the telephonic semi-structured individual interview may be audio-recorded.

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

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by person obtaining consent**

I (*name*) ..... declare that:

- I clearly and in detail explained the information in this document to  
.....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

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

.....  
**Signature of person obtaining consent**

**Declaration by researcher**

I (*name*) ..... declare that:

- I explained the information in this document to independent person who I trained for this purpose.
- I did/did not use an interpreter
- I will be available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

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

.....  
**Signature of researcher**

Current details: (23236522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.6 Forms\HREC\9.1.5.6\_NWU-HREC\_JCF\_Template\_Feb2019.docm  
7 February 2019  
File reference: 9.1.5.6

## APPENDIX I: DATA COLLECTION TOOL (DEMOGRAPHIC DATA, DEFINITION OF CONCEPTS AND INTERVIEW SCHEDULE)

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### DATA COLLECTION TOOL

Dear Participant

Thank you for your willingness to participate in the research study with title: *Healthcare providers' perceptions of providing comprehensive care to mental health care users in a community setting*

Please complete the following demographic information under Section A and read through the definitions of concepts that will be used during your telephonic semi-structured individual interview.

Please provide your contact number where you can be reached for your telephonic interview: \_\_\_\_\_

### **SECTION A: DEMOGRAPHIC DATA** (mark with X)

**Current occupation:**

Dental practitioner		Registered Nurse	
Dietician		Psychiatrist	
Medical practitioner		Psychologist	
Occupational therapist		Social worker	
Pharmacist		Speech therapy and Audiology	
Physiotherapist		Other: _____	

**Institution:**

Ward based outreach team		CHC		Regional hospital	
Clinic		District hospital		Other hospitals	

**Gender:**

Male		Female		Other	
------	--	--------	--	-------	--

**Home language:**

Tswana	
Sotho	
Xhosa	
English	
Afrikaans	
Other: _____	

**Years working in community setting with MHCU:**

Less than 1 year		5-6 years		10-15 years	
1-2 years		6-7 years		15-20 years	
2-3 years		7-8 years		20-25 years	
3-4 years		8-9 years		25 years +	
4-5 years		9-10 years			

**Role and responsibilities towards the MHCU:**

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## DEFINITIONS OF CONCEPTS

The following concepts are prominent in this research:

### MHCU

MHCU are individuals receiving care and treatment from mental health care facilities (South Africa Mental Health Care Act 17, 2002:5, 6). In this research study, MHCU refer to all individuals who seek mental health treatment, including newly mentally diagnosed patients and known mentally ill/psychiatric patients at a community setting in the North West Province.

### Comprehensive

Comprehensive means 'complete' or 'full', aimed at including all details, items, facts, information, that may be concerned for something to be achieved fully and thoroughly (Oxford advanced learner's dictionary, 2010:296).

### Care

Care is defined as attention or thought given to a matter which needs proper handling to avoid doing wrong or harm i.e. what an individual may need for their health or protection (Oxford advanced learner's dictionary, 2010:212).

### Comprehensive care

Comprehensive care means fulfilling maximum quality of care through developing community and home based care that focuses on early detection, follow-up care, rehabilitation and promoting available social support services (Maritz, 2010:61). It also involves the use of protocols and standards that emphasize quality assurance, advocacy, rights protection, as well as capacity and management development; leading to patient-centred care (Maritz, 2010:61).

In this research study comprehensive care therefore means quality care and treating MHCUs comprehensively by implementing and practicing proper and needed care on a daily basis, which includes rehabilitation, early detection of illness, follow-up care, social support services, advocacy, assessment, health education and receiving medication to MHCUs in the community setting.

### Perceptions

The Oxford advanced learner's dictionary (2010:1087) defines perception as the way one notices things, mostly with senses and also by the ability to understand the true nature of

something, meaning the reasoning, thinking, and viewpoint: simply, insight. In this study, perceptions refer to the meaning, thoughts, and viewpoints of healthcare providers regarding comprehensive care to MHCU in a community setting in the North West Province.

#### Community setting

According to Smith *et al.* (2012:2) community setting is a level of care where integrated, easy to access, health care services are provided by healthcare providers who are accountable, and who develop a continuous therapeutic relationship with health care users.

In this research study, a community setting will be where the MHCU receives mental health care services, live and work; specifically, the community setting in the North West Province.

## **SECTION B: TELEPHONIC SEMI-STRUCTURED INDIVIDUAL INTERVIEWS**

The following questions will allow the researcher to explore and describe perceptions on factors hindering comprehensive care to MHCUs in the community setting.

### **DATA COLLECTION TOOL/INTERVIEW SCHEDULE**

The following questions will be posed to the participants during the telephonic individual interviews. However, a semi-structured data collection method will be applied.

An interview schedule of about 3-5 questions is formulated, as that will allow the participants to explore and describe perceptions on factors hindering comprehensive care to MHCUs in the community setting, and the following are the questions that will be asked:

In your view, what does comprehensive mental health care entail?

In your opinion, what factors hinder comprehensive care to Mental Health Care Users (MHCU) in the community setting? (Why?) (Motivate)

Who do you think is needed to provide comprehensive care in the community setting? (Why?) (Motivate)

What do you think can be done to improve comprehensive care among MHCU in the community setting? (Why?) (Motivate)

Any other comments on comprehensive care to MHCUs

**THANK YOU FOR YOUR TIME AND INPUT!**

## **APPENDIX J: EXAMPLE OF A TRANSCRIPT OF AN INDIVIDUAL INTERVIEW WITH A HEALTHCARE PROVIDER**

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**Participant A**

**Phone ringing**

**Participant A:** Hey Sibs.

**Researcher:** Hello sister how are you?

**Participant A:** Sharp wena?

**Researcher:** I am good, as you know I am sister Sibalala and I am conducting my research interview with you today which is relate to my masters can I still continue?

**Participant A:** Yes, you are more than welcome.

**Researcher:** may I please try to remind you of some of the things that we discussed during the signing of the informed consent and addressing the research?

**Participant A:** Alright.

**Researcher:** Ok this is the formal interview and it is recoded as I told before and reminded you earlier on and for this interview I will kindly like to name you participant A and not your name because of the confidentiality related measures.

**Participant A:** Alright.

**Researcher:** And the recoding will take about 30-45 minutes if not close to an hour.

**Participant A:** Alright.

**Researcher:** Ok may I please remind you that aah your phone should be on silent mode so that there will be no incoming calls as we talk and that I will also like to ensure that the door is locked so that there is no entry of other people will occur during the interview, is that so?

**Participant A:** Yes, no problem.

**Researcher:** And if maybe you need to use the bathroom before I start with the interview I can pause a little while and then you go out and come back.

**Participant A:** Alright I am ok we can continue.

**Researcher:** But firstly I will like to thank you for allowing you to be part of my research study.

**Participant A:** You are most welcome.

**Researcher:** Ok the research topic is health providers' perceptions on comprehensive care to mental health care users in a community setting.

**Participant A:** Ok.

**Researcher:** And you qualify to be part of this research study because you are a professional nurse and are registered with the South African Nursing Council is that so?

**Participant A:** Yes, it is.

**Researcher:** And you are working in a community health centre and you and more than two years' experience being a professional nurse.

**Participant A:** True.

**Researcher:** Ok so now I would like to start with the, with asking of questions and if you maybe if you do not want to continue with this research you can tell me now because of is part of the measures that we discussed that the participation is voluntarily.

**Participant A:** Yes, Mam.

**Researcher:** So may I continue with the interview?

**Participant A:** Yes, you can.

**Researcher:** Ok. thank you.

**Researcher:** Ok thank you the first question that I am going to ask you is that in your view , I have five questions but the fifth question is just an additional one for you to add any other comment that you have with mental health care users.

**Participant A:** Alright.

**Researcher:** Ok thank you the first question is in your view what does comprehensive care to mental health care entail?

**Participant A:** It entails a holistic approach towards a mental health user with regard to identifying one, with regards to treating one, with regard to rehabilitating one and with regard to full compliance and adherence of medication for mental health care users who have mental illness.

**Researcher:** So I heard that you are naming them but not emphasising more may you please do that for me so that I know when you say treatment what are we talking about are we talking rehabilitation what are we really talking about.

**Participant A:** With the first one I said to identify one meaning there are people who are mentally ill in the community some are not confirmed so to speak, if we identify one with regard to signs and symptoms we are in the position to then refer the patient to the nearest facility in this case xxxxxxxx psychiatric hospital with regard to signs and symptoms that we will be seeing at that pointing and time with regard to the specific character we then refer, with regard to treatment we mean after the person has been identified and referred accordingly when they come back and are referred down to the local clinic we are in the position to then maintain the relationship with the person to make sure that they adhere to taking medication on regular daily bases we avoid having relapses we then look into the family support system as well we then look to the health care support system as well to make sure and assure that the patient actually complies and adheres to medication that he or she is supposed to be taking and if there are any further steps that need to be taken with regard to rehabilitation we introduce them to necessary vocational facilities that will be in a position to assist the person with regards to everyday life and to acquire skills on how to pursue and to accept their mental illness

**Researcher:** Ok so when you refer on your side, when you refer those ones who are being confirmed I'd like to assume that or maybe you can correct me when you said they are not being confirmed you mean the diagnosed.

**Participant A:** Yes if somebody comes and the family brings them normally with in the family there those ones who will say this person has been acting weird for the past couple of days and have been giving us problems and they lay out what the problem is and sometimes even by looking at the patient the things he or she will be saying and doing will then conclude on the fact that we query psychosis we may not necessarily declare which type of psychosis whether is depression whether is bipolar you understand what I am saying with regard to declaration of DMS5 or DMS6 in terms of classifying the type of psychosis the person is going through, so we will be in a position to see what the patient is presenting based what the patient is presenting we will then refer accordingly obviously they start at the general hospital where

they then do the 72 hours observation which will then conclude whether this person should be referred to a psychological institution.

**Researcher:** Ok so when they are referred to the hospital who do they meet I want to understand the comprehensive that they get when they arrive there.

**Participant A:** Ok if for augment he is from a clinical which is a community level we will obviously be the ones that will be in the position to assess the patient as professional nurses from there we do a referral to the general site of the hospital where the patient will be seen specifically by other professional nurses, by other professional teams in terms of the disciplines that are there in the hospital whether being a psychologist or a psychiatrist depending on the needs of the patient at that pointing time and then the team itself which is the professional nurse the doctor meaning the general doctor then the psychologist if not the psychiatrist will be in the position to be involved in the persons case to conclude and decide if whether the patient is in need of psychiatric admission and psychiatric treatment.

**Researcher:** Ok may I please go to the next question?

**Participant A:** No problem

**Researcher:** Ok the second question is in your opinion what factors hinder comprehensive care to mental health care users in the community the community setting?

**Participant A:** I will say majorly majorly stigma itself stigma from the community members itself to say we as professional we know you can never declare a person as mad in any African language we know that we have mental health care users so the stigma itself is the one that hinders most of the times when someone shows signs and symptoms people then conclude that is actually witch craft, they conclude that the family itself will perceive the fact that this person doesn't wat to take responsibility of their lives therefore they fail to see the necessity to take the person to professional help that's the first element which hinders'. The second element will be the fact that we know for sure as professional that there is what we call mental health act which involves different disciplines or team members to actually assist in giving the individual the necessary help meaning if an individual works around the township or location police person is responsible enough to declare that person as a mental health user therefore take them to the necessary facility but the system fails to do that for the mental health users all the times and obviously when you bring them when they finally brought to the community health centre when we identify accordingly and refer there is a follow ups that comes after that again in terms of the system in terms of the system again itself they fail to maintain and help the user to maintain and adhere to their treatment the acceptance part of them being a mental health user and knowing

that this is a life time thing that they need to hung at over years so I think the system does not have enough courage if not courage have enough instruments put into place to actually assist the mental health users to become full circle with their illness or with their mental health diagnosis.

**Researcher:** Ok thank you for that is there any other thing that you will like to add under the factors that hinder comprehensive care to mental health care users in the community sitting?

**Participant A:** Yes I think the shortage of nurses as well while we are all community health nurses while we are also qualified psychologist in the miner spectrum having your D4 or your degree for that matter you know that is your responsibility either way to take care of mental health care users you are qualified to render services to mental health care users in this instance so what will happen is because of the shortage itself it sometimes becomes very difficult for us to maintain a list of people that we have in the community and actually make sure that they adhere to compliance half the time we don't have the means we don't have the numbers to go out in the community to make sure that the user is comfortable the user complying the user is actually encouraged to living a normal life irrespective of them using medication or irrespective of them being mental health care users'.

**Researcher:** Ok thank you on adding on the second question can I continue to the other one or you still have some factors which hinder comprehensive care to them?

**Participant A:** We can move on.

**Researcher:** Ok the third question is who do you think is needed to provide comprehensive care in the community setting?

**Participant A:** I guess with regard to involvement we should include each and every person in the community for argument sake from a family level having an understanding of what the person is going through it helps a lot with regard to the family supporting the user and the community in terms of neighbours in the streets and the road that the user normally roams around it becomes a very crucial part to say we all know in the community that a specific character is having a problem or a mental illness for that matter so we are I the position to understand even when they do certain things that are out of character it is easy for them to identify and to say today this person did not take their medication or this person is relapsing, then they become part of this process so they are in the position to help out so by the time they come to the health facility they have identified that the person is in need of assistance and then we become part of that as well and with regard and referral or further referral or further support

we then are eager to become part and parcel of this persons illness and its recovery and its sustenance in the recovery itself so I believe that its multi-disciplinary starting from home starting from the community it elf going all the way to the level of rehabilitation to level of occasional stability.

**Researcher:** Ok thank you for that I fully understood when you said involvement and you give example of people who leaves in the community also including the family members and you also mentioned the rehabilitation part and the multi-disciplinary team and you kept saying when they come from the community and being referred by family members or members of the community we are then involved I want to understand the we part who are you talking of?

**Participant A:** I am talking about us at the health centre that is of proximity to the person to actually get the necessary assistance meaning us the nurses the doctors at the clinic and further referral to the hospital.

**Researcher:** So at the hospital who will the mental health care users fall into and what are the roles of that person specifically because at the clinic you mentioned that when they come there you asses them and then if need of diagnosis is there you refer the patient directly to the level of hospital and you also mentioned before you refer them to hospital there is a mental health act that can be used and normally the police and other people of the community can play part may you please emphasise on that part from the community to you to the hospital how do they really meet.

**Participant A:** Ok like I said the family will be involve in the family level part or the community itself and then when it comes to us as a facility nurses we will be involved with the need, for argument sake normally in health facilities especially the big ones we will normally have psychologist and all that so depending on the level of need or immediate need of the patient if the psychologist from the clinic does not seem fit to assess the patient and to conclude on his or her own we will be in the position to refer the patient further to the hospital like I said if the patient is not a known user you are in the position to send the person to general hospital where they will conclude after 72 hours if that person have typical psychosis symptoms that will need them then to be referred further to a psychiatric hospital where he will meet professional nurses who are qualified or have speciality in mental health care and then he or she will be introduced un regards to a psychologist if there is a need for that and a psychiatrist in terms the level of necessity for a patient to be invite such,

**Researcher:** Ok thank you remember the question was saying who do you think is needed and I am so glad that you also mentioned the speciality part.

**Participant A:** Yes

**Researcher:** May you please motivate further why do you think they need health care providers who are specialist on a certain thing when they are being referred to the hospital how will it help them?

**Participant A:** Like I said is one thing that I am a qualified nurse with specific and necessary equipped mental illness psychology I am aware of how to deal with one but I am not a specialist and as professional nurse to say given the tendencies and the necessary signs and symptoms that are specific to a specific DMS5 classification I am not in a condition to conclude on that but somebody with a speciality will be in a position to say given the necessary assessment done with regard to your MSC this person is classified as such that therefore need specific attending skills to deal with that kind of character which us necessarily do not have.

**Researcher:** Ok I understand now on the speciality part that they will be getting the correct measures of treatment and they will be diagnosed correctly according to how they are suffering

**Participant A:** And the support is very important exactly

**Researcher:** Ok thank you is there anything that you think you need to add under who you think is needed to provide comprehensive care in the community setting or I may move to the fourth question?

**Participant A:** Ok let me just conclude with regard to the fact that I personally feel that we do not have enough support especially from the involvement of others for argument sake we always have a problem where a family member will bring someone and they highlight the fact that they called the police they have called the EMRS but none of them are willing to come and assist unless they bring the patient to the clinic and sometimes is actually a serious exercise to the family to even convince the person to get in to a specific car to be brought to the facility so I feel sometimes that our other multiple disciplinary fails us and fail the family when in need of their services

**Researcher:** Ok so you are basically concluding on that who do you think they are needed in providing comprehensive care everyone should be included whether you are the police office, you are a community member, a family member the nurse the psychologist and all those other people?

**Participant A:** Definitely

**Researcher:** Ok so are you convinced you just answered or you need to add any other concerns?

**Participant A:** No I think for now I am ok

**Researcher:** Ok may I please move to the fourth question?

**Participant A:** Yes, please

**Researcher:** Ok the fourth question is what do you think can be done to improve comprehensive care among mental health care users in the community setting?

**Participant A:** Majorly majorly community health education with regard to the recent mental illness that are there that arise and that concern us as a community the fact that whether we like it or not sooner or later one of us will be on what we call a border line to become a mental health person in terms of understanding what mental health is and the definitely crossing over to the border line to having a mental illness therefore become a mental health user so if we go out in the community or most part in regular daily basis because even the pressures of life that we go through at the moment all of us I think are on the brink sooner or later of actually literally becoming on the border line of becoming a mental health user so there is an importance of understanding what a mental health care user is and different mental illnesses that are there which we will be in a position to accept an individual who says I think I need help I think I am in the position to become one of the mental health users because if the things that I am going through at the moment there is TTNC, there is depression there are so many of them out there that are actually going through the signs and symptoms but we are unaware because they are too scared or ignorant enough to recognise and realise when they really in dire need of mental health care.

**Researcher:** Ok I heard you mention going out to the community am I right to say that is community enrichment and community involvement?

**Participant A:** Definitely remember I mentioned stigma as well and the myth that go with stigma to say when somebody has what we call mental illness they are quick to say that is witch craft they are quick to say that this person is losing their marbles without necessarily understanding the actual illness the person is going through so I think with more guides out there with more road shows to actually emphasize the importance of mental health care I think people will understand more and I think people will be more into actually wanting and willing assist those who are going through mental illnesses.

**Researcher:** Ok thank you for motivating that when you go out to the community you will actually be going to educate members of the community right?

**Participant A:** Yes.

**Researcher:** A part for them knowing about the mental illnesses or mental disorders how do you think those people from the community are going to benefit from being taught or nurses going to the community to teach them more how will they personally gain from that?

**Participant A:** I think I've actually touched into I one of the benefits saying the will actually be in the position to asses themselves as individuals you will be given a ureter moment to most of them to say I was not aware this is what I was going through I was not aware that this is something so and so is going through I have noticed this and that in one person and I never know that this is the beginning of someone going through mental illness I think with enlightenment with education and with giving insight to what mental illness is all about is easy for someone from the community to then say I know now why so and so was acting up or was acting this way, way I know now when I feel this way or that way it simply means I am going through this and I need help

**Researcher:** Ok thank you for emphasizing more on that and for motivating so what else do you think can be done to improve comprehensive care to mental health care users apart from going out to the community to health educate them and also doing community involvement activities?

**Participant A:** I think what will one need is an ongoing screening of mental status of people doing an SME on regular basis where you will be able to identify those who come to the clinic on regular basis without necessarily going out there those are the people we want to identify as well so they are coming to us in stat of us going to them and we hardly ever notice but people are going through staff, people are going through difficulties, people are going through mental illness without them knowing that they are going through that so when you are in a consulting room whether from an acute or chronic point of view when somebody shows emotions or distancing themselves from the conversation that you are having them at that pointing time automatically it should give an alert sign to say why is the person being distance and is an everyday life is people that we see on regular basis and if I know this person to be a bubbly person and today they come and they don't show signs of life they don't show signs of bubblyness I should be worried and therefore I should be assessing this person on a regular daily basis when they come to the facility.

**Researcher:** Ok thank you on that so when you screen you will basically taking the objective data meaning you will be looking how they will react while you are giving them treatment and also when screening them without them noticing what will you really being doing will you ask them questions or there are specific things you that you going to.

**Participant A:** You are in the position to ask relevant questions that lead you to what you are looking for like for argument sake I ask somebody today you are quite why are you quiet and they start showing signs by crying and all that it means that there are something wrong with this person then I can easily pry why into they are crying other than that is normal thing like are they clean are they fully dressed, are they here are they alert of their surroundings to where they are, is this person taking care of themselves, are they eating well are they wasted have they lost weight what seems going on by just looking at the person. Which like you said is it objective data others will be influenced into giving that collective data as well by just asking certain specific questions.

**Researcher:** So apart from community enrichment health education and also screening them what do you think can be done to improve comprehensive care among these mental health care users in the community setting again?

**Participant A:** Personally I wish is a wish of mine we could have honest community support groups that are available to anyone who need to be part of them an honesty especially from a black persons point of view support groups is not a norm they are not something easy to bring about with regard to black people so I wish people can actually take it a fact that support groups are there to support them, to teach them, to help their knowledge as well with regard to what they already know or what they think they know so if we could just have community support groups that are out there that people can go to weather from a recreation point of view whether from a mental health point of view, weather from a sport point of view whichever way you look at it I think if we can have groups like that on a regular daily basis in community that we live in it will really help people mentally and in every sense of the word.

**Researcher:** Ok thank you on the support group where will this support group be held will there be structures

**Participant A:** Like I said is just a wish list on my part is a wish list because I know for a fact there are non-existing at the moment for my sake I wish and hope that one-day people will realise and take to count the fact that they are desperate for such.

**Researcher:** Ok on your wish list as you say that you know for sure that they are not there in the community will like them to be specifically in the health centre that you are working on or just around the community which you are working in?

**Participant A:** Well the community centre is supposed to be a super market facility where it actually offers each and each and every necessary need of a patient hence we to have what we call a holistic approach so obviously we are in need of one in facilities we do have support groups which actually assist the community in terms of certain things weather is alcohol anonymous weather is health care users group in any way you look at it we should have something like that unfortunately we don't have.

**Researcher:** Ok so basically you are saying there should be structures where these mental health care users just go to refresh themselves and think?

**Participant A:** Exactly.

**Researcher:** An in order for their mental health issues that they have outside the community clinic they can just go there and they will be assisted?

**Participant A:** Yes.

**Researcher:** Ok so apart from those one you mentioned the community involvement enrichment community health education, the screening of everyone who comes to the clinic you mentioned something related to mental status examination and also the support groups including the structures that you just mentioned that you wish had or maybe the community setting had is there any other think should be done to improve the mental status of the mental health care users?

**Participant A:** Truly speaking the way I see it there are things that I will really wish for in terms of mental health care users are not old people only but even young children we tend to forget about the little people in the community that goes through things as well and those things tend to pave the kind of people they will be as adults so I think to a certain degree I will want something in place to say we can assist children as well who go through traumatic experiences as well who need attention in terms of their mental state there are children going through ADD, there are children going through autism and staff and we honestly don't have anything with regard to that so one of this years I wish we can have programs that teach such.

**Researcher:** Ok thank you so much may I move to the fifth point or there are still something that you think it can really it can be done?

**Participant A:** No thank you so much I am good thank you

**Researcher:** Ok so on all of the questions that asked you and you responded positively are there any other comments on comprehensive mental health care users maybe I might not have asked the question here but you still have something that you really need to address under the mental health care users including the comprehensive care measures.

**Participant A:** Well I think I covered base in all aspects according to my knowledge either than that maybe an inclusion of medication that the person doesn't have to go far to actually get their medication I think is also something that need one to look at to say some of the people default because they can't afford to go to xxxxxxxx for argument sake to fetch medication on a regular monthly basis and I think there is a bit tedious for them I think they end up relapsing because of that community point of view we don't have the kind of medication that they use and when we order for them because obviously we have prescriptions to the pharmacy in terms hospital and when we order for them half the time the medication comes late or at times they don't come at all so I think that we need to look into that as well to say how do we then help the person with regard to adherents.

**Researcher:** Ok so when they come to the clinics maybe fore medication and there is no medication what happens to the patient?

**Participant A:** Obviously we will refer the patient back to the hospital because if we can't help the patient they then need to see what else they can do with the patient'

**Researcher:** Ok so on your wish list what do you think can be done around that matter because as you already mentioned that when they come to the clinic and the medication is not there you refer them back to the psychiatric hospital which is xxxxxxxx and some of them don't even go there because they can't afford it so they end up relapsing on the community level what do you think can be done so that their medication is there?

**Participant A:** I think the government need to put measures into place to make sure that medication to mental health care users is always available because failure to do that we then get crowded in terms of relapse in terms of the facility of xxxxxxxx that and is almost like a fatal exercise so to avoid such avail the medication avail the necessary support that is the most important thing.

**Researcher:** Ok so on the medication part you say that they come and sometimes they do not get it and I am curious on the point that you mentioned earlier on about staff shortage so

when they come to the facility how are they attended do they just come in and que with other patients or what really happens there?

**Participant A:** Ok for most parts they normally que with every patient because remember mental illness is considered chronic is not like some kind of illness so is considered chronic and every other person who is not a mental health care user is also part and parcel of actually connecting chronic so they will be in the position to join the que like every other person who comes for chronic medication however obviously if we are going to have a patient that shows signs and symptoms of confusion you will not want to keep that person in the que you as fast as you can as quickly as possible.

**Researcher:** Ok so for how long do they really be there I am concern because of on your wish list you also mentioned that there should be structures that they go to strictly to.

**Participant A:** Unfortunately for us and realistically speaking patients under general irrespective of why they are here they tend to stand in ques longer than anticipated we know that at most the patient should be in the health facility for at most three hours but sometimes is not like that due to the shortage of staff.

**Researcher:** And I am also glad that you mentioned stigma now when we mention that there should be structures that they should specifically go to will they not feel stigmatise in a way what do you think under that.

**Participant A:** The thing is with stigma let's say for argument sake an HIV person has to go to the clinic in regular basis to get medication no one will know what that person is there however with a mental health person it comes a bit different if we had facilities where mental health care users are to go and feel at home and welcomed why not but as long as the neighbours or people in the community understand why the person go there should be a necessary need for them to bother them or to bully them with regard to their illness why because they know why that person goes there.

**Researcher:** Ok I fully understand now are there any comments on the comprehensive care to mental health users that you just want to touch on before we end the interview?

**Participant A:** I think more than anything I wish we have more staff so that all nurses that are on duty will have commitment to special need of s patient mental health care users being one of them if I run a program for children somebody else should run a program for mental health care users so unfortunately for us as a team we don't necessarily have that numbers to actually be in a position to offer that.

**Researcher:** Ok I understand.

**Participant A:** And even the structure does not allow us to have such.

**Researcher:** Ok I understand I think that's all unless you still want to add something on the previous question that I asked or add something.

**Participant A:** I am ok.

**Researcher:** Participant A I will really like to thank you on being part of my research study from here the step that I will be taking I will send my supervisors the recordings of everything we discussed so that they can see the time the date and what we discussed during the interview.

**Participant A:** Ok no problem.

**Researcher:** After sending them I will be transcribing the recordings and later on it will be analysed.

**Participant A:** Ok no problem.

**Researcher:** So after analysing the information I will be corrodng the information meaning I will be putting it under topics and sub-topics so that for every participant there are point of views and perceptions will fall under said points. So afterwards I will be coming back again I will be sharing the information so that you will see where your input was and what others responded without obviously naming your name out and also of other participants.

**Participant A:** I will very much appreciate that.

**Researcher:** Ok is there anything you will like to add before I end the interview.

**Participant A:** There is not.

**Researcher:** Ok thank you for agreeing to participate in my study once more.

**Participant A:** You are welcome thank you.

## **APPENDIX K:**

### **FIELD NOTES**

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#### **INTERVIEW 1**

##### **DEMOGRAPHIC NOTES**

This first telephonic semi-structured individual interview with a healthcare provider in North West Mahikeng Sub-District was conducted on Friday the 13<sup>th</sup> of November 2020, at 10h00am and it lasted for about 41minutes and 22seconds. Researcher was at School of Nursing Science Biology Lab, and table with a chair was prepared by researcher, the room had light and temperature was well controlled and the room was locked, and a poster written “Please do not disturb research in progress” was put up outside the door. The healthcare provider was at her work place and indicated that she was free and that Fridays after 09h30 she is normally not too busy or not busy at all, the door was locked and she asked her colleagues not to disturb her as she will be busy with the research interview.

##### **DESCRIPTIVE NOTES**

The healthcare provider is an African Zulu speaking female, who has about 5-6 years working experience in a Community Health Centre as a Registered Nurse in Mahikeng Sub-District and also working with Mental Health Care Users. She described her role and responsibilities towards Mental Health Care Users as “MSE, possible referral, adherence and compliance”.

##### **REFLECTIVE NOTES**

The interviewer kindly and respectfully greeted the participant and indicated that the participant will be named as “Participant A” in order to maintain privacy and confidentiality. Researcher then fully introduced herself and reminded participant regarding major concerns regarding the research interview purpose like time likely to be taken, and also shared the research topic once more with the participant. During the research interview the participant was speaking English fluently and gave as much information as she could, while thinking deeply at some point. She gave examples where needed according to her explanation as a way of motivating and however factors hindering factors comprehensive care among Mental Health Care Users in a community setting.

#### **INTERVIEW 2**

##### **DEMOGRAPHIC NOTES**

This second interview took place on a Sunday, 15 November 2020. It was also a telephonic semi-structured individual interview, which started around 14h19pm and lasted for about 39minutes 21seconds. The researcher was in a locked house and the gate was locked, and the participant was at her home, in a locked room and indicated that electricity load shedding just struck but that won't affect our interview at all. For both researcher and participant, conducting interview was possible as both areas were conducive.

### **DESCRIPTIVE NOTES**

Participants current work occupation is a Registered Nurse, and have about 2-3 years working in a Community Health Centre in Mahikeng Sub-District. She is a female and home language is Pedi. Among some of the roles and responsibilities, she indicated the following "To provide moral support, to ensure MHCU takes medication, to treat symptoms and refer for further management".

### **REFLECTIVE NOTES**

During the interview the participant spoke softly, and she was however audible. Participant asked for topic explanation and by explaining the topic as it also includes some definition of concepts, researcher tried to explained fully so that the participant understand better. She answered questions accordingly and responded to the best of her ability.

## **INTERVIEW 3**

### **DEMOGRAPHIC NOTES**

The third interview done on a Sunday evening on the 15 November, at 18h59pm and it lasted for about 49minutes and 16seconds. The interview was conducted telephonically and the participants was ensured about door being locked and she ensure researcher that her room meet criteria to conduct research topic as she agreed to all measures asked by the researcher.

### **DESCRIPTIVE NOTES**

Third participant is a female, working in a Community Health Care in Mahikeng Sub-District and have about 3-4 years working experience. She described her roles and responsibilities to Mental Health Care Users as "Providing medication and refer them to xxxxx hospital when it's their six months' review, and encourage them to adhere and comply with their treatment".

### **REFLECTIVE NOTES**

Before starting the interview, the participant asked the researcher to speak slowly as researcher was going fast for her. The participant answered well and took time to respond properly as she thought through and took time before responding back. As participant was answering she also asked if it's o.k. for her to go back to answered question and add other information she would remember. At some point participant couldn't hear researcher clearly but at least that didn't disturb the research interview. Information regarding factors hindering comprehensive care among Mental Health Care Users was reached.



## APPENDIX L: CO-CODER

### CODE OF CONDUCT AND CONFIDENTIALITY UNDERTAKING

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#### CODE OF CONDUCT FOR RESEARCHERS

This code of conduct is applicable to all NWU researchers.

As a researcher of the North-West University (NWU), I subscribe to the rules of the NWU Institutional Research Ethics Regulatory Committee (IRERC), all applicable policies of the NWU as well as all national and international laws and regulations applicable to my field of study. Furthermore, I commit myself to abide by the ethical principles and responsibilities as set out in the Singapore statement on Research Integrity (22 September 2010), in any and all research endeavours that I undertake as a researcher of the NWU.

The four major principles of research integrity to which I will adhere and that will guide my research are:

- Honesty in all aspects of research
- Accountability in the conduct of research
- Professional courtesy and fairness in working with others
- Good stewardship of research on behalf of others

Consequently I will also adhere to the following ethical responsibilities:

1. I will take responsibility for the originality and trustworthiness of my research.
2. I will stay abreast of and adhere to all institutional, national, and international laws, regulations, and policies applicable and related to my research.
3. I will at all times employ appropriate research methods; base my conclusions on critical analysis of the evidence and report my findings and interpretations fully and objectively.
4. I will keep clear and accurate records of all research that I have conducted in a manner that will allow verification and replication of my work by others, if applicable.
5. I will, where applicable, share my data and findings openly and promptly, in line with external funding rules. This will be done as soon as possible after I have had an opportunity to establish priority and ownership claims.
6. I will take responsibility for my own contributions to publications, funding applications, reports and other representations of my research. I will also and only include authors who meet valid authorship criteria.
7. I will acknowledge the names and roles of those who made significant contributions to my research in publications, including writers, funders, sponsors, and others, but do not meet authorship criteria.
8. In my peer reviews, I will provide fair, prompt and rigorous evaluations and I will respect confidentiality when I review others' work.
9. I will disclose all conflicts of interest (financial and other) that could compromise the trustworthiness of my work in research proposals, publications, public communications, and in review activities.
10. When I publically address a community in the spirit of academic freedom, I will in all stages base my professional comments on research findings (if applicable) and my expertise. I will distinguish between professional comments and opinions based on personal views.
11. Should any irresponsible research practices and/or research misconduct become known to me or brought under my attention, I will report such irresponsible research activities to the appropriate authorities.
12. I will respond to irresponsible research practices or conduct, by taking prompt actions as set out in the procedures of the university. I will also protect those who report misconduct in good faith, to the best of my abilities.
13. I will endeavour to create and sustain an environment that encourage research integrity through education of students, research teams and peers, as well as abide by policies, and reasonable standards for advancement.
14. I will at all times weigh societal benefits against the risks inherent in my work.

Name: **PROF LA. SEHULARO** Signature: 

  
Date:



NORTH-WEST UNIVERSITY  
YUNIBESITHI YA BOKONE-BOPHIRIMA  
NOORDWES-UNIVERSITEIT

**CONFIDENTIALITY UNDERTAKING**

entered into between:

I, the undersigned

Prof/ Dr/Mr/Ms LEEPILE ALFRED SEHULARO

Identity Number [REDACTED]

Address [REDACTED]

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borchard Street, Potchefstroom, 2520

(hereinafter the "NWU")

**1. Interpretation and definitions**

1.1. In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1. "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2. "Commencement Date" means the date of signature of this undertaking by myself.

1.2. The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

**2. Preamble**

2.1. In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2. The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

### 3. Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

### 4. Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

### 5. Non-disclosure and undertakings

I undertake:

- 5.1. to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;
- 5.2. to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;
- 5.3. not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;
- 5.4. not to use any research data for publication purposes;
- 5.5. not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;
- 5.6. not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and
- 5.7. that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

### 6. Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

### 7. Jurisdiction


This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

### 8. Whole agreement

- 8.1. This document constitutes the whole of this undertaking to the exclusion of all else.

8.2. No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this Thursday 06 February 20 20

Witnesses: LA. SETULALO 

1 Sibulela Jantjie Innocentia 

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(Signatures of witnesses)

(Signature)