DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA

by

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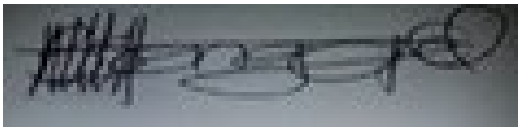
DECLARATION

I, **Bumani Solomon Manganye**, hereby declare that the dissertation titled "**Development of a Strategy to Promote Effective Management of Mental Health Care Users in Mental Health Establishments in Limpopo Province, South Africa**" submitted for the degree of **Doctor of Philosophy in Public Health (PhDPH)** at **the University of Venda, School of Health Sciences, Department of Public Health** is my original work and has not been previously submitted for a degree at this or any other institution, and it is my own work in design and execution. All reference materials contained herein have been duly acknowledged.

Bumani Solomon Manganye	**:**	
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DEDICATION

This study is dedicated to my late grandmother "Nwa- Nkatini" who believed in education even though she was not educated. The cattle you bought named "Mahlomisa" and instructed for it not to be slaughtered during your funeral so that your grandchildren can be sent to school proves that you had a bigger picture about the future. May your soul continue to rest in perfect peace grandma.

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ABSTRACT

Introduction and background

Mental health is a state of well-being whereby individuals can realize their own capabilities, cope with normal stressful situations in life and work productively while contributing to their communities. The prevalence of mental health disorders is increasing in global populations, more especially so in low-income countries. Treatment of people with mental disorders is also very poor in most countries as many mental health care users are discharged prematurely from the mental health establishments before they have fully recovered due to lack of infrastructure and human resources to deal with mental health problems.

Aim

The study aimed to develop a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa.

Objectives

The objectives of the study were to: explore the views and experiences of mental health care users related to the provision of care, treatment, rehabilitation, rights of mental health care users in the mental health care establishments in Limpopo Province; explore the views and experiences of mental health care providers caring for mental health care users in Limpopo Province; develop a strategy to promote management of mental health services in Limpopo Province and to develop a plan for piloting the developed strategy for managing mental health services in Limpopo Province.

Methodology

The study was guided by modified PRECEDE-PROCEED model. The study comprised of two phases, which were the needs assessment and development of a strategy. Phase 1 covered the needs assessment and was conducted in three stages. In the first two stages, the convergent mixed methods approach was used and ran concurrently (qualitative, quantitative) and the third stage was the integration of data. The study was conducted at 13 selected mental

health establishments in the five districts of Limpopo Province. In the qualitative study of mixed method research, non-probability purposive sampling was used to select 34 mental health practitioners, and 19 stable mental health care users. An unstructured interview guide was used to conduct in-depth individual face-to-face interviews and trustworthiness was ensured throughout the study through the application of credibility, dependability, conformability and transferability. Data were analyzed using the eight steps of Tesch's open-coding. In the quantitative approach of mixed method research, a convenient sampling was done to sample 339 respondents and a self-administered questionnaire was used to collect data whereby only 305 questionnaires were received.

Validity and reliability measures were applied and ensured throughout the study. Data were analyzed using the Statistical Package for the Social Sciences, version 26.0. In the third stage, the integration of the results was done where both qualitative and quantitative data were merged using side-by-side comparison and interpretation of data done, followed by discussions. Phase 2 covered strategy development and the development of the plan to pilot the developed strategy. The diffusion of innovation theory was incorporated in the development of the strategy and, again, the PRECEDE-PROCEED model was used to address the plan to pilot the developed strategy. Ethical considerations were followed throughout the study.

Results

Six themes emerged from the qualitative data analysis and they were confirmed by statistical evaluation of quantitative data where a convergent parallel mixed method was noted. Six themes emerged, including structural-related challenges, inadequate management of mental health care users when admitted, improper application of safety measures in the wards, poor mental health care user support, insufficient knowledge regarding mental health care and strategies to improve the management of mental health care users.

The strategy to improve the mental health services in the Limpopo Province was then developed with the stakeholders, who were the members of the district mental health forum. The strategy components included: increased knowledge and encourage a healthy attitude about mental health, improve social environment, improve and develop social skills of mental

health care users and improve self-efficacy to obtain and take treatment by mental health care users.

Recommendations

The recommendations were outlined, based on government, policymakers, education and practice, and further research. It is also recommended that the pilot and process evaluation of the developed strategy be carried out.

Keywords: effective management, forensic observations, mental health care users, mental health care providers, mental health establishments, readmissions, relapse psychosis, state patients, strategy

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length of Stay
BCTs	Behaviour Change Techniques
BRICS	Brazil, Russian Federation, India, China and South Africa
CCTV	Closed-Circuit Television
CEO	Chief Executive Officer
CPA	Criminal Procedure Act
CTR	Care, Treatment and Rehabilitation
DALYs	Disability Adjusted Life Years
DG	Disability Grant
DIT	Diffusion of Innovation Theory
DoH	Department of Health
DOT	Directly Observed Therapy
DSM IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DMHF	District Mental Health Forum
EMS	Emergency Medical Services
FGDs	Focus Group Discussions
HBCW	Home-Based Care Worker
HIV	Human Immunodeficiency Virus
ID	Identity Document
JCPS	Justice Crime Prevention Safety and Security
MDGs	Millennium Development Goals
MDT	Multidisciplinary Team
MH	Mental Health
MHCA	Mental Health Care Act
MHCP	Mental Health Care Practitioner

MHCU	Mental Health Care User
MHE	Mental Health Establishment
mhGAP	Mental Health Gap Action Plan
NGO	Non-Governmental Organization
NHI	National Health Insurance
OPD	Outpatient Department
OT	Occupational Therapy
PN	Professional Nurse
PRECEDE	Predisposing, Reinforcing, and Enabling Constructs in Educational / Environmental Diagnosis and Evaluation
PROCEED	Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development
PTB	Pulmonary Tuberculosis
RVD	Retroviral Diseases
SA	South Africa
SAPS	South African Police Services
SDGs	Sustainable Development Goals
SASSA	South African Social Security Agency
SIPD	Substance Induced Psychosis Disorder
SP	State Patient
SPSS	Statistical Package for the Social Sciences
SW	Social Work
TB	Tuberculosis
VDMHF	Vhembe District Mental Health Forum
WBPHCOT	Ward-Based Primary Health Care Outreach Team
WHO	World Health Organization
YLL	Years of Lost Life

CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction and Background

The prevalence of mental health disorders, according to the World Health Organization (WHO), is increasing in populations, more especially in low-income countries. Common mental disorders refer to two main diagnostic categories: depressive and anxiety disorders. Depression has been the leading mental disorder with about 300 million people that is equal to 4.4% globally in 2015 (WHO, 2017). It was estimated that more than 322 million people suffer from either depressive or anxiety disorders (WHO, 2017). Mental health disorders account for 12% of the global burden of disease and it was estimated that it will increase to 15% by the year 2020 (Brown, Funk & Sarceno, 2007). In the decade leading to 2017, there has been a notable rise in the number of people suffering from mental conditions and substance use disorders by 13%, globally (WHO, 2019).

More than 182 million people were suffering from mental health disorders and substance abuse in 2012 (Whiteford, Degenhardt, Rehm, Baxter, Ferrari, Erskine, Charlson, Norman, Flaxman & Johns, 2013). It was also estimated that the number will double in 2020, globally (Whiteford *et al*., 2013). In 2019, there has been an increase from 182 million to 1 billion people who are suffering from mental and substance disorders (WHO, 2019). The prevalence varies according to sex and age ranging from 15-29 years and a late peak in adulthood, with 2.6% in males that is regarded as low in Western Pacific and high amongst females of more than 5% in the

African regions (WHO, 2017). Mental health and addictive disorders accounted for 7% of all global diseases in 2016 as measured by Disability Adjusted Life Years (DALYs) and 19% for all years lived with disabilities. These disorders affect significantly the global population burden of diseases, mostly in the upper- and middle-income population, and it can be attributed to lack of treatment (Rehm & Shield, 2019). However, depression disorders were more related to most DALYs in both males and females, but with higher percentages in females as they have internalizing disorders because they tend to internalize most of their mental, emotional and economic burdens in life. On the other hand, males were found to be afflicted with a higher percentage of substance abuse disorders (Rehm & Shield, 2019).

Comparing common mental health disorders estimates in Brazil, Russian Federation, India, China and South Africa (BRICS) countries in 2015, Brazil was found to be high number of people suffering from mental illness with 15.1% of depressive and anxiety disorders. Brazil was followed by Russian Federation with 8.6% and South Africa at number three with 8%, followed by India with 7.5% and, lastly, China at the bottom of the list with about 7.3% (WHO, 2017). Three hundred and twenty-two (322) million people are living with depressive disorders and 264 million are living with anxiety disorders in the world (WHO, 2017).

Mental, neurological and substance use attributed to 14% of the global burden of disease as measured by the DALYs (WHO, 2008b). To respond to the challenges faced in the management of mental health services, the WHO introduced the Mental Health Gap Action Plan (mhGAP). The purpose of the mhGAP was to reduce the gap in mental health service delivery and enhance capacity building for the member of the state to respond to the growing challenges in mental health. In 2013, the World Health Assembly adopted the Mental Health Action Plan (2013-2020) aimed to better the management of mental health through preventing, promoting, caring, treating and

rehabilitating mental health users (WHO, 2013a). Furthermore, the WHO (2017) report alludes that mental health disorders, neurological disorders and substance use, accounts for more than 10% to the global burden of disease and it affects all age groups and people of different socio-economic status (WHO, 2017). One out of ten people is affected with mental health disorders worldwide and it was estimated that more than 877 000 deaths were due to suicide globally in 2015 (WHO, 2017).

Treatment of people with mental health disorders is also very poor in many countries and the cost estimated to be more than $603 billion globally (Sanni & Adebayo, 2014; WHO, 2015). Mental health is neglected globally, hence, the gap for treatment of mental health is huge (WHO, 2008a), and the gap is likely to be greater in low-income countries where the resources dedicated for the treatment of mental disorders are scanty. Despite the escalating number of people with mental disorders, primary health care services are still insufficient to cater for the needs of Mental Health Care Users (MHCUs) and in other instances, primary care workers fail to detect mental disorders or provide evidence-based treatment (WHO, 2008a). The reasons why mental disorders are not detected early at the primary care level are due to various factors, including patient and health care worker-related factors. Patient-related factors include failing to recognize symptoms of mental illness and focusing mostly on the physical signs like pain. Health care worker-related factors include inadequate training in mental health issues, burnout and stigma (Kiima, Njenga, Okonji & Kigamwa, 2004; WHO, 2008a).

The structure of mental health services delivery is aligned with the WHO (2008a) recommendations (Figure 1.1). For mental health systems or mental health structures to work efficiently and effectively, the service needs support, collaboration, information sharing and supervision across the different levels of care, including the involvement of MHCUs. The mental health system is, therefore, structured to include primary care,

community-based setting, general hospitals and specialized psychiatric hospitals (DoH, 2012).

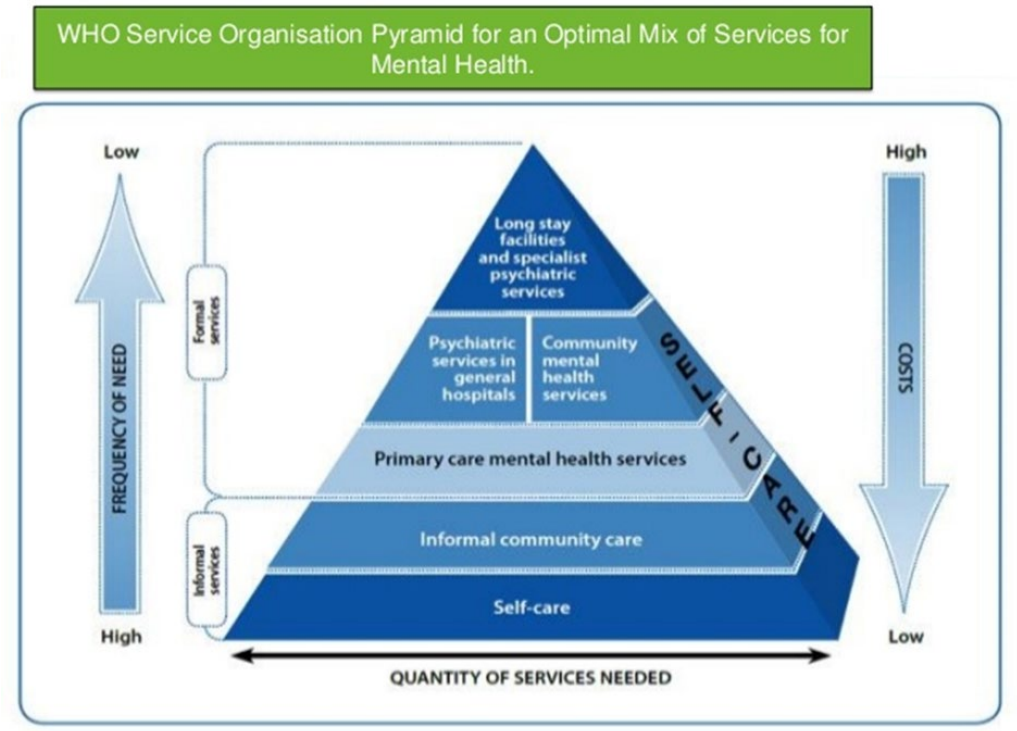

Figure 1.1: WHO service organization pyramid for an optimal mix of services for mental health. **Source:** Adapted from WHO (2008a).The transition from Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs) has been an achievement in the mental health directorate as the current SDGs include or incorporate mental disorders and substance use on it while the former MDGs did not (Stein, 2014; WHO, 2015). In South Africa, mental illness was ranked number three in neuropsychiatric disorders. Mental disorders contribute much to the overall burden of diseases following Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and other infectious diseases (Munjal, Ferrando & Freyberg, 2017). As an example, a study conducted in the Western Cape showed that many MHCUs consult tertiary institutions for 72-hour observations due to infrastructural drawbacks and inadequately trained staff in the general hospitals (Lund, Kleintjes, Kakuma & Flisher, 2010). As a result, MHCUs are discharged

prematurely to the community-based care due to a shortage of beds leading to the revolving door of relapsed cases and a high rate of defaulters (Temmingh & Oosthuizen, 2008; van Rensburg, 2012).

MHCUs using substances were found to be relapsing in higher numbers than other categories and were being readmitted more than three times in mental health establishments (Morel *et al*., 2020). Several factors contribute to the readmissions of MHCUs in the mental health units like lack of support and environmental factors (Miller, Ronis, Slaunwhite, Audas, Richard, Tilleczek & Zhang, 2020). Other factors include age, gender where males are readmitted more compared to females. Socio-economic factors also play a role in the readmission of the MHCUs (Miller *et al*., 2020). A major problem experienced in the South Africa is that mental health services continue to be under-funded and under-resourced (Lund, Boyce, Flisher, Kafaar & Dawes, 2009; Lund *et al*., 2010). Lack of public awareness concerning mental health exacerbates the widespread of stigma and discrimination towards MHCUs (DoH, 2012).

Prior to democracy in South Africa, mental health care users were stigmatized, alienated, and disempowered. The Mental Health Act (MHA) 18 of 1973 was focusing on the rights of the community while infringing on the rights of MHCUs. The MHA focused more on the treatment of mental health care users to protect society rather than their individual rights (Burns, 2008). In the Post-Apartheid regime, there was the promulgation of the Mental Health Care Act (MHCA) 17 of 2002, which now focuses more on the protection of the rights of MHCUs. The MHCA is based on various principles and include that the care and treatment of mental health care users need to be provided in establishments near their homes and be regarded as MHCUs and not mentally ill patients (Burns, 2008). South Africa, like other developing countries, has made tremendous progress in delivering services to people living with mental illness

although there are still many gaps that need to be filled (Petersen, Lund, Bhana & Kleintjes, 2015). According to the District Health Barometer 2014 to 2015 (Massyn, Day, Dombo, Barron, Padarath & Africa, 2015), the readmission rate for MHCUs in districts where there is a specialized mental health establishment was higher than those without such a facility. Worryingly, all four districts with high readmission rates were the National Health Insurance (NHI) pilot site. Limpopo Province was number four in terms of admissions rates nationally with a prevalence of 2.8% in 2015. Furthermore, there was an increase from 1.0% in 2013 to 1.2% in 2014 (Massyn *et al*., 2015).

1.2 Problem Statement

The MHCA requires that MHCUs be observed for 72-hours before they can be admitted to the mental health unit. The observations allow for the exclusion of other medical disorders that may be the cause of psychosis. When 72-hour observations are conducted, according to the MHCA, users will be properly diagnosed and given correct treatment that will make them remain stable in the community and go back to their respective workplaces. MHCUs will be staying at home with their family members and leading a normal life without relapse psychosis. During support visits and mental health meetings, the researcher interacted with all members of the district mental health and legal forums, and there were many complaints from family members of MHCUs. The complaints included that their relatives are being discharged from the hospital prematurely before they are fully recovered or stable and are being abused physically or sexually by fellow users. Furthermore, those MHCUs who are violent and aggressive are not observed properly as they are secluded and heavily sedated for the duration of the observation period. They are transferred to mental health units without being observed properly and with no interviews conducted to elicit the cause of psychosis. The Mental Health Care Practitioners (MHCPs) also mentioned a

challenge or problem where MHCUs are being admitted frequently (revolving door) in mental health units, some MHCUs get readmitted more than once within two months while others tried to absconded from the institution as shown in Table 1.1.

Table 1.1: Re-admission rate per regional and specialized institutions and number of MHCUs who abscond per month (May 2017)

Name of the District	Type of hospital	Name of hospital	Number of MHCUs admissions per month	Number of MHCUs readmissions per month	Number of MHCUs who absconded per month
Capricorn	Specialized Hospital	Thabamoopo	6	2	2
Vhembe	Regional Hospital	Tshilidzini	14	6	1
	Specialized Hospital	Hayani	4	2	2
Mopani	Regional Hospital	Letaba	40	8	3
	Specialized Hospital	Evuxakeni	60	23	4
Sekhukhune	Regional Hospital	Philadephia	28	12	0
	Regional Hospital	ST Rita	30	9	2
Waterberg	Regional Hospital	Mokopane	34	1	1
Total	**8**	**8**	**216**	**63**	**15**
Source: Limpopo Provincial Mental Health Monthly Statistics, 2017 (DoH, 2017)					

The mental health care services remain very poor due to a lack of proper skills in diagnosing and managing MHCUs by the MHCPs in mental health establishments. Some facilities in the province are mixing mental health care users declared by the court to be mentally ill (state patients) with those who have committed crimes (forensic observations or observandi) in the same unit. The attitude of MHCPs was also cited as being negative towards the care of the MHCUs leaving users alone without food or clothes in the unit. The researcher also observed that service providers are being abused or even killed by MHCUs. As an example, a nurse in one of the mental health

establishments in Vhembe District was attacked from behind and killed by a MHCU while doing her daily routine in the maximum-security ward. Based on the above statements, there is a dire need to develop a strategy to promote the effective management of mental health care users in Limpopo Province.

1.3 Rationale

Several studies were conducted regarding MHCUs focusing on the human rights of patients when admitted to the mental health establishments (Burns, 2008; Mayers, Keet, Winkler & Flisher, 2010; Mkize, 2007). Furthermore, other studies were mainly concerned with the poor infrastructure for MHCUs (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Flisher, 2009; Peterson & Lund, 2011). Another study focused on the mental health gap in South Africa where the author mentioned the development of the MHCA as a huge milestone in the care and treatment of MHCUs (Burns, 2011). Lastly, taking stock of mental health services in South Africa, a study recommended that there is a need to prevent revolving door patterns for MHCUs in mental health establishments so that they stay in the community and provide psychosocial rehabilitations for MHCUs at the primary level (Lund, Petersen, Kleintjes & Bhana, 2012). No known study has been done to develop a strategy for the management of MHCUs in Limpopo Province, hence the proposed study.

1.4 Significance of the Study

The developed strategy might influence policymakers to review the current policies in the care and management of MHCUs when admitted to the mental health establishments. The management of the mental health establishments and mental health units might benefit from the results of the developed strategy as it might close the gap of the revolving door for MHCUs in the mental health units. The researcher is of the view that the findings of this research study might also benefit the MHCUs and

the MHCPs, as the strategy will be focusing on how to improve the mental health services in the Limpopo Province. The management of the mental health establishments may also benefit from the findings of the study as the challenges about care, treatment and rehabilitation of the mental health care users would have been identified.

1.5 Purpose of the Study

The purpose of the study was to develop a strategy to promote effective management of mental health users in mental health establishments in Limpopo Province, South Africa.

1.6 Objectives of the Study

The objectives of the study were to:

1. Explore the views and experiences of MHCPs and MHCUs related to the provision of care, treatment, rehabilitations, rights of MHCUs in the mental health care establishments in Limpopo Province.

2. Explore the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province.

3. Develop a strategy to promote management of mental health services in Limpopo Province.

4. Develop a plan for piloting the developed strategy for managing mental health services in Limpopo Province.

1.7 Definitions of Terms

The following concepts were central to the study and are conceptually and operationally defined as follows:

1.7.1 Mental Health Establishment

The whole or part of a government or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, rehabilitative, preventative or other health services. This includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals (DoH, 2012). In this study, mental health establishment means the hospital which admits mental health care users in Limpopo Province.

1.7.2 Effective

'Effective' is defined as the capability of producing the desired result or the ability to produce the desired output. When something is deemed effective, it means that it has an intended or expected outcome, or produces a deep, vivid impression (Sotiadis, Van Zyl & Nduna, 2014). In this study, effective means the correct and proper implementation of the policies, guidelines and protocols in the management of mental health care users in mental health establishments.

1.7.3 Strategy

A strategy is defined as a coordinated plan which guides decisions and also an evolving theory of winning high-stake challenges through creating power, use of resources and opportunities in uncertain environments (Khalifa, 2019). In this study, strategy was referred to as a plan of action designed to achieve a long-term goal or

overall aim to improve care to mental health care users in Limpopo Province.

1.7.4 Mental Health Promotion

Mental health promotion encompasses actions and advocacy to address the full range of potentially modifiable determinants of health, including actions that allow people to adopt and maintain healthy lives and those that create living conditions and environments that support health (DoH, 2012). In this study, mental health promotion means the promotion of mental health service delivery in Limpopo Province.

1.7.5 Mental Health Care Users

Mental Health Care Users (MHCUs) are persons receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing their mental health status. This includes a user, state patient and mentally-ill offender and where the person concerned is below the age of 18 years or is incapable of taking decisions (DoH, 2012). In this study, MHCU means a person who was admitted to the mental health establishment and being stable after receiving care, treatment and rehabilitation in Limpopo Province.

1.7.6 Management

The organization and coordination of the activities of a business to achieve defined objectives consist of the interlocking functions of creating corporate policy and organizing, planning, controlling, and directing an organization's resources to achieve the objectives of that policy (Drucker, 2006). For this study, management means the organization, supervision and management of MHCUs who were admitted to a mental health establishment in Limpopo Province.

1.7.7 Mental Health Care Practitioners

A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services are referred to as mental health care practitioners (MHCPs) (DoH, 2012). Regarding this study, MHCP means a nurse, psychiatrist, medical practitioner, occupational therapist, psychologist or social worker, physiotherapist and dietician working in a mental health establishment in Limpopo Province.

1.7.8 State Patients

State patients are those individuals who have committed serious crimes like murder and declared by the court to be unfit to stand trial during the court proceedings, and who are not responsible for the crime committed due to their mental illness or defect, and referred to a specialized mental health establishment for care, treatment and rehabilitation (Marais & Subramaney, 2015). In this study, state patients mean all MHCUs who has been declared by the court and receiving care in mental health establishments in Limpopo Province.

1.7.9 Relapse Psychosis

Relapse psychosis is a severe mental disorder where an individual loses touch with reality and manifests abnormal thinking and perception like hallucinations, illusions and failure to differentiate between reality and the imaginary world (Sass, 2018). In this study, relapse psychosis means the condition of MHCUs who are mentally ill and cannot distinguish between the reality and imagination, and admitted to a mental health establishment in Limpopo Province.

1.8 Thesis Outline

1.8.1 Chapter 1: Overview of the Study

In this chapter, the researcher presented the overview of the study which included the introduction and background to the study, problem statement, rationale, significance of the study, the purpose of the study, objectives of the study and definition of terms.

1.8.2 Chapter 2: Literature Review

In this chapter, the researcher discussed the literature review according to the following aspects: introduction, global overview of mental health disorders, legislation governing mental health services, management of mental health services, challenges related to mental health services and summary.

1.8.3 Chapter 3: Research Methodology

This chapter outlined the philosophical world view of the study, the conceptual framework, and the modified PRECEDE-PROCEED model, that guided the study. The study comprised of two phases, which were the *Needs Assessment* and *Development of a Strategy*. Phase 1 covered the needs assessment and was conducted in three stages, the first two stages used convergent mixed methods and ran concurrently (qualitative, quantitative), and the third stage embodied the integration of data. Phase 2 included the strategy development and the development of the plan to pilot the developed strategy. Ethical considerations followed during the study were also discussed.

1.8.4 Chapter 4: Presentation of the Qualitative Data

This chapter presents the qualitative results. Themes and subthemes were developed and the results of both MHCPs and MHCUs were integrated and discussed in detail

with quotations from the participants.

1.8.5 Chapter 5: Presentation of the Quantitative Data

This chapter presents the results from the quantitative strand, using tables and charts.

1.8.6 Chapter 6: Comparison, Integration and Interpretation of the Qualitative and Quantitative Results

This chapter discusses the results from the qualitative and quantitative findings jointly, using the convergent parallel mixed methods design. The chapter compares, relates and then provides an interpretation of the study findings. The results from the qualitative strand were compared with quantitative findings. A side-by-side comparison was applied and a table was used to present the results from both the qualitative and quantitative designs. Results were presented separately, but discussed jointly, where statistical values confirmed the themes from the qualitative data analysis. A summary of the results was also presented.

1.8.7 Chapter 7: Strategy Development

This chapter describes the steps used in the development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa. Needs assessment guided the development of the strategy and helped in developing the Logic Model of the Problem with the stakeholders, then worked on the Logic Model of Change. A four-component strategy was developed and validated by the forum for the relative advantage, compatibility, complexity, trialability and observability. The Diffusion of Innovation Theory (DIT) Model was incorporated in the development of the strategy. Validation of the developed strategy was presented and the plan to pilot the developed strategy was provided.

1.8.8 Chapter 8: Summary, Strengths, Limitations, Recommendations and Conclusions

This chapter presents the conclusion of the study based on the objectives of the study that included the developed strategy and plan for piloting the strategy. Strengths, limitations, recommendations and summary of the study were also outlined. The strengths of the study were the use of theories, the use of convergent mixed methods to balance the results.

1.9 Summary

This chapter provided the overview of the study which included introduction and background to the study, problem statement, rationale, significance of the study, the purpose of the study, objectives of the study, definition of terms and outline of the chapters. The next chapter covers the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Mental health issues were ignored since ancient times, hence, the World Health Organization (WHO) launched the *Comprehensive Mental Health Plan* from 2013 to 2020 with the main aim to bring about changes on how mental health care problems or issues are being handled all over the world. Considering the human rights of people living with mental illness, MHCUs deserve to be treated with respect and dignity, and not discriminated or stigmatized because of their condition (Saxena, Funk & Chisholm, 2015). A literature review identifies the body of literature that is relevant to the research, to indicate the relationship of the proposed research study to the literature (De Vos, Delport, Fouché & Strydom, 2011).

The following literature review was done using the integrative literature review following the seven steps as discussed by (Creswell & Clark, 2018) and the keywords were used to search for peer-reviewed scholarly articles related to the study in question on websites such as PubMed, EBSCOhost, Sabinet, ScienceDirect and Google Scholar. The literature reviewed in this study were sourced predominantly from developed countries and Sub-Saharan African countries, including South Africa. In this study, the literature review was discussed as follows: Global overview of mental health disorders, legislation governing mental health services, management of mental health services and challenges related to mental health services.

2.2 Global Overview of Mental Health Disorders

The definition of 'Mental Health' was transformed in the early 1980s when it was categorized and classified based on the causes using the Diagnostic Statistical Manual for Mental Disorders (DSM-III) from the American Psychiatric Association for Standardization of Mental Health Diagnosis (Mayes & Horwitz, 2005). Mental illness is a chronic condition that interferes with the person's ability to think and it affects both the mood and the feelings of the person. But it can be controlled or managed therapeutically. People with mental illness need care, treatment and support from their relatives and friends and significant others. The definition of mental health disorders varies from a wide range of conditions from psychotic disorders, like schizophrenia, to more benign disorders, such as mild depressions and all those neatly organized disorders that are more disputed in the DSM. Personality disorders are also included in the definition of mental disorders (Ahonen, 2014).

The development of DSM-V in the field of mental health contributed to the elimination of many mental disorders where about 600 conditions were then classified according to the International Statistical Classification of Diseases and Related Health Problems (ICD). Also, the ICD has about 157 listed mental disorders with the main diagnosis as compared to the preceding DSM-IV which was double in several listed conditions. It can be argued that some of the conditions listed in the DSM-V cannot be applied in certain cultures because the DSM-V was developed looking at American and European patients (Morrison, 2013).

A fundamental challenge in defining mental health disorders is that it deals with the main symptoms, not the signs, because the judgement in the diagnosis of mental health disorders mainly focuses on the communications of the person during the interview or interaction with the community (Rogers & Pilgrim, 2014). Politicians and

judiciary authorities have decreed and declared that mental illness is a disease like any other diseases, while (Szasz, 2011) argueds and defined mental illness as a metaphor. Ohio State Law conceptualized mental illness as a medical construct, which suggests that mental illness was defined from the clinician's perspective, not from the judges or legislators' perspective. However, the law does recognize mental health issues or challenges as mental health has several legal effects which may hold the person not guilty for any criminal act the person might have committed and render the user incompetent and have him/her admitted as an involuntary user (Weihofen, 1960). The law may also protect the MHCU in case of divorce and assist in signing a binding contract due to his/her mental incapacity.

Mental illness was ranked at number three in the neuropsychiatric disorders and was seen as the contributions in the overall burden of diseases of mental illness in South Africa while HIV and AIDS and other infectious diseases remain at the top (Bradshaw, Norman & Schneider, 2007). The epidemiological survey which was conducted for the first time nationally found that 16.5% of adults in South Africa experienced mood disorders, impulse and anxiety disorders throughout a 12-month survey (Williams *et al*., 2007) and it was also found that most of the mental illness disorders start to show the symptoms before the age of 14 (McCabe, 2005).

However, there was a significant increase in the prevalence of mental disorders from 16.6% to 22.1% in people who were suffering from depressive, anxiety, posttraumatic stress disorders, schizophrenia and bipolar mental disorders (Charlson, van Ommeren, Flaxman, Cornett, Whiteford & Saxena, 2019). The study further estimated that one in five people from conflict settings areas suffers from either posttraumatic disorder or anxiety disorders (Charlson *et al*., 2019) which is in contrast with the findings from the prevalence report which estimated that one in fourteen people suffers from depressive, anxiety, posttraumatic stress disorders, schizophrenia and

bipolar mental disorders (Feigin, 2016). The 12 months prevalence of serious mental illness in the United States (US) was found to be at 4-6.8% in half of all the participating countries and this is an indication that mental health disorders are growing and the expansion of treatment to all countries can be cost-effective in the economy of the country. Many mental health disorders begin from childhood to adolescence and these adversely affect the transition of WHO World Mental Health (WMH) data in many countries (Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel, Üstün & Wang, 2009). The prevalence continues to grow also in developed countries as shown in a study conducted in Washington DC, where it was found that 43% of the participants met the lifetime classification of having a serious mental illness (Lynch, DeHart, Belknap, Green, Dass-Brailsford, Johnson & Whalley, 2014). The study further suggested that there is a critical need to assess the prevalence of serious mental illness with the co-existence of substance use and posttraumatic stress disorders to address the needs of female offenders (Lynch *et al*., 2014).

Mental health disorders are prevalent in all participating countries in the WMH surveys and it was found to be at 18.1-36.1% (Kessler *et al*., 2009), and it was estimated that mental illness accounts for more than 32% of Years Lived with Disability (YLD) 13% of Disability Adjusted Life Years (DALYs) instead of the previous estimates of 21.2% of YLDs and 7.1% DALYs (Vigo, Thornicroft & Atun, 2016). The most common mental health disorders per DSM-IV include anxiety, externalizing, mood, and substance use disorders and they range from 25th-75th inter-quantile percentiles. Mental and substance disorders were identified as the 5th leading contributor to the global burden of disease as measured by DALYs as out of 36.2 million, 22.5 million was identified as a high risk for suicide per DALYs (Ferrari, Norman, Freedman, Baxter, Pirkis, Harris, Page, Carnahan, Degenhardt & Vos, 2014). Moreover, depression had the highest proportion of more than 46% of suicide estimates as compared to anorexia

with the lowest proportion of 0.2% of the global burden of mental health disorders (Ferrari *et al*., 2014). With the inclusion of suicide in the global burden of disease, there was an increase in the overall burden of mental and substance use disorders from 7.4-8.3% where the estimate would be ranked from the 3rd to the 5th leading cause of burden. In 2010, mental and substance use disorders accounted for more than 183 million DALYs of all worldwide DALYs and it was found to be the leading cause of death accounting for 8.6 million for the Years of Lost Life (YLL) (Whiteford *et al*., 2013). The highest proportion of DALYs was found to be in Eastern Europe and Asia, and highest amongst males who were between the ages of 20-30 years old (Ferrari *et al*., 2014).

Several factors like gender, culture, age, socio-economic status and conflict play a role in identifying the prevalence of anxiety disorders, however, the global prevalence of anxiety disorders was 7.3% and it also ranged from 5.3% in African cultures to more than 10% in Euro/Anglo cultures (Baxter, Scott, Vos & Whiteford, 2013). When it comes to gender, more females were found to be suffering from anxiety disorders than males and people from poor socio-economic background are prone to suffer from mental illness due to stress experienced and lack of employment (DoH, 2013).

In the systemic review of the global prevalence of common mental disorders, it was found that more than 32% of the respondents were identified as having experienced a common mental disorder during their lifetimes (Steel, Marnane, Iranpour, Chey, Jackson, Patel & Silove, 2014). Females were found to be having a high prevalence of mood and anxiety disorders as compared to their male counterparts meanwhile males were having a high prevalence of substances use as compared to females. The prevalence of mental illness was found to be more than 3% of common mental disorders and more than 10% of non-severe mental illness. Gender differences were noted in substance use disorders as more males were using substance than females.

Previous studies in European and Asian countries found that females tend to suffer from depression than males (Lund, Myer, Stein, Williams & Flisher, 2013). The prevalence of common mental disorders varies according to regions. North and South East Asia displayed a lower prevalence in one year and lifetime prevalence as compared to other countries and Sub-Saharan countries' one-year prevalence rates were found to be low, whereas English-speaking countries returned high lifetime prevalence of common mental disorders (Steel *et al*., 2014).

The WHO special initiative for mental health was launched to scale up the implementation of mental health services which emphasize the need for universal mental health coverage to ensure access to quality and affordable mental health services for 12 priority countries to more than 100 million people by 2023 (WHO, 2019). The initiative has two strategic actions with targets that are to be met by 2023 and identified several challenges in the implementation and delivery of mental health programs. The challenges include severe violations of rights of mentally ill people, stigma and discrimination, lack of sustainable funding in mental health, low treatment coverage for mental illness, high mortality of young people from suicide and sexual violence, especially in areas affected by the humanitarian crisis (WHO, 2019). South Africa is no exception as it is affected by the prevalence of anxiety and depression disorders which is caused by loss of earnings and unemployment among adults. It also puts more pressure on the economy of the country and people from low socio-economic status being at risk of mental illness (Lund *et al*., 2013).

2.3 Legislation Governing Mental Health Services

The mental health care act (MHCA) is available in all countries, but it differs when it comes to implementation. In America, the new mental health act was cited as not being fair and not considering the MHCUs as there are 2.7 million users who were

uninsured in the current affordable care act (Kenney, Zuckerman, Dubay, Huntress, Lynch, Haley & Anderson, 2012). But their act has some good things that mental health care users are happy about, including the user who is younger than 26 years of age can remain covered by parents and also it prevents insurance companies to refuse MHCUs to be covered despite their pre-existing mental conditions (Kenney *et al*., 2012). It was also the same case in Nigeria as the MHCA protects the rights of MHCUs and offer equal access to care, treatment and discourage the stigma toward people living with mental disorders. This was satisfactory to the WHO, though it has several challenges that include not having enough health care workers to deal with mental health issues at primary levels, not having the inpatient units and outpatient clinics that are linked to the general hospital (Sanni & Adebayo, 2014).

The legislation used in Nigeria is not different from the MHCA in India as the Act strives to dispel stigma and discrimination by treating mental illness like any other general condition and the MHCA considers mental illness to be a malady that can be cured like other diseases if diagnosed early (Khandelwal, Jhingan, Ramesh, Gupta & Srivastava, 2004; Sarkar, 2004). The MHCA used in Nigeria and India, is the same as the one being used in South Africa where the rights of MHCUs are being protected.

Swaziland has the mental health legislation that was revised in 1978, but there is not much data on mental health as their mental health indicators might have been merged in the general health statistics. The report by WHO indicated that there is no mental health report for Swaziland and in the country's general policy, there is nothing mentioned about the state of mental health and there are no plans for mental health (WHO, 2013b) and this might mean that the rights of MHCUs are not protected by the state. In South Africa before 2002, legislations were based on alienation, discrimination and disempowerment of people living with mental illness or MHCUs. The MHCA 18 of 1973 was mainly focusing on the treatment of the MHCUs rather

than their rights and the concern was on the welfare and safety of the society. The human rights of the users were not considered; hence, the priority was given to the individual rights (Burns, 2008) and the mental health service delivery under the MHCA was not based on principles of ethics, beneficence, justice autonomy and no-maleficence.

MHCUs were previously referred to as psychiatric patients or mentally ill people according to the MHCA 18 of 1973, but it all changed with the promulgation of the new MHCA 17 of 2002, where now they are being referred as users of the mental health services and their rights are being protected. Mental illness is regarded as any chronic condition that can be managed with treatment. Their rights to sexual relations, legal representatives and confidentiality are being exercised with the new mental health care act (DoH, 2002).

The MHCA 17 of 2002 stipulate that care, treatment and rehabilitation of mental health care users must be in a way that restores the patient's dignity and uphold the user's rights during the time of admission in the mental health establishment (DoH, 2002), but this is not being observed in other mental health establishments due to lack of mental health facilities or the wards' infrastructure that are not properly designed to cater for MHCUs (Petersen *et al*., 2015).

South Africa is currently using the MHCA number 17 of 2002 with its main objective to protect the rights of mentally ill people. The MHCA stipulates that people with mental illness need care and support from their relatives, friends and significant others. These patients are protected by the MHCA 17 of 2002, which stipulates their rights when admitted in the mental health establishment. The act refers to them as MHCUs and they are admitted under sections 27, 33 and 34 as assistance, voluntary or involuntary users (DoH, 2002).

Post the World Health Assembly meeting, as expected, South Africa developed the National Mental Health Policy Framework and Strategic Plan 2013-2020 in line with the recommendations of the WHO Action Plan to fast track the delivery of mental health services that are integrated at all levels, comprehensive, equitable and accessible to the citizens of South Africa. The National Mental Health Policy Framework and Strategic Framework has been recorded as a huge milestone in the transformation of mental health (DoH, 2012) where its primary purpose is to improve the management of MHCUs in mental health establishments which is in line with WHO recommendations.

Mental health policies and guidelines are developed in line with the MHCA 17 of 2002, as amended, and taking into consideration the National Mental Health Policy Framework and Strategic Plan 2013-2020 as these two documents play an important role in the care, treatment and rehabilitation of MHCUs. All provinces are expected to develop their mental health policies and guidelines in line with the MHCA as it is regarded as a legal framework and is there to protect the rights of MHCUs (DoH, 2002).

The majority of MHCUs files assessed in Weskoppies hospital were correctly diagnosed according to the DSM-IV and the MHCUs were receiving appropriate care treatment and rehabilitation even though half of their documents did not meet the requirements from the MHCA or they did not adhere to the Act at all (Madlala & Sokudela, 2014).

Formal coercion to MHCUs by family members was found to be prevalent in involuntary patients. This shows that MHCUs are aware of their rights before admission to the mental health establishment. They referred to the Mental Health Care Bill of 2013 which gives a clear description of the procedures to be followed by MHCPs

when admitting the MHCUs in the Unit, but the Bill is silent about the compulsory treatment of MHCUs. The majority of MHCUs were not in support of their admission (involuntary) and they referred to their admission as unlawful because they thought they were forced into admission in the mental health establishment (Katsakou *et al*., 2012; Ramachandra *et al*., 2017). The MHCUs thought that their involuntary admission to the mental health establishment would have been taken care of their problems in the community mental health facilities without coercion. They had a strong view that their rights were violated, and their forceful admission poses a permanent threat to their independence (Ramachandra *et al*., 2017).

Several Acts regulate the management of mental health services, including the Mental Health Care Act (MHCA), Criminal Procedure Act (CPA), National Mental Health Policy Framework and Strategic Plan 2013 to 2020, Forensic Mental Health Observation Protocol, Policy for Mental Health Management, Policy Guideline on 72-Hour Assessment of Involuntary Mental Health Care Users and Policy Guideline on Seclusion and Restraint of Mental Health Care Users.

Criminal Procedure Act number 51 of 1977 in section 79 of the ACT, as amended, requires the offenders to be sent to the mental health establishment for mental health assessment by three psychiatrists for a period of 30 days. Nursing reports will be required to assist the judge in prosecuting the offenders. While section 42 of the MHCA is being used for the detention of the MHCUs in a mental health establishment (Ormerod & Laird, 2015). The MHCA was seen to be implemented successfully in Kwazulu-Natal despite the challenges of staffing, training and infrastructure which were noted as a big challenge (Ramlall, Chipps & Mars, 2010). With the recent developments in mental health, there is a clear distinction between medical and mental hospitals, as users have rights and their care is regulated, paid by public money through tax and it is the government's responsibility to provide the service to

MHCUs who need care treatment and rehabilitation, either as an inpatient or outpatient (Szasz, 2011). Their care is classified following the mental health care acts, either assisted, voluntary, involuntary, mentally ill prisoners, state patients, and emergency MHCUs (DoH, 2002).

2.4 Management of Mental Health Services

2.4.1 Promotion of Mental Health Services

To promote and strengthen mental health services, advocacy for policy development is needed to provide comprehensive and sustainable programs for the care, treatment and rehabilitation of mental health users, this was evident in the study done in the poorest country Zanzibar using the multifaceted approach to develop and maintain policies related to mental health (Jenkins *et al.*, 2011) and policy developers were encouraged to take into account resources allocated to mental health units when planning and allocating resources in general.

Fifty (50) years ago, mental illness was the responsibility of the federal government in America and government was supposed to promote and provide care to mentally ill patients. The concept of mental illness was also classified as not treatable or controllable, and people suffering from mental illness were subjected to detainment in mental hospitals. However, some private practitioners who use to provide care to mentally ill patients, and the cost of the services was being incurred by the clients themselves or their family members. These private non-psychiatric physicians were solely there to attend to both voluntarily and involuntarily care to the mental health care users (Szasz, 2011).

There were several myths in the early sixties (1960) about mental illness compared to now, as the condition can now be classified as a disorder that can be treated

successfully and can be treated like any other physical illness. Other classifications of conditions of mental disorders were removed from the DSM classification, such as homosexuality, and new conditions were introduced and classified like attention deficit hyperactivity disorder (ADHD). This was due to the involvement of both political and judicial sectors, including the economic field.

Philosophers, scientists, physicians, sociologists and the public developed an interest in finding “What is mental illness?”, but today that is no longer the case because everyone understands the concept of mental illness. Mental illness was also seen as a result of the diagnosis of brain disorder, this was not scientifically proven, and it was a myth. All these myths about mental illness offended psychiatrists and MHCUs as they were previously treated as prisoners (Szasz, 2011).

Mental health promotion was poor during olden times, and people will mental illness were badly mistreated in the seventeenth century, tortured by pouring cold water on their bodies, beaten and tying them with chains and being immersed in cold water as a sign of divine treatment that was used for witches. If a patient sank in water, it would prove that they were innocent, but if they floated in the water it was seen as a sign of guilt and the water was used to cure madness (Porter, 2002).

The Task Sharing Model, whereby the care of MHCUs can be shared with carers in the community can be adopted by different countries in trying to address the challenges of mental health issues in Africa. This will mean that the health care system will have to train informal caregivers who will assist in the early identification of signs of mental illness. When the model is well implemented, there will be an increase in access to mental health services and quality care will be provided to the MHCUs while admitted in the Unit (Musyimi *et al*., 2017).

Family members play a significant role in the promotion and management of MHCUs as they are the ones who reside with the patient full time and can either contribute to relapse or the well-being of the patient. If MHCUs are not supported, they tend to seek help from emergency units in the mental health establishments (Woollcott, 2008). Support for MHCUs plays an important role in the speedy recovery of the patient and can lead a patient to be retained at home for a longer period without any outbursts or relapses. Social support with special emphasis on care by family members allow nurturance and might provide a strong sense of independence amongst people with mental health problems (Langeland & Wahl, 2009).

The MHCUs if supported well by nurses, relatives and friends in the community might have a feeling of being welcomed at home and this reduces the level of relapses and readmissions which, in turn, costs the government a lot of money in treatment and rehabilitation of the MHCUs. With the prevalence of 1.1% of adults, about 5.1 million people have been diagnosed with schizophrenia (Whiteford *et al*., 2013; WHO, 2001). This indicates that many people diagnosed with schizophrenia will experience relapse or chronic impairment and may require long-term support (Warner, 2013).

Views of MHCUs can be considered as a therapeutic milieu since the user has been granted the opportunity to be the actor or narrator of the care that needs to be provided to him/her (Velpry, 2008). The views and experiences of MHCUs about structure provision were that nurses were aware of the patient's situation and they were very helpful in assisting the users by being there physically and providing routine mental health care. They also reported that they were connected to the MHCPs and were allowed to bend ward rules in some instances (Voogt, Goossens, Nugter & Achterberg, 2015). The MHCUs have expectations from MHCPs when admitted to the mental health unit. The expectations include that MHCPs need to be aware that MHCUs are human beings who should be taken seriously, and not treated like they

do not exist by informing them what to do rather than dictating what need to be done. The MHCUs further elaborated on the structure as the inclusion of the following:

- Knowing the situation of the MHCU, like understanding the feelings of patients and their problems;
- Remaining in touch and connected with the MHCU;
- Dealing with rules, times, and habits on the mental health unit;
- Applying Care, Treatment and Rehabilitation (CTR) to MHCUs (treatment plan) which was being left to be dealt with by a specialist in the field;
- Explaining and understanding how things are done in the Mental Health Unit; and
- Moderating of MHCUs' thinking so that they can deal with the rules and discover ways to like and abide by them.

However, admission to the hospitals brought many reactions to the majority of the MHCUs who were admitted in the mental health establishment as they were sad, unpleased, unrelieved and being confused about their admission in the unit (Ramachandra *et al*., 2017). A relatively small proportion of MHCUs indicated that fewer treatment options were available in the hospital to promote mental health services (Livingston, Nijdam-Jones & Brink, 2012), and the availability of mental illness treatment (psychotropic medicine) was highly appreciated and said to be having many positive effects to MHCUs because they will stay stable for a longer period without relapsing and being admitted in the mental health establishment. However, in many low-income countries it was found that there is a shortage of supply

of psychotropic medication in the mental health establishments. This shortage of medicine compelled some of the MHCUs who had medical insurance to buy their own treatment in private pharmacies and leaving those who were from poor families to suffer the shortage (Iseselo & Ambikile, 2017). Even those with insurance verbalised it was difficult to maintain the supply of psychotropic medicine through the private pharmacy as mental illness is a chronic condition that needs to be controlled by medicine for life.

The outcome of care in MHCUs always improved when there is a multidisciplinary approach to care and use of specialized nurses in the care of mental health establishments and it is also attributed to the positive management of patients as the staff is knowledgeable in the care, treatment and rehabilitation of MHCUs or to patients with chronic illness (Grol, Wensing, Eccles & Davis, 2013).

Positive patient management of MHCUs in the mental health establishments might contribute to a speedy recovery and improve the quality of life to the MHCUs as they will be discharged early and integrated back into their communities and family members and relatives and through psychosocial rehabilitations where they will generate income for themselves and contribute to the economy of New Hampshire state (Bush, Drake, Xie, McHugo & Haslett, 2015).

On a contrary to WHO's recommendations, a study done in England found that hospitalization is seen as the best way to manage the MHCU and that is the only place where their relapsed psychosis can be averted so that no further harm happens to the community of MHCU as the user will receive treatment and recover in a safe place (Katsakou, Rose, Amos, Bowers, McCabe, Oliver, Wykes, Priebe & Stefan, 2012). Coercion was also seen as necessary to MHCUs when they relapsed as they could not recognize that they needed help through hospitalization (Katsakou *et al*., 2012).

In order to understand the concept of mental health promotion and culture, professional nurses were urged by their employers to understand where their MHCUs are coming from, as not all MHCUs are violent as a society might hold such perception (Desmond, 2016). This means that they need to understand how their cultural practices may promote or affect MHCUs and their families in seeking medical care and advice when they observe symptoms of mental illness.

Mental health promotion and culture has been an issue that many people never wanted to open up and talk about mental health issues, including in nursing as a participant in a study in Britain argued that using a photo to describe how s/he feels it's dodgy and they were concerned about what will the next person say about the picture (Aranda, Goeas, Davies, Radcliffe & Christoforou, 2015) while a good picture with a good story about mental health can promote mental health by influencing others to live better while promoting their mental health.

2.4.2 Mental Health Service Delivery Strategy

In Tanzania, improving the provision of mental health services of the country was said to be essential by ensuring the availability of psychotropic medicine as all mental health establishments in the county. The availability of psychotropic medication will assist in addressing the challenge of untreated mental health problems and it is a government's responsibility to make sure that they provide the funds for the purchasing of psychotropic medications and to call for other stakeholders and funders to assist in increasing the availability of medication at all times in the mental health establishments (Iseselo & Ambikile, 2017). Improvement of the services rendered to MHCUs can be achieved by evaluating the provider and user's views regarding the care being provided in their respective units and identifying gaps in the service provision from both sides, the provider and the recipient of the care (Livingston *et al*.,

2012). Collaboration of MHCPs is one of the strategies in the improvement of care to MHCUs as they will receive holistic care while admitted in the mental health establishment (Livingston *et al*., 2012; van Hasselt, Oud & Loonen, 2013). Collaborative chronic care models were found to improve the quality of care or outcomes in the primary health care facilities to the clients with mental health disorders and other health problems, as there was a clear integration and management from all clinicians, and the model if implemented well, it might give the direction to the development of policy to manage MHCUs (Woltmann *et al*., 2012).

Service delivery to MHCUs can be improved by increasing health care professional's awareness in early recognition and identification of signs and symptoms of mental illness so that the MHCUs can be referred to the appropriate facilities or mental health establishments to receive CTR to avoid the further cost in Pakistan country's economy (Quraishy, Taufiq, Ali & Jamali, 2016) and it was suggested that if more MHCPs can be educated or trained on mental health issues, the service might improve even if there will be no psychiatrist to review the MHCUs (Mwape *et al*., 2010).

Training of MHCPs on early recognition of the signs and symptoms of mental illness was identified as a strategy to improve the management of MHCUs (Quraishy *et al*., 2016) and reduce the further delay in referral of patients to the psychiatrist for CTR. Meaning that early referral to the mental health establishments can improve the quality of care that is provided to MHCUs.

Patient-centred care is important in the management of improvement of services rendered to MHCUs (Livingston *et al*., 2012). The characteristics of patient-centred care can be found in any mental health establishment and patients recommended the approach as it assisted the MHCPs to improve the care they provide to MHCUs, although in a forensic mental health unit the safety of the MHCPs need to be taken

into consideration as other users might assault or injure the care providers (Hoptman, Yates, Patalinjug, Wack & Convit, 1999; Livingston *et al*., 2012). Intensive case management was found to be of importance in the care of clients who require forensic observations, as most of the clients will still be suffering from severe mental illness and need proper care and monitoring by health professionals. For proper assessment and diagnosis to exclude any illness not related to mental illness health professionals must be available always. Emergency management of MHCUs needs mental health practitioners who are more vigilant when providing care to clients being observed for forensic compared to the state patients (MHCUs) who are stable and been receiving treatment in the hospital for quite a long period of more than 4 days to one month (Dieterich, Irving, Park & Marshall, 2010).

Avoiding the mixing of MHCUs in the same unit prevent risks in mental health units as the clinical risk might go beyond patient safety as it was found in California where a MHCU killed a psychiatric technician during care giving ("Murder of psychiatric technician fuels California hospital safety push. (cover story)," 2013). This means that it is not only patients who are at risk for assault, even the staff member is at risk while working with forensic cases. Hence, it is vital to have a unit that will only cater to the 30-day forensic observations referrals rather than mixing them with MHCUs in the same unit at a mental health establishment and to strengthen safety measures in the forensic observation unit. According to the research done in New York (Wiley, 2006), separate units for forensic observations were recommended as it enhanced the quality of care provided to both the MHCUs and forensic observations as the two categories are not the same and need not be treated the same in the same manner in one unit.

An urgent need to review and modify the MHCA and other legislations was identified as a strategy out to facilitate the improvement of the care that they are currently receiving while admitted to the mental health establishment. Members of MHCUs were

seen as the ones who play a vital role after the MHCUs have been discharged from the mental health unit, hence, a need to empower them with skills and knowledge on the management of users at home is a key (Ramachandra *et al*., 2017).

There is a need to improve the management of mental health services in the South Africa as to avoid the catastrophic events that happened in Gauteng Province, where more than 37 MHCUs died after being de-institutionalized from Life Esidimeni to the Non-Governmental Organization (NGO) with no resources (human and infrastructure) and not being ready to receive and care for MHCUs (Lund, 2016). However, the report released by Ombudsman, Professor Malegapuru Makgoba on the 1st of February 2017 revealed that at least more than 100 mental health patients died at the 27 unlicenced NGOs in Gauteng Province, after they were transferred from Life Esidimeni Centre (Ogunbanjo, 2017). Health professionals allocated in the mental health units might influence the outcome of fully rehabilitating the users only when they are ready to work with MHCUs without discriminating them, this may in turn, reduce the average length of stay (ALOS) in hospitals thus reducing costs to the government (Carta *et al*., 2013).

2.4.3 Practices of Mental Health Practitioners in the Care and Management of Mental Health Users

Patients who were admitted to the mental health establishment expressed that they were afraid of being admitted and they were threatened to commit themselves to care, treatment and rehabilitation by MHCPs (Ramachandra, Ramu, Selvi, Gandhi, Krishnasamy & Suresh, 2017, Katsakou, Rose, Amos, Bowers, McCabe, Oliver, Wykes & Priebe, 2012). The study further showed that the majority MHCUs were not forced to be admitted, had power and felt free to do whatever they wanted to do in the hospital during their stay. The MHCUs who were admitted involuntary were the ones

reported to have been forced into admission in the hospital than voluntary patients (Ramachandra *et al*., 2017). The reason for the involuntary patients to feel they were forced might be due to their state of mental health as they are more severely ill than voluntary MHCUs.

The practices of MHCPs in the management of MHCUs in the South African context is that they are mixing and managing the MHCUs in the same unit and also conducting forensic observations in the same unit where MHCUs have been admitted. South Africa does need transformation with the application of the five control knobs (Roberts, Hsiao, Berman & Reich, 2008) in managing the mental health establishments and the flagship frameworks for leadership, namely; Regulation, Persuasion, Payment, Organization and Finance so that separation and management of MHCUs and forensic observation by financing the construction of new mental health establishments with different units for managing and accessing forensic cases.

Mixing the different categories of MHCUs and forensic observation in the same unit undermines the rights of both the MHCUs and the forensic observations as the Constitution of South Africa protect their rights (De Waal, Currie & Erasmus, 2000). Forensic observations and MCHUs are supposed to be protected and their rights to human dignity respected during the care, treatment and rehabilitation when admitted to the mental health establishment.

The MHCPs are quite aware of the privileges that MHCUs must receive while admitted to the mental health establishment. In a study conducted in Tanzania, MHCPs were aware that users need to receive free care and treatment as they are exempted from the cost-sharing system like other physical patients. The MHCPs just need to complete certain forms and refer the users to the social worker for a stamp to be exempted from paying for the treatment they received. The exemption is clearly

stipulated in the treatment policy of mentally ill patients, however, the policy was not fully implemented as there will be no funds to cover the treatment costs of MHCUs (Iseselo & Ambikile, 2017).

Seclusion being used as a punishment to MHCUs can lead to conflicts between the MHCPs and patients. MHCPs are aware that seclusion, manual restraints and coerced medication are not supposed to be used as a punishment in order to make the acute ward for mental health a happier place for both staff and patients, hence, the Safe Wards Model that cut conflicts in a mental health establishment was described by a team of researchers (Parish, 2013). Gaps between theory and practice were also cited as a challenge as what MHCPs were taught in text boobooks was different to what they need to put into practice. The context of the books that are used to teach MHCPs do not correlate with the practical settings (Marie, Hannigan & Jones, 2017). The MHCA has items that are difficult to implement as the infrastructure does not allow the full implementation of the Act. Other challenges include lack of support and skills to successfully implement the act and MHCPs are overburdened with the work load in the mental health establishments (Burns, 2008).

2.4.4 Mental Health Management in Institutions and Community Level

Mobile mental health services were found to be vital in the community, however, there is evidence that the needs of people living with mental illness were unmet in rural areas. In a study done in Northwestern Greece, the case load of mental illness is increasing, while the care and services provided to the MHCUs are inadequate. They also found the home visit to be very useful to a person with mental illness, as support was provided to them and the rate of relapses decreased, though the resources were scarce (Peritogiannis, Mantas, Alexiou, Fotopoulou, Mouka & Hyphantis, 2011). Their findings indicate that the program of mental health mobile in community-oriented, can

yield successful results in the management of MHCUs, as they can provide ongoing support and counselling that might assist MHCUs to cope with their illness, thus promoting community mental health (Peritogiannis *et al*., 2011).

Primary health care facilities are the first contact with the patient be it a MHCU or any other client in the community. Primary health care nurses working at the community health clinics are the first to come with a preliminary diagnosis of mental illness as they are the one who first comes into contact with the patient and make a referral to the hospital for a 72-hour assessment and management. When a MHCU is discharged from the mental health establishment or mental health unit, on the day of discharge, they are sent to the primary health care facilities with a referral letter for the continuation of care, treatment and rehabilitation.

The continuation of care from the primary health care nurse include home visits to the family of the MHCU to check if the patient is taking his/her treatment, coping and adjusting well (Rabkin, Mutiti, Mwansa, Macheka, Austin-Evelyn & El-Sadr, 2015). The ward-based outreach primary health care team (WBPHCOT) assist by visiting patients daily and reporting back to the primary health care nurse if there is any form of abuse to the patient by the family members or community (Rabkin *et al*., 2015).

A study conducted in England found that the introduction of community treatment support to MHCUs by significant others reduced the admission rate to the hospitals as MHCUs who received counselling once were found to have problems and encouraged to participate in support groups of patients with the same problems. But they acknowledged that admissions were not on the same diagnosis. Those who are receiving support from friends and family members in the community were not seen to present for readmissions in the hospital, meaning that community support is vital to patients with mental illness (Green & Griffiths, 2014).

Separate mental health units to house or that only cater or admit MHCUs in New York were also supported by the Governor to enhance quality care provided to the MHCUs and forensic observation (Wiley, 2006). The separate mental health units were supported by the state legislature of the country as they deemed it necessary to have a special unit designated for mental health users only.

Occupational therapies also play a role in the improvement of services provided to MHCUs while admitted to the mental health establishment. However, MHCUs felt that they need to be provided with training and skills that can assist them when they are discharged from the unit as the majority of MHCUs discharged were unable to find appropriate jobs even though they submit their curriculum vitae or attend job interviews (Boycott, Akhtar & Schneider, 2015).

Several studies in different countries have revealed that multidisciplinary team collaboration in the care and management of MHCUs can bridge the gap of service provision of mentally ill patients as providers will be able to treat the patient holistically (Dario, Saccavini, Mancin, Pellizzon & Favaretto, 2016; Livingston *et al*., 2012; Marie *et al*., 2017; Perkins *et al*., 2010; Quraishy *et al*., 2016; van Hasselt *et al*., 2013). It is also good to train the traditional healers about mental illness as it was found that the reason for the MHCUs to delay is seeking help from the health facilities is that MHCUs first consult the healer before they can decide to consult the health specialist (Quraishy *et al*., 2016).

Collaboration between primary health care physicians and office-based psychiatrists seem to be increasing in certain countries, and such collaboration might improve the quality of care MHCUs receive when visiting the primary health care facilities. The visit can either be for prescription of anti-depressant or anti-psychotic drugs. Physicians also showed their involvement in the care, treatment and rehabilitation of MHCUs

(Olfson, Kroenke, Wang & Blanco, 2014). The collaboration and involvement of physicians in the care of MHCUs was not the case in the homeless people as the visit to the general practitioner by MHCUs was found to be poor in England (Woollcott, 2008). Providing patient structure to MHCUs allow patients to develop trust in their MHCPs and it facilitates the speedy recovery of the patient. This implies that the MHCPs need to be there physically supporting and assisting the MHCUs to cope with their daily life routine (Voogt *et al*., 2015).

A study conducted in mental health centres found MHCUs always recover well when they are provided with support, hence, it is vital to support MHCUs while admitted in the mental health unit (Marie, Hannigan & Jones, 2017). Guiding MHCUs on the things they can achieve after discharge from the mental health establishment by taking MHCUs serious and involving them in the planning of their care (Voogt *et al*., 2015). Mental illness is a chronic condition that needs to be managed with psychotropic medication. The availability and constant supply of psychotropic medication are very crucial in the management of MHCUs admitted in the mental health establishment. When medication is always available, it will assist in addressing the challenge of untreated mental illness and the government need to prioritize mental health and mobilize funders or stakeholders to channel funds towards the purchasing of psychotropic medication (Iseselo & Ambikile, 2017).

2.5 Challenges Related to Mental Health Services

2.5.1 Patient | Mental Health Care User-Related Challenges

The physical health of MHCUs with severe mental illness is a challenge as they need an optimal approach and collaboration by health professionals. These patients are not the same as the general public, hence, they need a special approach and collaborative care from multidisciplinary teams (MDTs). The MHCUs with severe mental illness

expressed their fear to visit the doctor because of experiencing an inferiority complex. The MHCUs reported MDTs do not communicate with each other regarding their medication and care, and it affects their care because of lack of collaboration. The MHCUs also suggested collaboration by the teams as the best solution to their care to avoid telling their stories several times to different people who are providing care to them while admitted (van Hasselt *et al*., 2013).

The MHCPs or professionals were always seen as having power over the MHCUs during admission and stay in the mental health unit. The MHCUs view MHCPs wanting to be seen that they are in charge by imposing the time to sleep and making sure that users adhere to the ward routine (Katsakou, Rose, Amos, Bowers, McCabe, Oliver, Wykes & Priebe, 2012). The view was not the same as the study conducted in Canada amongst forensic patients who felt that hospital staff always valued and respected their views in the mental health unit and the setting satisfactorily met the requirements for a therapeutic milieu (Livingston *et al*., 2012). They also felt that they were not given enough information regarding their CTR in the unit. The MHCUs also expressed that they were not involved in decision-making and this contributed to the users feeling out of control while admitted as they were locked up without being told the reason for being locked in the unit (Katsakou *et al*., 2012).

The MHCUs verbalized that their rights were violated by MHCPs during the admission and stay and felt like prisoners during their lock-up period in the mental health unit as they were not explained the reasons for admission (Katsakou *et al*., 2012). However, few MHCUs agreed that they really needed the treatment, but they disagreed with the involuntary admission process as they were not consulted concerning their admission. The challenge of autonomy and rights of MHCUs need to be maintained by health care providers. The MHCUs mentioned their freedom is what they want when admitted to the mental health establishment as other users are not used to be dependent on

other people for their daily needs. The kind of setting in structured nursing allowed MHCUs to be aware of what is expected of them and how to behave to avoid breaking the ward rules (Voogt *et al*., 2015), because when they break the ward rules they will be subjected to solitary confinement or seclusion by staff in the mental health unit. Some MHCUs felt that when they were sent to seclusion, their rights were being violated in the process.

Health insurance is considered as one of the benefits to the MHCUs who have an insurance card as they visit the private pharmacy and buy medication for themselves, even though the treatment in the private is considered to be expensive. This is not a good thing for patients who are paying out of their pocket as the majority of the MHCUs cannot afford to buy the medication at the private pharmacies. Only 20% of the total population is being covered by a health insurance policy which indicates that the policy is not practised well in low- and middle-income countries. The purpose of the national health insurance is to make health care services, including mental health services, to be more accessible and affordable through the use of public funds pooling (Iseselo & Ambikile, 2017).

Noncompliance to anti-psychotropic drugs was highly associated with the risk of high relapses of MHCUs. The survey also found that the shorter the duration of mental illness contributes to the high number of MHCUs being relapsing as others discontinue treatment abruptly. However, the rating scale was recommended to be useful in preventing the high number of relapses amongst MHCUs rather than using observations only. It also reduces the worries by significant others of MHCUs and MHCPs as there will be no relapses (Bogers, Hambarian, Michiels, Vermeulen & de Haan, 2020). Furthermore, a study conducted in Malawi reported that there was a high number of readmissions from relapse psychosis by MHCUs who defaulted treatment intentionally to be admitted to a mental health establishment (Barnett, Kusunzi,

Magola, Borba, Udedi, Kulisewa & Hosseinipour, 2020). This kind of practice puts the already overburden mental health establishments under severe strain because MHCUs are supposed to be kept stable in the community (Barnett *et al*., 2020). Frequent readmissions of MHCUs in mental health establishments were found to be a challenge in a study conducted in Britain as MHCUs were admitted more than three times within a short space of time. Associated factors for relapsed were identified as unemployed, being black and having a care coordinator who monitors the treatment compliance and staying in an accommodation with support (Evans, Harris, Newman & Beck, 2017).

During the last three decades, the deinstitutionalization of mental health services led to faster transitions from psychiatric hospitals to the community. However, a significant number of patients have had serious problems after being discharged from hospitals which increased the number of psychiatric emergency referrals and readmissions (Barekatain, Maracy, Hassannejad & Hosseini, 2013). They further pointed out that hospital readmission shortly after discharge is increasingly recognized as a marker of inpatient quality of care and a significant contributor to rising health care costs. Furthermore, they indicated that psychiatric readmissions have a negative impact on patients and their families while increasing health care costs.

This has also been supported by Gbiri *et al*. (2011) who said that the relapse in psychiatric disorders is highly distressing, costly and engenders burnout syndrome among mental health workers and family members who provide care and support to mentally ill patients (Gbiri, Badru, Ladapo & Gbiri, 2011). Jencks, Williams & Coleman (2009) asserted that nearly one fifth of Medicare beneficiaries discharged from acute care hospitals are readmitted within 30 days, incurring additional costs of several billion dollars annually. Although it remains unclear whether such readmissions are entirely preventable, there is good evidence that targeted interventions initiated before

and/or shortly after discharge can decrease the likelihood of readmission (Jencks, Williams & Coleman, 2009). The role of psychiatric hospitals has shifted dramatically in that patient programs are now focussing on acute stabilization, leaving most treatment to community-based providers and projects. There are high chances of people with schizophrenia being readmitted within 30 days after being discharged due to the presence of comorbidities (Reeves, Weinstock, Epstein-Lubow, Metrik & Gaudiano, 2021).

Despite briefer stays, hospitalization remains a high-cost component of the mental health service system, amounting and accounting for approximately 70 percent of all dollars spent on mental health care in the past decade. Several authors reported that psychiatric disorders occur among 20 percent of children aged 9-17 years. Hospitals continue to play a significant role in the children's mental health service system, despite an increase in the use of community services in the past decade (Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1996; Geller, 2000; Lich, Urban, Frerichs & Dave, 2017).

Readmission of inpatients has been one of the most important problems in the field of psychiatry for the last decades. Since the dramatic decline in long-term hospitalization and consequent reductions and closures of state-operated hospitals, reducing readmission to specialized mental health establishments is an ethical matter which can reduce the economic burden (Duhig, Gunasekara & Patterson, 2017). The problem has a major role in reducing the quality of life and increasing the years of lost life. Readmission patients are those who, due to their psychological and social conditions, as well as the conditions of assistance and community resources, remain subject to repeated hospitalizations in psychiatric hospitals. Junior and Neto (1981) as quoted by Barros *et al*. (2010) affirmed that the process of being repeatedly hospitalized characterizes a new form of institutionalism.

The situation that emerges, therefore, has serious clinical consequences for the patients, who may evolve a condition of institutionalism. Therefore, these patients may suffer from a series of functional, social, and psychological losses. Furthermore, the permanency of patients with high numbers of hospitalizations emphasizes the limitations of the mental health services network. These services, although undergoing a process of change, still endure old models, practices and problems not yet overcome, and in some locations are found in insufficient numbers and/or with reduced teams (Barros, Marques, Carlotti, Zuardi & Del-Ben, 2010).

The success of hospital intervention, as assessed by improvement during the admission on an outcome measure of acute psychiatric services, does not influence the likelihood of readmission in the 30 days or 6 months following discharge for inpatients with a range of psychiatric disorders. Rather, patients who were at an increased risk of readmission were those with a greater impairment in self-care, more severe symptoms, and more persistent illnesses thus overpopulating psychiatric and general hospitals whilst contributing negatively to the shortage of resources at health care facilities (Ortiz, 2019).

2.5.2 Mental Health Care Practitioner-Related Challenges

MHCUs experienced a significant delay before they see a psychiatrist while admitted to the hospital (Quraishy *et al*., 2016), which places a burden on the economy of the nation. One of the challenges contributing to the delay in seeing a psychiatrist is that professionals lack knowledge in early recognition of the mental illness signs which delay MHCUs to be diagnosed and receiving CTR. Kenya introduced the task shifting in the care of MHCUs, however, the health providers experienced several challenges concerning the care of MHCUs such as mistrust of their capacity in the care of mental health (Musyimi *et al*., 2017).

Misunderstandings in their culture and stigma was also a challenge the MHCPs faced when providing CTR in the unit. Stigma was cited as due to a lack of knowledge about mental illness. Lack of support to nursing and nursing development was cited by participants not to be existing when it comes to mental health. Participants expressed that the ministry is supportive of nurses working in mental health establishments and they felt marginalized as their rights were not being taken into consideration as they are working in a poor environment on daily basis with their safety compromised (Marie *et al*., 2017).

Collaboration between the Multidisciplinary Teams (MDTs) was also found to be a challenge in the provision of quality mental health services to MHCUs as there were no clearly defined roles between the team members. Other team members were found not doing their job which leads to overwork by other team members (Marie *et al*., 2017).

For the service to be efficiently and effectively provided to mental health establishments, team work is regarded as key in the management of MHCUs. MDTs need to collaborate in the care of the MHCUs. Lack of collaboration amongst team members of health care professionals was found to be the main factor hindering the provision of effective and efficient services to MHCUs (van Hasselt *et al*., 2013).

As long as stigma is still persistent in mental health units, the care of MHCUs will not improve as stigma and discrimination hinder and affect the way health care services supposed to be delivered in the health care setting (Milton, Mullan & Hunt, 2016). Stigma can be in the form of media, health care and public discrimination and it affects the quality of care MHCUs receive when admitted or discharged from the mental health unit (Borelius, Lindhardt & Schalling, 2014).

2.5.3 Institutional-Related Challenges

According to the study done in Bulgaria, one of the MHCUs was assisted by the court of law after being detained and suffered for seven years in a mental health care home. His challenges included unsatisfactory living conditions like insufficient food to eat, dilapidated buildings, toilets not working due to lack of water or blocked, being abused by the providers, and treatment that the user received was seen to be very poor (Laing, 2014).

Shortage of treatment was cited as one of the challenges that MHCUs faced while admitted in mental health establishments. The shortage had a negative impact on the lives of MHCUs as they depend on psychotropic drugs to remain stable and psychiatric medications are the ones reversing their psychosis once they fall into a relapsed state (Iseselo & Ambikile, 2017). The shortage was caused by the hospital not ordering in time the medicine that is required and at times financial constraints contributed to the shortage and it made patients angry at nurses for not issuing the medication (Iseselo & Ambikile, 2017).

Mental services were centralized in the urban-based tertiary mental health establishment far away from their homes and communities and general medical practitioners were not required to take any responsibilities for mental health. Certification of MHCUs was open for abuse by people where anyone who is not related to the patient was allowed to send the user for admission due to jealousy. This made the users when admitted spending a lot of time in the institution and they were not having rights for representations or appeal against the decision for his/her admission (Burns, 2008). Treatment infrastructure issues were challenges at the mental health establishment for CTR. The challenges of infrastructure included lack of venue to conduct the proper assessment to the MHCUs, the unavailability of drugs was

mentioned by several participants as a burning issue as in most cases the drugs to treat mental illness were out of stock in the mental health establishment and health care providers unable to interpret the mental health forms (Musyimi, Mutiso, Ndetei, Unanue, Desai, Patel, Musau, Henderson, Nandoya & Bunders, 2017). The MHCPs also cited the shortage of medical staff to provide quality treatment to the MHCUs.

Infrastructure in mental health establishments is still a challenge in developing countries, including South Africa, and the summit held in 2012 recommended that resources to include infrastructure development in mental health and the country needs to invest more in mental health, as prevention of mental illness can save the country from unnecessary spending on preventable mental illness, hence, reducing the burden of disease on mental illness (Petersen *et al*., 2015).

Infrastructure in mental health institutions is very poor as other hospitals do not even have the facilities for forensic observations which create a problem when the observations cases sent by the Court needs to be assessed properly for 30 days (Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Flisher, 2009). The MHCA requires all the districts and regional hospitals to have a designated 72-hour mental health unit where they will assess and treat or manage the MHCUs before transferring them to the mental health establishment (Petersen, Bhana, *et al*., 2009).

The responsibility of the DoH was clearly stipulated in the Justice Crime Prevention Safety and Security (JCPS) protocol for mental health observation that the DoH is responsible for the provision of beds for forensic observations in a mental health establishment (Justice, 2013), but this is not being done as it is stipulated because there are no designated units for forensic observation, hence, there is the mixing of MHCUs and forensic referrals in the same unit which, in turn, tends to compromise the quality of care provided to both the MHCUs and forensic observations.

The Department of Justice and Constitutional Development (DoJCD) and other stakeholders involved in the management of forensic observation acknowledged the backlogs (Justice, 2013), concerning the cases that are not referred for forensic observation due to poor or lack of infrastructure for such services in South Africa and all the departments committed themselves to work very hard to solve the current matter at hand of mixing forensic observations and MHCUs in the same unit at the mental health establishment. Objective number three of the forensic mental health observation is to reduce delays and unnecessary detention to the MHCUs in the police cell (Justice, 2013).

Mental health service delivery was inconsistent as there is always a shortage of treatment of MHCUs in mental health establishments (Iseselo & Ambikile, 2017). The inconsistency of service delivery brought instability in the care of MHCUs as users were not provided with the proper care they needed as the majority of them stopped taking their treatment and resulted in a high number of relapses and admissions in the mental health establishment (Marie *et al*., 2017).

The shortage of psychotropic medications was acknowledged by the management such as the district mental health coordinator who attested that the shortage of medication is a serious challenge and MHCUs were told to go to the pharmacy and purchase their own medication as there is no continuous supply of medicine in their mental health establishments. It was further mentioned that their reasons for the shortage are the long process of ordering medication and complicated ordering procurement (Iseselo & Ambikile, 2017).

The challenge South Africa is facing is the strengthening of the district health system for the improvement and management of chronic conditions which includes mental health disorders. This will offload the workload from the nurses as there is a shortage

of human resources, including nurses in the primary health care facilities; it will also enable them to pay more attention to the needy clients, who need intervention care like MHCUs and establishment support groups for mental health (Mayosi & Benatar, 2014).

In South Africa, mental illness and culture are regarded a complex issue and psychiatrists are facing different challenges, but still need to accelerate the progress of transcultural medicine that will enable psychiatrists to detect mental illness at an early stage as many patients with mental illness remain undetected because of the traditional beliefs about mental illness. In traditional medicine, the treatment of MHCUs is being offered by the traditional healer and it takes time to stabilize the patient and it will be influenced by values and attitudes of the society as they will be concerned about the person returning to work and this kind of thinking differs with the Western attitudes (Pretorius, 1995)

The distribution of resources must be fair, and managers and policymakers need to be transparent when allocating resources to provinces to avoid favouritism of certain provinces and to increase the number of staff allocated in mental health unit, including nurses (Borelius *et al*., 2014). Continuous up-to-date education to the MHCPs when new policies emerge, they need to be implemented to increase the knowledge of staff members in dealing with MHCUs in the unit (Marie *et al*., 2017). MHCPs need to be taught and encouraged to manage well the scarce resources allocated to them.

2.5.4 Community-Related Challenges

Mental health remains one of the most neglected and under-resourced area in public health, and even though the need is increasing, the mental health research output of is low and is fraught with many demands like poor funding, lack of trained personnel,

little infrastructural support (Sharan, 2007). People with mental health are stigmatized and discriminated against by the family members and significant others, community members and the health sector. The MHCUs are found in the community after being discharged from the institution where they were receiving care, treatment and rehabilitation (CTR). The MHCUs, in general, are not perceived well by the community and they tend not to be managed well due to their vulnerability in the community. They are also stigmatized and discriminated against by the community at large due to their mental illness (Tzouvara & Papadopoulos, 2014).

Stigma and discrimination of mentally ill people or MHCUs also vary according to the culture as revealed by a study conducted in Greece, where the community viewed people with mental illness positively, but perceived them as inferior and with a low social standard. The study further concluded by saying it will be of better practice if anti-stigma campaigns in Greece are established towards MHCUs to dispel the misconceptions the community hold towards MHCUs (Tzouvara & Papadopoulos, 2014). Stigma and discrimination towards mental health programmes is a challenge MHCPs face while working with mentally ill patients. This was found to have a social impact on the carer's life as other MHCPs were ridiculed and called names by society. The stigma extends to MHCUs and their family members for having someone with mental illness in their family (Marie *et al*., 2017). The stigma was found to be the result of a lack of awareness of mental health and mental health not being funded enough and no one in the public wants to work with someone who has a history of mental illness (Borelius *et al*., 2014).

In the 21st century, there are still countries that still hold the belief that mental illness is caused by witchcraft and superstitious powers. Indonesian mental ill patients were chained and shackled in the dark huts by their family members. Families alluded to their actions as a cry for help as the government was not doing anything for them and

they had to take action for their loved ones (Luki, 2016). The causes of mental illness vary according to the perceptions of individuals. A study conducted in Germany found that the public still believes that mental disorders are caused by biological factors, which can be due to brain disease or injury. On the other hand, psychosocial disorders like depressions were said to be caused by life events, stressful relationships and lack of social support (Schomerus, Matschinger & Angermeyer, 2006).

Most of the cultures in the Sub-Saharan countries still believe that mental illness or disorders are caused by supernatural forces, and can be treated through orthodox, spiritual healing or traditional healing. This view only implies that MHCUs will never be taken for Western medicine treatment. It was also found that people with a lower educational background or those who are illiterate preferred traditional or spiritual healers for the treatment of mental illness (Adewuya & Makanjuola, 2015). This was because people with low educational level lack understanding about mental illness.

Families or individuals who had never taken care of a MHCUs preferred traditional healers or spiritual healers, or both, for the treatment of mental illness, and before they can seek Western medicine, firstly they try different pathways to find a solution and compare the treatment options (Adewuya & Makanjuola, 2015). Beliefs and behaviours of families with MHCUs were found to be influenced by values and norms of the community they are residing in, and beliefs impact families seeking treatment in Western medicine because they tend to believe that mental illness is caused by supernatural forces as the community believed.

Other challenges that hinder early identification of mental illness is that people think that genetic factors are the main cause of either schizophrenia or depression, compared with the previous public beliefs that an individual's weak character can contribute to the development of mental disorders (Nakane, Jorm, Yoshioka,

Christensen, Nakane & Griffiths, 2005). When someone lost a close relative through death, it was said to be the cause of depression, but not forgetting the upbringing of the child as it was regarded as a contributor to the development of schizophrenia or depression (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Nakane *et al*., 2005), and it was also found that others have a mental illness because it was the will of God. A person's own bad character was also pointed out as the cause of mental illness and other factors, including alcohol and drug abuse, were found to cause mental illness (Link *et al*., 1999).

Gender also plays a significant role in the beliefs, perceptions or causes of mental illness as it was found that males were the ones who prefer to accompany the MHCU for the treatment either in the traditional or spiritual healer than females (Adewuya & Makanjuola, 2015). The authors asserted that women were viewed as weak and easily affected by mental illness or conditions when compared to males.

The challenges of MHCUs go beyond the mental health unit as others were concerned that they found it difficult to get a job as employers do not want to hire someone who has a history of mental illness. Although the majority mentioned that not being trained makes them fail to compete with others while applying for a job as employers will take those who have qualifications first and users will be told there is no job left for them (Boycott *et al*., 2015).

2.6 Summary

This chapter outlined the literature review that was conducted. The literature review revealed that the care or management of MHCUs in mental health establishments is not good due to poor infrastructure and shortage of staff to deal with MHCUs in different countries. The rights of MHCUs were found not to be observed by service

providers which can be regarded as violations of the MHCA. The literature review also discussed the challenges that MHCUs experience when admitted in mental health establishments. Furthermore, the provider-related, institutional-related and community-related challenges were identified and discussed.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter provided a literature review of mental health disorders from the perspective of different countries, including South Africa. In this chapter, the research methodology will be outlined in detail on how the study was conducted. The philosophical worldview and conceptual framework used in the study are reflected. The study comprises of two phases, i.e., the needs assessment and the development of a strategy. Phase 1 covered the needs assessment and was conducted in three stages, the first two stages ran concurrently in which the qualitative and quantitative approaches were used, whereas the third stage encompassed integration of data. Phase 2 covered the strategy development, validation of the developed strategy and a plan to pilot the developed strategy. The ethical measures applied in study and how the study findings will be disseminated are also stipulated.

3.2 Philosophical Worldviews

The philosophical worldview proposed in this study was pragmatic. The term worldview is defined as a basic set of beliefs that guide an action (Guba, 1990). There is an ongoing debate regarding how researchers hold and apply worldviews and beliefs in their research designs. Four types of worldviews are extensively discussed in the literature, viz., post-positivism, constructivism, transformative and pragmatic worldviews. However, in this study, the pragmatic worldview was used as it focuses on both qualitative and quantitative methods.

It is the philosophical worldview that underpins mixed methods research (Creswell & Clark, 2018). In this study, pragmatic worldview was chosen because the convergent parallel mixed method was used to collect both qualitative and quantitative data. As a pragmatist, the researcher did not view the world as an absolute unit, hence, there was a need to conduct the study using both qualitative and quantitative methods (Creswell & Clark, 2018).

3.3 Conceptual Framework

The PRECEDE-PROCEED model was used as a conceptual framework that guided the study (Green & Kreuter, 2005). The PRECEDE model or framework was developed in the 1970s. The acronym PRECEDE stands for Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation. As its name spells out, it represents the process that usually leads to or precedes an intervention. In 1991, PROCEED was added to the framework to recognize the importance of environmental factors as determinants of health and health behaviours and it stands for Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development. The PRECEDE-PROCEED model is more of a streamline and it consists of eight phases (Green & Kreuter, 2005) as indicated in Figure 3.1.

The PRECEDE components of the PRECEDE-PROCEED model, guided the needs assessment which was Phase 1 of the study. In the PROCEED components, only Phase 5 was used to guide the development of the piloting plan for the developed strategy. The researcher felt that it would be better to start with pilot to assess the feasibility of the developed strategy and make a necessary adaptation. The Diffusion of Innovation Theory (DIT) was incorporated in the development of the strategy which is not part of the PRECEDE-PROCEED model. The DIT considered the criteria to be

used when developing the innovation (The Strategy). DIT is one of the oldest theories developed by Rogers (2010), who discerned that innovation needs to be adopted by individuals.

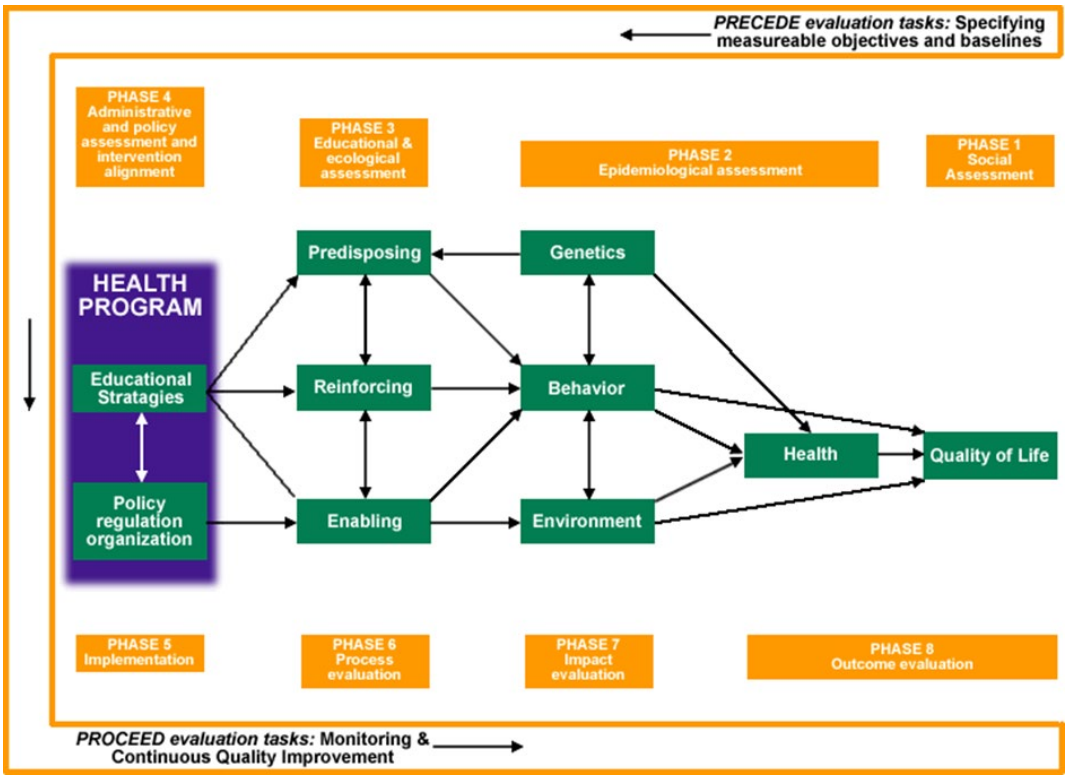

Figure 3.1: PRECEDE-PROCEED planning model adapted from Green & Kreuter (2005).

3.4 Phases of the Study

The study comprises of two phases, i.e., the needs assessment and development of a strategy arranged according to the objectives. The summary of the phases, the component of the conceptual framework, objectives and methods are displayed in Table 3.1.

3.4.1 Phase 1: Needs Assessment

This phase covers the needs assessment and was conducted in three stages, the first

two stages ran concurrently (qualitative and quantitative) and in the third stage integration of data were done.

Table 3.1: Summary of phases, objectives and methods

Phases	**Phase 1**		**Phase 2**	
Conceptual Framework/Theory	**PRECEDE**		**DIT**	**PROCEED**
Objective	Conduct needs assessment		Develop strategy	Develop a plan for Piloting the developed strategy
Design	Convergent parallel mixed methods		Workshop	
Population	**Qualitative**	**Quantitative**	Mental Health Forum	
	MHCPs and MHCUs	MHCPs		
Sampling	Purposive	Convenient sampling	Purposive	
Data collection	Interviews	Self-administered questionnaire	Workshops to review documents (policies, reports)	
Data analysis	Tech methods	Descriptive statistics		

This phase covered the first objective:

- To explore the views and experiences of MHCPs and MHCUs related to provision of care, treatment, rehabilitation, and rights of MHCUs in the mental health care establishments in Limpopo Province.

3.4.1.1 Study Design

A mixed methods approach was used in this study. According to Creswell (2014), mixed methods research is an approach to inquiry that involves the collection of both qualitative and quantitative data, two forms of data being integrated, and using

different designs that may involve philosophical assumptions and theoretical frameworks. In this study, mixed methods research assisted in describing the identified mental health challenges in mental health establishments in Limpopo Province. The two methods combined produced a better and clearer picture of the mental health challenges than using a single research approach.

Several authors (Creswell & Creswell, 2017; DeVos *et al*., 2011; Driscoll, Appiah-Yeboah, Salib & Rupert, 2007; McBride, MacMillan, George & Steiner, 2018) have described the vitality of using mixed methods research as the identified health problem could be solved by combining both qualitative and quantitative approaches in one study. The method was appropriate for this study because the researcher was interested in developing a strategy to promote the management of mental health services in Limpopo Province. The approach helped to answer questions that could not be answered by quantitative or qualitative approaches alone and provides strengths that offset the weaknesses of both qualitative and quantitative research.

The study employed the convergent mixed methods design in this phase. Convergent, parallel mixed methods is a form of mixed methods design in which the researcher implemented qualitative and quantitative strands concurrently with the purpose of comparing or merging quantitative and qualitative data in order to provide a comprehensive analysis of the research problem (Creswell & Clark, 2018).

In this study, the researcher typically collected both forms of data roughly at the same time and then integrated the information in the interpretation of the overall results as shown in Figure 3.2. Priority was given to both methods (qualitative and quantitative) and each method addressed related aspects of mental health care services in Limpopo Province in a complementary manner. The merging or integration of the two methods, therefore, occurred after the analysis of data in both study strands. The

results from both approaches were then compared and synthesized to produce a more comprehensive understanding of the research problem.

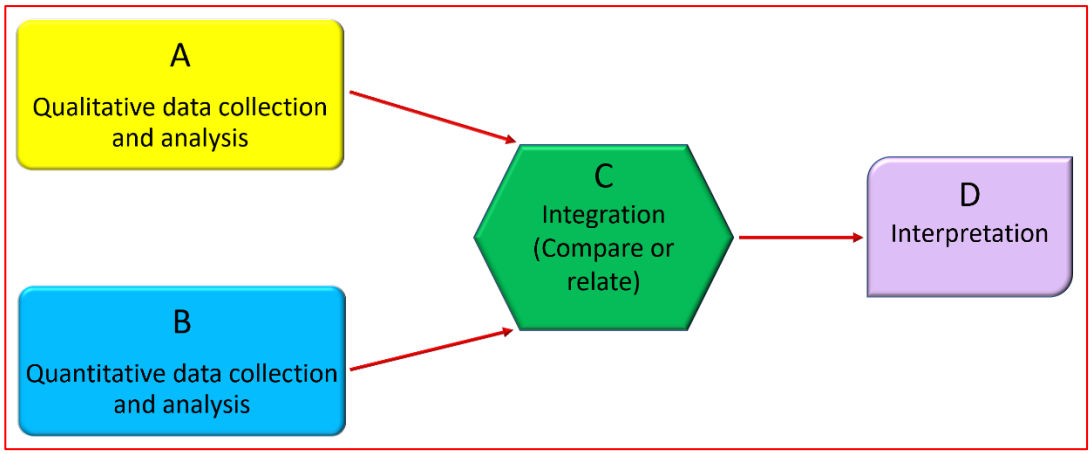

Figure 3.2: Convergent parallel mixed method design. Adapted from Creswell (2014).

Figure 3.3 displays a schematic of research activities and procedures applied in this study. The phase comprises of three stages; qualitative, quantitative and integration of data, as mentioned above.

3.4.1.1.1 Stage 1: Qualitative Approach

The qualitative approach addresses the first two objectives as outlined above. Qualitative research is described as a systematic, subjective and interactive approach that is used to investigate, explore, describe and understand life experiences; and it also gives meaning to them in an in-depth and holistic fashion, through a collection of rich narrative materials (Creswell, 2013).

Qualitative research methods were used in this study to explore the views and experiences of MHCPs and MHCUs in mental health delivery in mental health establishments in Limpopo Province. The researcher wanted to get an understanding of problem to develop a strategy.

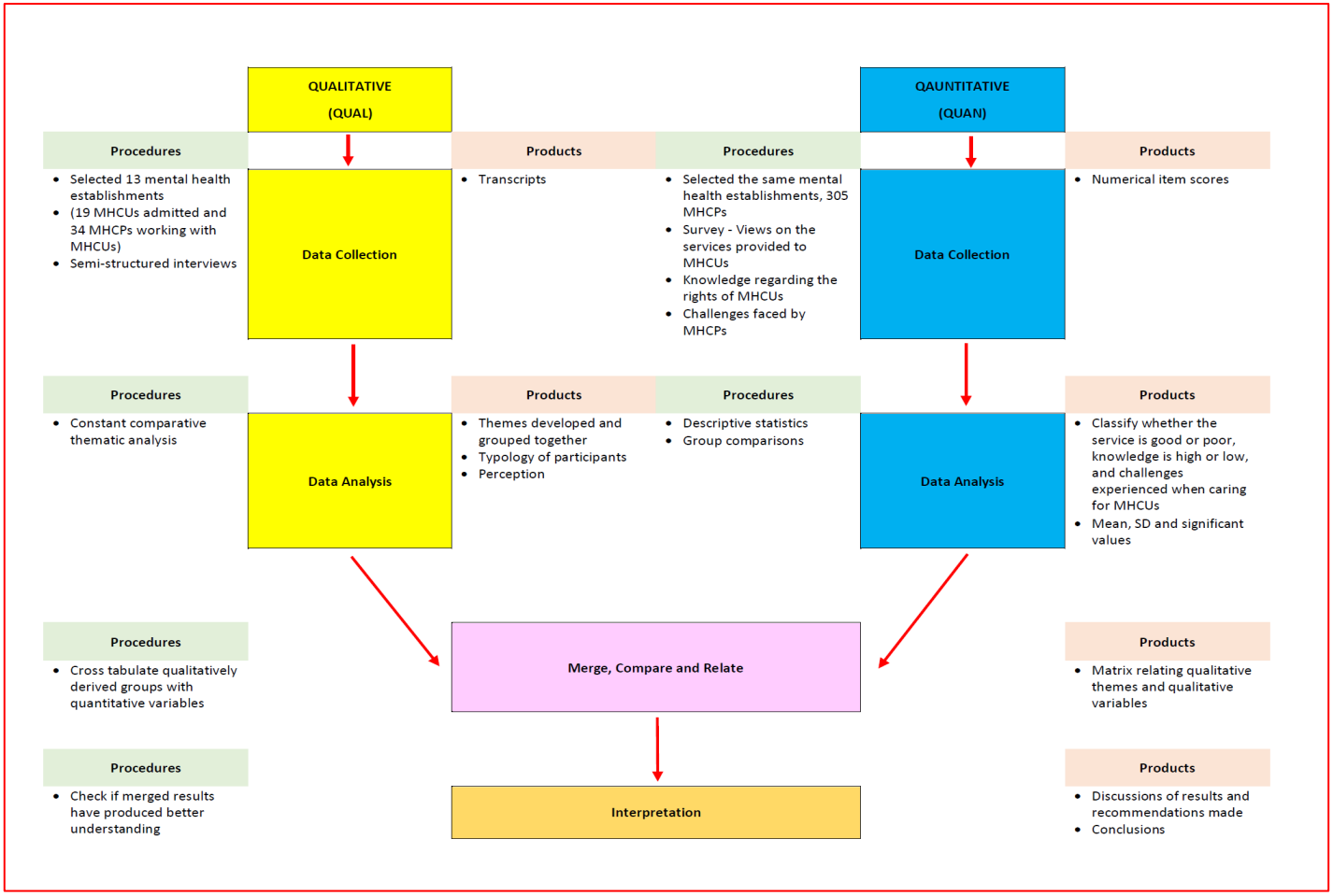

Figure 3.3: Schematic presentation of activities procedures applied.

❖ Study Design

Explorative, descriptive and contextual designs were used.

▲ *Explorative Design*

The explorative study assisted in exposing a relatively unknown research section to gain insight on the views and experiences on the delivery of mental health services in mental health establishments in Limpopo Province. The explorative design enabled the researcher to collect in-depth information (Delport & Fouché, 2011).

▲ *Descriptive Design*

A descriptive design clarified the myths that individuals had about the promotion of the provision of effective management of mental health services (Grove, Burns & Gray, 2013; Polit & Beck, 2012a). This design enabled the researcher to conduct an intensive examination of the phenomenon, that is, the provision of effective management of mental health users in mental health establishments. It also gave a picture of the specific details of a circumstance, giving answers to how mental health services can be promoted and managed effectively in mental health establishments as compared to the current state (Plonsky, 2015).

▲ *Contextual Design*

The MHCPs as participants in this research were interviewed within their environmental setting, that is, at the hospital where they provided or rendered mental health services. Participants were allowed to express their views, experiences and the reality of what was happening in the provision of mental health services in their units.

❖ Study Setting

The setting of research is defined as the geographical location and other related

conditions where the study will take place and data will be collected during the research process (Polit & Beck, 2010). The research study was conducted at the selected mental health establishments (hospitals) in Limpopo Province. The Province is divided into five districts, namely, Mopani, Sekhukhune, Vhembe, Capricorn and Waterberg, of which Mopani, Vhembe, and Sekhukhune are the most rural.

Limpopo Province comprises 464 outpatient mental health clinics, 29 day-treatment centres, 9 mental health establishments, 3 community residential facilities, and 3 mental health establishments designated to provide and accommodate MHCUs, one each in Mopani, Vhembe and Capricorn districts (Lund *et al*., 2010). Almost all of the 40 hospitals in Figure 3.4 are gazetted to conduct 72-hour observations and provide care, treatment and rehabilitation (CTR) of the MHCUs who only need to be admitted for 72 hours before they are transferred to the hospital designated to provide CTR. The two mental health establishments in Vhembe and Capricorn are designated to provide forensic observations and provide short- and long-term management of MHCUs, including state patients. The institution in Mopani District admit both short-term and long-term acutely ill MHCUs, and state patients, but without conducting the forensic observations due to structural challenges.

The study focused only on institutions that conduct observations (72-hour observation and forensic) and admits state patients, including chronic mental health users. The reasons for only focusing on these institutions were that district and regional hospitals admit MHCUs and conduct 72-hour observations. Regional hospitals are regarded as a referral institution from District hospitals and the staff complement is high with at least one MHCP who has a speciality in Forensic Nursing or Psychiatric Nursing (Advance Psychiatric Nursing Science). While the specialized mental health establishment is used as a referral from all institutions when they have failed to manage the MHCUs and their resources cannot accommodate CTR of the MHCUs.

The staff distributions for each mental health establishment is summarized in Table 3.2.

Figure 3.4: A map portraying the hospitals in Limpopo Province.

❖ Study Population

The study population consisted of all MHCPs (Psychiatric Nurses) and MHCUs (Patients who were stable during data collection) in all selected mental health establishments in Limpopo Province.

Table 3.2: Summary of staff distribution in mental health establishments

District	Hospitals		Staffing per unit						
	Type of hospital	Hospital	Total	Psych nurses	Doctors	Clin Psych	Social worker	OT	Total
Capricorn	Specialized	Thabamoopo	3	204	5	1	2	1	9
	District	Helen Franz	6	14	1	0	1	0	2
		Lebowakgomo	7	12	1	0	1	1	3
		Seshego	6	15	1	0	1	1	3
		W.F Knobel	5	11	1	0	1	1	3
		Zebediela	3	09	1	0	1	1	3
	Tertiary	Makweng	5	11	1	1	1	1	4
		Pietersburg	8	14	1	1	1	1	4
Vhembe	Specialized	Hayani	4	196	7	0	1	1	9
	Regional	Tshilidzini	14	26	1	0	1	2	4
	District	Siloam	38	54	2	0	2	2	6
		Malamulele	32	46	1	0	1	2	4
		Elim	7	17	1	1	1	1	4
		Lous Trichard	1	5	1	0	1	1	3
		Messina	3	9	1	0	1	1	3
		Donald Fraser	26	38	1	0	1	1	3
Mopani	Specialized	Evuxakeni	3	113	4	1	2	2	9
	Regional	Letaba	40	56	1	1	1	2	5
	District	Kgapane	6	14	1	0	1	1	3
		Maphutha Malatji	4	14	1	1	1	1	4
		Nkhensani	8	20	1	1	1	1	4
		Sekororo	6	14	1	0	1	1	3
		Van Velden	4	10	1	0	1	1	3
Sekhukhune	Regional	Philadephia	16	34	1	0	1	1	3
		ST Rita	22	36	1	0	1	1	3
	District	Dilokong	6	14	1	0	1	1	3
		Groblersdal	5	10	1	0	1	1	3
		Jane Furse	4	10	1	0	1	1	3
		Matlala	5	11	1	0	1	1	3
		Mecklenburg	3	09	1	0	1	1	3
Waterberg	Regional	Mokopane	20	35	1	1	1	1	4
	District	Ellisras	4	8	1	0	1	1	3
		F.H Odendaal	5	9	1	0	1	1	3
		George Masebe	5	13	1	0	1	1	3
		Thabazimbi	6	14	1	0	1	1	3
		Voortrekker	4	10	1	0	1	1	3
		Warmbaths	5	11	1	0	1	1	3
		Witpoort	3	08	1	0	1	1	3
Total		**40**	**500**	**1288**	**52**	**9**	**41**	**42**	**135**

Psych nurses: psychiatric nurses; Clin Psych: clinical psychologist; OT: occupational therapist
Source: Limpopo Province Monthly Mental Health Statistics (DoH, 2017)

❖ Sampling

Sampling is a way of selecting a group of people, events, behaviours or other elements with which to conduct a research study (Grove *et al*., 2013; LoBiondo-Wood & Haber, 2011). A multistage sampling was conducted to sample hospitals and participants.

▲ *Sampling of Hospitals (Mental Health Establishments)*

Non-probability purposive sampling was used to select the mental health establishments. Purposive sampling is where the researcher consciously selects certain elements, events or incidents to be included in the research. The researcher selected hospitals with high admission rates (Grove *et al*., 2013). Since mental health services are provided in almost all the hospitals, the researcher selected 11 hospitals of the total number of hospitals and purposively selected the 2 specialized mental health establishment that only admits MHCUs in Limpopo Province.

The hospitals were selected based on a high admission number of MHCUs (DoH, 2017) (Table 3.3) are as follows: Vhembe District (Siloam, Elim Hospital, Tshilidzini Hospital and Malamulele Hospital); Sekhukhune District (St. Rita Hospital, Matlala Hospital and Philadephia Hospital); Capricorn District (Makweng Provincial Hospital); Mopani District (Letaba Hospital and Nkhesani Hospital); and Waterberg District (Warmbaths Hospital). The two specialized mental health establishments, namely, Evuxakeni Hospital in Mopani District, and Hayani Hospital in Vhembe District were purposely selected. A total of 13 hospitals were selected for this the study.

▲ *Sampling of MHCPs and MHCUs*

The purposive sampling method was also used to select psychiatric nurses working in mental health establishments, however, only 34 MHCPs participated in the study. The researcher purposively selected 19 MHCUs, two, sometimes three users per

mental health establishment who were admitted in the mental health unit during the data collection process, based on their mental stability. Purposive sampling was appropriate and relevant to the study as the researcher needed to select information-rich cases or those cases that were informative about the purpose of the study.

▲ *Inclusion and Exclusion Criteria*

In order to be included in the study, the MHCP was supposed to have had at least one year of experience working in the mental health, observation unit or maximum-security ward in the selected facility. The MHCUs who formed part of the study were those who were stable during data collection. Exclusion criteria were all MHCUs and MHCPs who did not meet the inclusion criteria

▲ *Instrument*

The researcher was the primary instrument in data collection in qualitative research. Face-to-face unstructured interview guides (Annexure K for MHCPs and Annexure L for MHCUs) were used in data collection. The following central questions were used in the guides of the MHCPs and MHCUs. The central question for MHCPs was:

> *Can you share with me your views and experiences of mental health services provision in mental health establishments?*

and for MHCUs:

> *Can you share with me your views and experiences on the mental health services delivery in mental health establishments?*

The interview guides also contained probing questions that were intended to elicit views and experiences from the participants (Creswell, 2014).

Table 3.3: Summary of mental health care user admissions 2017

District	Type of hospital	Hospital	MHCU admissions/month
Capricorn	Specialized	Thabamoopo	3
	District	Helen Franz	6
		Lebowakgomo	7
		Seshego	6
		W.F Knobel	5
		Zebediela	3
	Tertiary	Makweng	5
		Pietersburg	8
Vhembe	Specialized	Hayani	4
	Regional District	Tshilidzini	14
		Siloam	38
		Malamulele	32
		Elim	7
		Lous Trichard	1
		Messina	3
		Donald Fraser	26
Mopani	Specialized	Evuxakeni	3
	Regional	Letaba	40
	District	Kgapane	6
		Maphutha L Malatji	4
		Nkhensani	8
		Sekororo	6
		Van Velden	4
Sekhukhune	Regional	Philadephia	16
		ST Rita	22
	District	Dilokong	6
		Groblersdal	5
		Jane Furse	4
		Matlala	5
		Mecklenburg	3
Waterberg	Regional	Mokopane	20
	District	Ellisras	4
		F.H Odendaal	5
		George Masebe	5
		Thabazimbi	5
		Voortrekker	4
		Warmbaths	6
		Witpoort	3
Total		**40**	500
Source: Limpopo Province Monthly Mental Health Statistics (DoH, 2017)			

▲ *Pre-Test*

The pre-test of the tool was conducted before the main study started to check if the information received from participants was relevant to the objective of the study. The pre-test assisted in checking if adaptations of the instrument were necessary and providing better understanding on how to probe during the interview so that important information will not be missed during the main study. To pre-test the instruments, 2 MHCPs and 2 MHCUs were interviewed individually. The first participant interview took more than an hour, then more probing questions were prepared to direct the conversation. The results of the pre-test were also included in the main study.

▲ *Data Collection*

Data were collected from participants using in-depth individual face-to-face interviews. The main central question guided the conversation followed by probing questions for more information. The three phases of data collection were followed during the research study which were the preparatory, interview and post-interview phases.

▲ *Preparatory Phase*

The preparatory phase refers to the planning for data collection, the discussion between the researcher and participants before the actual phase of the interview is conducted (De Vos, Strydom, Fouche & Delport, 2011). The preparatory phase followed institutional ethical clearance and permission to access mental health establishments from the DoH and relevant authorities. The researcher has worked together with the chief executive officers and operational managers of the mental health units to select the stable MHCUs and MHCPs who had Psychiatric Nursing Science credentials and who agreed to participate. Appointments were secured with the participants for a suitable date and time for data collection.

▲ *Interview Phase*

The interview phase refers to the beginning of a conversation between the researcher and a participant with the specific objective of gathering information about a topic that is being researched (Englander, 2012). During the meeting between the researcher and the participants, the researcher created an environment that was favourable for conversation by warmly thanking the participants for their willingness to be recruited and implying that s/he is an expert in the topic of the interview. The researcher explained the purpose of the interview to the participants and made sure that all ethical measures were applied. Permission to use a voice recorder was requested and granted by participants. The researcher showed participants the stop button on the audio recorder so that they can press it if they did not want the information to be recorded. Field notes were taken by the researcher and served as a backup for data collected, nonverbal information was captured, and no confidential information was tendered as participants had never switched off the tape recorder during data collection. Data saturation was reached at participant number 29 for MHCPs, while for MHCUs it was reached at participant number 14, but the researcher added 5 more participants for each category, however, no new information surfaced (Creswell & Poth, 2016).

▲ *Post-Interview Phase*

The post- interview refers to the time after the actual interview between the researcher and the participants (Englander, 2012). When the interview was over, the researcher punched out the record tab, listened to the recorded interviews and checked for audibility and completeness. All data recorded were carefully labelled with identification numbers with the date of data collection. The data collection process is summarized in Table 3.4.

Table 3.4: Qualitative data source

General Type?	Who/What?	How Many?	Comments
Individual Interviews (unstructured interviews)	MCHPs working at a mental health establishment	34 (purposively selected 13 in mental health establishments)	The central question was: **What are your views and experiences of mental health service delivery in mental health establishments?**
Individual Interviews (unstructured interviews)	MHCUs admitted at the mental health establishment	19 (purposively selected 13 in mental health establishments)	No existing survey, the researcher developed the survey. The central question was **What are your views and experiences on mental health service delivery in mental health establishments?**

❖ Data Analysis

Data analysis refers to the systematic organization and synthesis of research data, conducted to reduce, organize, and give meaning to the data (Burns & Grove, 2010; Polit & Beck, 2012a). Transcribed interviews for MHCPs were done before analysis, however, for MHCUs data were transcribed and translated into English. Data were analyzed by the researcher and coded by an independent coder through the use of Tesch's eight steps of open-coding (Creswell, 2014):

▲ *Step 1*

Get a sense of the whole. The researcher read all the transcriptions carefully and even jotted down some ideas as they came to mind as it happened during the interview.

▲ *Step 2*

The researcher picked one document (one interview), the most interesting one, the shortest, and the one that was on top of the pile. The researcher went through it; not thinking about the substance of the information, but its underlying meaning. The researcher wrote thoughts in the margin.

▲ ***Step 3***

After the researcher has completed the task for several participants, the researcher made a list of all topics. The researcher clustered similar topics into columns.

▲ ***Step 4***

The researcher took the list of all topics and returned to the data. The researcher abbreviated the topics as codes and wrote a code next to the appropriate segments of the text, and tried the preliminary organizing scheme to see if new categories and codes emerge.

▲ ***Step 5***

The researcher found the most descriptive wording for the topics and turned them into categories. The researcher reduced the total list of categories by grouping topics that relate to each other and drew lines between the categories to show interrelationships.

▲ ***Step 6***

The researcher made a final decision on the abbreviation for each category and alphabetized each code.

▲ ***Step 7***

The researcher then assembled the data material belonging to each category in one place and performed a preliminary analysis.

▲ ***Step 8***

Records of the existing data and direct quotations by the participants were used to support each theme, category and subcategory. An independent external coder was

used to check the themes and subthemes.

❖ Measures to Ensure Trustworthiness

Trustworthiness refers to the degree of confidence qualitative researchers have in their data. Data are assessed using criteria of credibility, dependability, conformability and transferability (Polit & Beck, 2012a). In this study, the trustworthiness of data was ensured by using the following criteria:

▲ *Credibility*

Credibility refers to confidence in the truth of data and interpretation of such data (Polit & Beck, 2010). In this study, credibility has been achieved by ensuring that the population was accurately identified based on their knowledge regarding the phenomenon under study. Furthermore, credibility was achieved as the researcher remained in the field during data collection for a long time until saturation has been reached. Using a variety of sources in data collection refers to triangulation, which was also achieved by ensuring that the research topic or problem in question was fully explored using in-depth face-to-face interviews with the participants. Prolonged engagement, for eight months in the field and member checking were ensured.

- ***Prolonged Engagement***

Prolonged engagement refers to the investment of sufficient time during data collection to have an in-depth understanding of the group under study as it will enhance credibility (Polit & Beck, 2010). The researcher met with the participants in the hospital settings where they worked and introduced himself, explained the procedure and secured an appointment for data collection that was convenient for them. All these were done in order to establish rapport and build trust. Data were collected on the appointment date set and agreed upon, and participants were

interviewed to the point where data saturation was reached.

- ***Member Checking***

Member checking means that the researcher provides feedback to study participants about emerging interpretations and obtains their realities (Polit & Beck, 2010). In this study, member checking was done by going back to the mental health establishments whereby the preliminary findings of the research were discussed with the participants. Eight participants were reached to confirm if what has been captured is a true reflection of what they said during the interview. The researcher showed the transcripts of dialogues in which they have participated, to ensure that their words as recorded by the voice recorder matched what they intended.

▲ ***Dependability***

Dependability refers to the stability (reliability) of data over time and conditions, that is, if the work was to be repeated, in the same context, with the same methods and with the same participants, similar results would be obtained (Polit & Beck, 2010). The processes within this study were reported in detail, reflecting in-depth coverage of the proper research practices followed. This has enabled the readers of the research report to develop a thorough understanding of the methods and their effectiveness.

▲ ***Confirmability***

Confirmability refers to objectivity that is the potential for congruence between two or more independent people about data accuracy, relevancy, or meaning (Polit & Beck, 2008). This was ensured by having an assistant transcribing the same data and then by checking for agreement. Shortcomings in the study methods and the potential effects thereof were recognized. An in-depth methodological description was done to allow the integrity of research results to be scrutinized.

▲ ***Transferability***

According to Polit & Beck (2008), transferability refers essentially to the generalizability of the data—this is the extent to which the findings can be transferred to or have applicability in other settings or groups. Provision of background data to establish the context of the study and detailed description of the phenomenon in question was done to allow comparisons to be made. Transferability was also achieved by ensuring the complete description of sampling methods, how data were collected and analysed, and the use of the independent coder. Furthermore, transferability was achieved using the thick description of the nature of the study participants and their experiences in the study in question. The researcher also made observations during the conduction of the interviews.

3.4.1.1.2 Stage 2: Quantitative Approach

Quantitative research is an inquiry into a problem where findings are measured and analyzed statistically. It is a systematic collection of numerical information where statistical procedures are being used (Grove *et al*., 2013). In this study, an enquiry was made on the views and experiences of MHCPs caring for MHCUs in Limpopo Province. A quantitative approach was used to achieve the second objective which was to explore the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province. The specific objectives of Stage 2 were to:

- Describe the views of mental health service providers regarding the care being provided to MHCUs in their hospitals/facilities in Limpopo Province;
- Determine knowledge and awareness of MHCPs regarding the rights and privileges of the patients during admission and stay in a mental health establishment;

- Describe the challenges faced by the MHCPs during their daily work activities in Limpopo Province; and
- Discuss the views of the MHCPs on how these services rendered to MHCUs can be improved.

Study Design

A cross-sectional descriptive study design was used to get the picture of mental health management in mental health establishments in Limpopo Province. This enabled the researcher to conduct an intensive examination of the phenomenon, that is, the provision of effective management of MHCUs in mental health establishments. The study design assisted by giving the researcher a picture of the problems or challenges on the delivery of mental health services in mental health establishments in Limpopo Province (O'Dwyer & Bernauer, 2013).

Study Setting

The study setting was the same as presented in the qualitative approach described in Stage 1 (Figure 3.4).

Study Population

The population were MHCPs who provided care to MHCUs in all selected mental health establishments in Limpopo Province.

Sampling Method

A convenient sampling was used to select the MHCPs. The MHCPs were divided into two subcategories, viz., clinicians (medical doctors, psychiatrists, psychiatric nurses and clinical psychologists) and allied health staff (occupational therapists and social workers) who provided CTR of MHCUs in all selected mental health establishments.

The researcher used convenient sampling because the population were available and willing to participate in the study during data collection in selected mental health establishments in Limpopo (Table 3. 5).

▲ *Inclusion Criteria*

To be included in the study, the respondent had to meet the following criteria:

- ❄ The MHCP had at least one year of experience working in the 72-hour observation unit, maximum security ward or mental health unit in the selected facility;
- ❄ Available for participation on the day of data collection; and
- ❄ The participant gave consent to participate in the study.

▲ *Exclusion Criteria*

- ❄ All other health professionals providing care that is not linked to CTR of MHCUs, including enrolled and registered nurses without psychiatric nursing.

▲ *Sample Size*

The sample size was calculated using Slovin's formula (Ellen, 2012), where n is the participant sample size, N is the population (1423) and e the accepted level of error which was 0.05.

$$n=N/ (1+ (Ne^2))$$

$$n=1423/ (1+ (1423X0.05^2))$$

n=1423/ (1(1423X0.0025))

n=1423/ (1+ 3.6)

n=1423/ 4.6

n=309

The researcher added 10% to the above total in anticipation of non-responses and the total size was 339 as a precautionary measure.

▲ *Sampling of Respondents*

A convenient sample of 339 respondents was selected to participate in the study (Table 3.5). The researcher selected one medical doctor in all selected mental health establishments, except for specialized mental health establishment where 13 doctors were selected. Clinical psychologists are regarded as scarce skills, only 8 were selected, 4 were from the general mental health establishments and the other 4 from specialized mental health establishments. One occupational therapist or social worker was selected from the mental health establishment, while the rest were selected from the specialized mental health establishment, including the physiotherapist and dietician who were only found in mental health establishments. Nurses form the critical mass in the health system mental health provision, therefore, were supposed to be highly represented. A total of 238 Psychiatric Nurses were selected and the high distribution 130 respondents per specialized mental health establishments, whereas 5 respondents were from each general mental health establishments. Table 3.5 provides a summary of respondents in mental health establishments in Limpopo Province.

Table 3.5: Respondents in mental health establishments in Limpopo Province 2017

MHCP Category	Total	Male	Female
Doctors	37	17	20
Clinical Psychologists	8	3	5
Social Workers	26	10	16
Occupational Therapists	25	16	9
Psychiatric Nurses	238	134	104
Total	**339**	**180**	**159**
Source: Limpopo Province Monthly Mental Health Statistics (DoH, 2017)			

▲ *Instrument*

A questionnaire (Annexure M) was used to collect data from MHCPs in all selected mental health establishments in Limpopo Province. The questionnaire was developed by the researcher after an extensive literature search regarding the CTR of MHCUs. The questionnaire was coded for easy capturing. The language used was English as all respondents were professionals and they understood English, the type of questions used was closed-ended, including open-ended, and the Likert scale type of questions were also used to assess the views of mental health service providers (MHCPs) regarding the care being provided to MHCUs in their hospitals/facilities.

The questionnaire consisted of four sections: Section 1 was about demographic data of the respondents; Section 2 was about the views and experiences of service providers (MHCPs) caring for MHCUs; Section 3 was about the knowledge of MHCPs regarding the rights and privileges of MHCUs while admitted in the mental health establishment; Section 4 was about the challenges MHCPs faced daily while providing care to MHCUs in mental health establishments in Limpopo Province. The questionnaire took approximately 30-45 minutes to be completed.

❖ Pre-Test

The questionnaire was pre-tested with 30 MHCPs from Sekhukhune District to check if it will produce the desired results. The MHCPs were distributed as follows: 6 occupational therapists, 3 medical doctors, 7 social workers, and 14 psychiatric nurses. The 30 MHCPs who participated in the pre-test were selected outside the selected mental health establishments, although in the same setting. The results showed that the tool needed to be adjusted, by adding the code, years of experience and rights of MHCUs when admitted in mental health establishments and the results were used to modify the data collection tool. All 30 respondents were not included in the main study. Two research assistants were trained on how to administer the tool to the respondents, and they both participated in the distribution of questionnaires during the pre-test and the main study.

▲ *Data Collection Method*

Permission was requested from the relevant authorities to see the respondents during their convenient time and informed consent was obtained before data collection. A total of 339 questionnaires were distributed to MHCPs to complete. However, only 305 returned the completed questionnaires. The MHCPs were given questionnaires to complete by the researcher and the two research assistants about the views and experiences of mental health service delivery in mental health establishments in Limpopo Province from July 2018 to February 2019. The data collection is summarized in Table 3.6.

▲ *Data Analysis*

Statistical analyses need raw data to be captured in a numerical code or numbers depending on how data will be collected (Brink, Van der Walt & Van Rensburg, 2013; De Vos *et al*., 2011).

Table 3.6: Quantitative data source

General Type?	Who/What?	How Many?	Comments
Surveys (Questionnaires)	MCHPs working at a mental health establishment	339 (Purposively selected in13 mental health establishments)	The researcher developed the questionnaire. The questionnaire contained the following information: the demographic characteristics of respondents, Views of mental health service providers (MHCPs) regarding the care being provided to MHCUs in their hospitals/facilities, Views on the provision of mental health services and MHCPs relationship with MHCUs, Knowledge of MHCPs regarding the rights and privileges of MHCUs during admission and stay in a mental health establishment, Experiences of MHCPs during their daily work activities in mental health establishments in Limpopo Province

The coded questionnaire was used to capture the raw data and data were analyzed using the Statistical Package for Social Sciences (SPSS) version 26.0 as the questionnaire was numbered and coded. Data were analyzed and presented in frequencies and percentages to describe the experiences of MHCPs of mental health service delivery in mental health establishments. The results were summarized in the form of tables and charts. An interpretation in quantitative research means that the researcher concludes the results for the research and the larger meaning of the results (Creswell, 2014).

❖ Validity and Reliability

▲ *Validity*

Validity is the degree to which an instrument measures what it is intended to measure while reliability is the degree of consistency or dependability with which an instrument measures an attribute (De Vos *et al*., 2011; Polit & Beck, 2012a). The statistician and language expert checked the questionnaire for external validation before it was used.

The validity of the instrument was established in two ways, namely, face validity and content validity.

▲ *Face Validity*

According to Jolley (2020), face validity refers to whether the instrument appears to measure what it is supposed to measure, based on an intuitive judgment made by experts in the field. The questionnaire was presented to the supervisors, at departmental seminars, and the university's higher degrees committee, to assess its appropriateness. The instrument was modified according to the feedback received. The instrument met the objectives, since questions in all sections were meant to determine experiences in mental health service delivery in mental health establishments in Limpopo Province.

▲ *Content Validity*

Content validity is an assessment of how well the instrument represents all the components of the variable to be measured (Jolley, 2020). To test for content validity, the questionnaire was constructed after an extensive literature review using different internet search engines. The instrument was presented at several research seminars, to evaluate the content validity. Among the panel, were supervisors and lecturers from the Department of Health Sciences. The feedback was used to modify the instrument. Finally, the researcher conducted the pre-test from the respondents who did not form part of the study, though from the same setting.

▲ *Reliability*

According to Jolley (2020), reliability of data-collection instruments is the degree to which the instrument can be depended upon to yield consistent results, if used repeatedly over time on the same person or used by two researchers, and refers to

the accuracy and consistency of information obtained in the study. The reliability of the instrument was established through a pre-test. The researcher used the test-retest reliability method to determine how reliable the instrument was. The instrument was administered to one group of 30 respondents twice at different times, after two weeks apart to check if the instrument would yield the same results. After the test-retest, the instrument was edited, and few items were added, like codes for the gender, district and years of experience. The same questionnaire was used for all groups that were involved in the study. It was also used the same way for all 305 respondents in the study.

3.4.1.1.3 Stage 3: Integration (Compare or Relate)

The researcher merged or integrated the results of the study by doing side-by-side comparison of both qualitative (themes) and quantitative data (statistical findings) that either confirmed or refuted the statistical results. Qualitative data were presented on the left, and then quantitative data presented on the right and compared to check if the themes from qualitative yielded the same results from the quantitative statistics. The last step was for the researcher to merge the two data strands in a complementary manner, followed by a discussion of the results.

3.4.1.1.4 Interpretation

The interpretation was detailed in the discussion of the research study results (Chapter 6). The report encompassed the analyses of the two datasets, i.e., qualitative and quantitative data. The researcher was able to note the convergence between the two sources of information where qualitative results were confirming quantitative results (Creswell, 2014). The researcher found that the information from qualitative and quantitative yielded the same results where the two methods converged. Transcripts from quantitative data and themes developed from qualitative data

analysis yielded the same results. The integration phase is shown in Table 3.7.

Table 3.7: Convergent design matrix

COMPONENTS	PROCEDURES	PRODUCTS
QUALITATIVE ❄ What are the experiences of mental health service delivery in mental health establishments?	❄ Data collected through individual interviews where an unstructured interview guide was used for MHCPs working at the mental health establishments and MHCUs admitted at the mental health establishment.	❄ Transcribed interviews were analyzed by the researcher and coded by an independent coder through the use of Tesch's eight steps of open-coding, as described in Creswell (2014).
QUANTITATIVE	❄ Data collected using an open-ended questionnaire from MHCPs working at the mental health establishment	❄ Data analyzed using the SPSS using descriptive statistics ❄ n=305 (13 mental health establishments or designated forensic observations institutions/ 72-hour observations were purposively selected) ❄ The analysis approach was parallel while merging the respective analysis results (Comparing from side-to-side)
INTEGRATION OF RESULTS	❄ The integration involved merging the results from the individual interviews from MHCUs and MHCP, and questionnaires with mental MHCPs to make the comparison clearer and more understandable than what was presented by one method alone either qualitative or quantitative.	❄ Interpretation of results ❄ Discussion of results ❄ Recommendations made according to the results ❄ Conclusion

3.4.2 Phase 2: Strategy Development, Validation and Development of a Pilot Plan

This phase comprised of three stages: strategy development, validation and development of a pilot plan. The objectives in Phase 2 were to: develop a strategy to promote the management of mental health services in Limpopo Province, develop a plan to pilot the developed strategy for managing mental health services in Limpopo Province.

3.4.2.1 Stage 1: Strategy Development

An existing mental health forum consisting of MHCPs (psychiatric nurses, occupational therapists, social workers) was adopted to facilitate the strategy development. The findings of the needs analysis were presented to the stakeholders, namely, the District Mental Health Forums (DMHF). A day's workshop to develop the strategy was conducted in the Vhembe District Department of Health guided by Diffusion of Innovation Theory (DIT) and Behaviour Change Techniques (BCTs). The Logic Model was used to identify and define the problems faced by MHCUs in mental health establishments and the strategy was then developed with the stakeholders.

3.4.2.2 Stage 2: Validation of the Developed Strategy

Validation of the developed strategy was done using the DIT criteria by members of the Vhembe District Mental Health Forum (VDMHF). The forum was to evaluate the strategy for relative advantage, compatibility, complexity, trialability and observability of the developed strategy (Rogers, 2010). The researcher complied to the Covid-19 regulations by allowing members of the forum to validate the strategy online by avoiding frequent meetings. Email addresses of forum members were requested from the district mental health manager. Then, the draft strategy components were sent by email to all members of the forum to validate using the criteria mentioned above. The forum was given a deadline of two weeks to return the feedback to the researcher for consolidation.

3.4.2.3 Stage 3: Plan for Piloting of the Developed Strategy

The fourth objective in Phase 2 was to develop a plan to pilot the developed strategy for managing mental health services in Limpopo Province. This phase was in line with Phase 5 of the PRECEDE-PROCEED Model or the PROCEED component of the

model which is implementation. The researcher felt that before the actual implementation for the strategy could be carried out, it would be best to pilot the developed strategy to check the feasibility and adapt where necessary.

A collaborative endeavour, in many cases, engages people working on the front line of health care, whether running specific programmes, or working in health systems, who ask the questions around which it is built. It was therefore essential that all stakeholders understood the importance of collaboration in the implementation the research endeavour (Peters, Tran & Adam, 2013).

3.5 Ethical Considerations

The permission to conduct the study was asked, informed consent, beneficence, right to self-determination, confidentiality and anonymity were discussed with the participants before interviews.

3.5.1 Permission to Conduct Research

The research proposal was presented to the School of Health Sciences Higher Degrees Committee for quality control purposes and submitted to UHDC for approval (Annexure A) then to submitted to the Research Ethics Committee of the University of Venda for ethical clearance (Annexure B). The ethical clearance(**SHS/18/PH/09/2205)** was used to apply for permission to conduct the study from the Limpopo Provincial Department of Health (Annexure C1). The permission from the Department of Health was used to ask permission to access the Districts (Annexures D1 to J13), then the permission from Districts was used to access selected mental health establishments (Annexure I). Furthermore, permission was granted from mental health establishments (Annexure J1 to J13) to access participants.

3.5.2 Respect for Human Rights

Participants' rights were respected, and they were allowed to give their informed consent, after being fully informed about the research, that it is voluntary, freely and confidentially. Anonymity and privacy were maintained throughout the study as no names were mentioned during the interviews. Participants were told about their rights to withdraw participation at any point of the research process without any threats. The language best understood by the participants was used—in the case for MHCPs it was English, but MHCUs were allowed to express themselves using their vernacular.

The consent form and the questionnaire were written in English and interviews were conducted in English for MHCPs but MHCUs in the preferred language that they understood. Three languages were used to interview MHCUs and are Xitsonga, Tshivenda and Setswana. Right to fair treatment and selection, was applied in the sense that participants were treated fairly and afforded all members with equal opportunity for being included in the study (Grove *et al*., 2013).

3.5.3 Informed Consent

The researcher provided the participants with the information letter (Annexure N) to read about the research aims and objectives of the study. A consent form (Annexure O) was used to inform the participants about their participation and rights in the study. Participants were informed about the purpose, the expectations and how confidentiality and privacy would be ensured and how the rights would be protected (Grove *et al*., 2013).

The willing participants were requested to give written informed consent (Annexure O) A total number of N=324 (305 MHCPs and 19 MCHUs) participants signed the informed consent and participated in the study. The 34 MHCPs who were interviewed

in the qualitative strand were also included in quantitative strand.

3.5.4 Voluntary Participation

Participants were informed about their rights that if they wished not to continue with the interview, they could quit participating any time during the research if they felt like it, without fear of victimization or penalties (Polit & Beck, 2012b). Participants were informed that they could withdraw participation at any point of the research process without threats, that is, physical, emotional, psychological, social or any form of harm. However, there were no participants or respondents who withdrew from the study.

3.5.5 Confidentiality

The researcher made every effort to ensure that confidentiality was upheld because that is what most of the ethical codes require. Participants' identities, their hospitals and residences were not exposed in any form or published with the results. The research report findings did not mention names of participants, but numbers were allocated to all participants, e.g.,"Participant number 1" which is not in any way linked to the participants. Numbers/codes instead of names were used to identify hospitals and respondents were not required to write their names on the questionnaire.

Confidentiality was always ensured throughout the study. The researcher kept all information and stored it safely (Polit & Beck, 2012a). The participants were assured of confidentiality and informed that the information collected would be limited to the researcher and his supervisors.

The documents of the research study will be destroyed in the period exceeding 5 years after the research results have been published.

3.5.6 Beneficence

The ethical principle of beneficence involves doing well, as well as preventing and removing any potential harm. In this study, no psychological or physical harm was anticipated; and should any harm had occurred to the participants, the study would have been discontinued (Iphofen & Tolich, 2018).

3.5.7 The Right to Self-Determination

The right to self-determination is based on the ethical principle of respecting people and states that humans are capable of controlling their own destiny (Burns & Grove, 2010). Participants were given adequate information regarding the research study and the participation was voluntary. Participants were not coerced to participate in the study. The participants were given a chance to ask questions. During the actual interview, participants were shown the stop button on the recorder which they could use if some of the information was sensitive and they did not want the public to hear such information. However, no participant stopped the record button during the interview.

3.6 Dissemination of Results

The findings and recommendations made will be submitted to the University of Venda Library. Three copies will also be submitted to Vhembe and Mopani District Health, and the Department of Health Provincial Office. The study findings will be published in accredited nationwide and universal peer-reviewed journals, and presentations given at seminars and symposiums. Proper formal feedback will be given in one of the arranged mental health research seminars in Vhembe District at provincial level as it is a culture of conducting research seminars in Limpopo Province.

3.7 Summary

In conclusion, this chapter discussed the research methods used in the study whereby convergent mixed methods were used. Phase 1 concerned the need assessment and exploring the views and experiences of MHCPs and MHCUs during mental health service delivery in mental health establishments in Limpopo Province. Phase 2 described how the strategy to improve mental health care services in Limpopo Province was developed. A pilot plan of the developed strategy was discussed and ethical considerations adhered to in the study were outlined.

CHAPTER 4

PRESENTATION OF THE QUALITATIVE DATA

4.1 Introduction

The previous chapter described the research methods used in the two strands of the study. This chapter presents the results of the qualitative strand. The objective for the qualitative research study was to conduct a needs assessment of the implementation of care in the mental health care services by exploring the views and experiences of MHCPs and MHCUs related to the provision of care, treatment, rehabilitations, and rights of MHCUs in the mental health care establishments in Limpopo Province. In-depth face-to-face individual interviews were conducted with both the MHCPs and MHCUs in their respective wards in the hospital/mental health establishment. The findings from MHCPs and MHCUs were integrated. There were not much differences between what was said during the interviews of MHCUs and MHCPs.

4.2 Characteristics of the Participants

Thirty-four (34) MHCPs, psychiatric nurses with psychiatric nursing science qualifications and nineteen (19) MHCUs participated in the study. All 34 MHCPs in the study were African and they were all South African. Regarding gender of the MHCPs,14 were males and 20 females, and for MHCUs, 6 participants were females and 13 males. Table 4.1 shows the biographical data of the MHCPs. The majority of participants (n=20; 60%) were between the ages of 26-40 years and the smallest proportion of participants (n=2; 5%) were 51 years old and above. With respect to designation, the majority of the participants were professional nurses (n=30; 88%) in

in the mental health establishments while the remainder (n=4; 12%) were operational managers.

Table 4.1: Biographical data of mental health care practitioners

Variable	Frequency	Percent (%)
Age		
26-30	8	23
31-35	5	16
36-40	7	21
41-45	8	23
46-50	4	12
51 and above	2	5
Total	**34**	**100**
Designation		
Professional nurse	30	88
Operational manager	4	12
Total	**34**	**100**
Years of experience		
1 to 5	4	12
6 to 10	10	29
11 to 15	6	18
16 to 20	4	12
21 to 25	5	16
26 to 30.	3	8
31 and above	2	5
Total	**34**	**100**
Highest level of education		
Diploma	24	71
Degree	10	29
Total	**34**	**100%**

In terms of years of experience, most of the participants (n=20; 59%) had one 1-15 years of experience. Few participants had experience of 31 years and above (n=2; 5%). With regard to the level of education the majority of participants (n=24; 71%) had a Diploma in Nursing Science and the remainder (n=10; 29%) had a degree in Nursing Science as their highest qualifications. Table 4.2 shows the biographical data of the MHCUs.

Table 4.2: Biographical data of mental health care users

Variable	Frequency	Percent (%)
Age		
36-40	12	63
41-45	5	26
46-50	2	11
Total	**19**	**100**
Occupation		
Student	2	11
Unemployed	17	89
Total	**19**	**100**
Support system		
Receiving disability grant (DG)	14	74
Not receiving DG	5	26
Total	**19**	**100**

The ages of participants ranged from 36-50 years old. The majority of the participants (n=12; 63%) were between 36 and 40 years of age. MHCUs who were aged between 41 and 45 years accounted for a quarter (n=5; 26%) of the study population. Few participants (n=2; 11%) were between 46 and 50 years old. Only two MHCUs (n=2; 11%) were students at a higher learning institution while the majority (n=17; 89%) were unemployed. The majority of the MHCUs (n=14; 74%) were receiving a disability

grant from the government to assist them in their daily living, however, about 26% (n=5) of MHCUs had their disability grants terminated at the time of the interview.

4.3 Presentation of the Results

From the data analysis, 6 main themes emerged. Table 4.3 summarizes the themes and sub-themes of MHCPs reflecting the experiences of MHCPs and challenges that they face when delivering mental health services to the MHCUs in the mental health establishments in Limpopo Province. Six themes emerged: Structural-related challenges, Inadequate management of MHCU when admitted, Improper application of safety measures in the wards, Poor MHCUs support, Insufficient knowledge regarding mental health care and Strategies to improve the management of MHCUs.

4.3.1 Theme 1: Structural-Related Challenges

Structural-related challenges were raised as a problem and four sub-themes: No wards for MHCUs, Poorly built structures, Lack of privacy and No seclusion rooms.

4.3.1.1 Sub-Theme 1.1: No Wards for Mental Health Care Users

The findings of the study revealed that several institutions do not have a mental health unit designated to admit MHCUs. However, in institutions where they do not have a mental health unit, MHCP improvises by dividing space for the mental health unit in general medical wards (male or female) and create space to accommodate mental health users. In other institutions, they do not admit MHCUs at all—rather they refer them to the nearest mental health establishment for care, treatment and rehabilitation. A letter of rejection to conduct a study from one of the institutions in Vhembe District was given to the researcher where the Chief Executive Officer (CEO) indicated that there is no mental health unit and mental health services are not offered.

Table 4.3: Themes and sub-themes of mental health care practitioners and mental health care users

Main Themes		Sub-Themes	
1.	**Structural-related challenges**	1.1	No wards for MHCUs
		1.2	Poorly built structures
		1.3	Lack of privacy
		1.4	No seclusion rooms
2.	**Inadequate management of MHCU, when admitted**	2.1	Poor reviewing system of patient's treatment and protocols
		2.2	MHCPs not willing to work with MHCUs
		2.3	Inadequate and ineffective treatment used to manage MHCUs
		2.4	No danger allowances
		2.5	Rights of MHCUs not adequately observed
3.	**Improper application of safety measures in the wards**	3.1	Poor implementation of safety measures by security
		3.2	Mixing MHCUs with medical patients
		3.3	Shortage of staff
4.	**Poor MHCU support**	4.1	Poor visitation by family members
		4.2	Lack of support from community members

/*Continued …*

Table 4.3: Themes and sub-themes of MHCPs and MHCUs (continued)

Main Themes		Sub-Themes	
		4.3	Poor support by government
		4.4	Poor awareness regarding mental health
5.	**Insufficient knowledge regarding mental health care**	5.1	Poor insight regarding mental state by MHCUs
		5.2	Insufficient knowledge about mental health care by MHCPs
		5.3	Insufficient knowledge about mental health care by community members
		5.4	Misuse of resources
6.	**Strategies to improve the management of MHCUs**	6.1	Decentralization of mental health services
		6.2	Halfway houses for MHCUs
		6.3	NGOs (home-based caregivers)
		6.4	Health education regarding mental health issues
		6.5	Mental health advocacy
		6.6	Workshops on new information regarding mental health
		6.7	Infrastructure improvisation

One participant said: "Challenge that we have is the structure as itself because is not that well developed we admit mental health users in medical units, we do not have eeh, eeh mental health care unit like a psychiatric unit for mental health users so we admit them mix them if they are more because we only have one room in male and one in female so in that room in female we only have two beds only and in male ward we only have three beds .so if they are four then we mix them with medical patients, we just mix them."

One participant said: "We just improvise and converted the general male and female ward, be a separate room where we use it as a seclusion room and say that admission separate unit for them (MHCUs) with only four beds."

One participant said: "We do not have a specific unit, for the mental health care users then we a …a ...a improvise, room or room that is a normal room for medical patients, we use it to admit MHCUs."

One participant said: "The first one is, to me, I regard it as a great challenge or the highest challenge of them all, is that we do not have a psychiatric unit. Yah, We used to have psychiatric unit the whole ward, but it was burned a few years back but it was never built again and then they asked for one cubicle room from a medical ward so that we can be with the patients and the a…"

One participant said: "August, September it's along the way meaning people who suffers from mental illness it is their month, most of them they …they start to be psychotic around this coming month that's why we are having a…an overflow now, so as you can see we do not we do not have a ward it just a…a…a cubicle that we asked from male medical for us to get just one cubicle to keep these psychiatric patients when they are psychotic in the community so that we can stabilize them, so this is

what is happening in this institution."

The lack of mental health structures often makes it difficult for the MHCPs to provide quality care as there is always an overflow of MHCUs who might pose a danger to the staff members and other patients as they usually fight and injure one another. Participants also cited that they were not certain if they would complete their shift without being injured due to the dangerous behaviour of the patients they cared for and they were afraid to report the incidents happening in their cubicles for fear of losing their jobs. The overflow of patients was thought to be from certain months or season of the year where they usually have more admissions.

The participant further said: "We are allocated in one in one cubicle of the medical ward, so you find that in this cubicle we have got 7 beds and you find that we have got an overflow of patients and people who we are having who are supposed to stay for 72 hours they are more highly dangerous than psychiatric patients whom are admitted maybe at any other hospitals because these ones are psychotic. So the dangers of a patient fighting each other and injuring each other or injuring the staff members is very much high so whenever one comes to work you do not know what's going to happen, are you going to work from 7 to 7 and go home the way you came or something is going to happen to you, a lot of incidents have happened is just that a because of a we cannot report them a… because we are afraid of losing our jobs a…we just keep quiet about it because we cannot report our employer to the public, but a lot of things are happening in this ward..."

Abscondment of MHCUs was mentioned as a serious challenge due to the lack of a specific mental health unit as they either escape through the windows or climb the ceiling and jump out of the mental health establishment. As a result, MHCPs cited that they always resort to sedation by using chemicals or sometimes use mechanical

restraints because MHCUs break the burglar proofing and abscond.

One participant said: "That's the main problem because they escape through, they just go through the ceiling and then escape, so is not easy to contain them here because we do not have a specific unit for mental health."

One participant said: "Because we do not have a proper facility, we start to resort to sedation and to close those burglars, sometimes they just break those burglars' doors and escape so it's a serious challenge."

One participant said: "Yeah!!, for us not to have our specific unit, it becomes a very big challenge because here they will influence one another, they will try to jump out of the window, they will try to, someone plotted against us that they wanted to get out of the room, you see the…the ceiling, so…so they tried going out using the beds and went straight up so they were running up, they were running above the…the…the ceiling there. Fortunately, enough we managed to…to…to get them before they escape."

One participant said: "We…we depend on sedation, if ever the patient is violent, someone is aggressive, sedation it's our only resort we do not have a seclusion room, because they just gave us a cubicle, it's like it's like allocated for us to admit psychiatric patients, we have a serious challenge of ward here for mental health."

One participant said: "Because we do not have seclusion per ser, struct… a…a…a structural seclusion, it makes it difficult for us to observe them, because if you keep restraining the person, keep sedating them you cannot see their behaviour. So it is a serious challenge for us not to have a psychiatric unit."

Furthermore, MHCPs cited that they were overwhelmed caring for both MHCUs and

medical patients at the same time. They mentioned that caring for MHCUs need patience and more staff to monitor them as MHCUs will be frequently asking to be let out to go and ease themselves while there are those medical patients who need to be cared for. They further mentioned that 72 hours of observation is no longer practised. MHCA 17 of 2002 requires that all MHCUs be observed for 72 hours before they are admitted to the mental health establishment, however, in the results of the study it was not the case.

One participant said: "Ok, another challenge is When…we…when …when we keep the mental care users in that ward nee! they always call you every 15 minutes, like their cubicle it's always locked, we lock the room, every 15 minutes they want the room to be unlocked they say we want to go to the toilet, hee!, we want to take bath, hee! and then we find that we are busy with other medical patients and then we are short-staffed so it's always become a challenge to us because we cannot go there every 20 minutes and open… open for them monitor them when they go to the toilet and make sure that they come back to lock the room, after every 20 minutes they call you again and then here we are short-staffed we have other 20 medical patients to take care of, no is not usually easy so it becomes a challenge to us."

One participant said: "A… when this cubicle was asked, it was supposed to be a 72 hours observation, but because of the challenges that are above our scope of practice a…its no longer functioning as 72 hours, is functioning as a ward in a cubicle with many patients and four nurses who are attending them, so the issue of 72 hours is no longer existing."

Without a proper mental health unit for MHCUs, participants mentioned that they were forced to prematurely discharge the MHCUs before they were stable to create space for new MHCUs who are coming in. This practice, however, was cited as not good as

MHCPs are wasting government resources by readmitting the same patients time and again as they keep on returning few days after discharge. On the other hand, MHCPs are not engaging or occupying the MHCUs fully as they cannot play games due to lack of space, and wards were cited as not conducive and congested.

One participant said: “When we discharge the patient, two days after, he comes back again for 7 to 8 days, but if we can see that you are no longer psychotic the way you were and the ward is too full and because we were supposed to run 72 hours observation of which we cannot practice because of the space, we are compelled to discharge you if you are better. I’m not saying that you are ok or you are stable, you are just better you from the condition you were when we, when we admitted you.”

One participant said: “(interrupt) it is not working because we are wasting the hospital a materials like the papers because we will discharge them, 2 days after they come back and we do readmission again, the same process writing on new papers, psychiatric assessment and everything, so there’s no progress there will never have a progress unless they build a psychiatric unit or psychiatric ward (patient coughing) for us.”

One participant said: “A… hey is difficult the OT… the they are heading visits, the only entertainment here for them is that TV which you see there, yah we just switch on the TV and watch TV with them or we also have Morabaraba board, those who can play can play, but playing inside a place which is congested, somehow it also not conducive so we end up watching TV only with them.”

Furthermore, MHCUs confirmed what was said by MHCPs regarding lack of enough space in the mental health establishments, they cited that due to space limitations, they do not engage in ward activities as required like playing games. Lack of resources

or equipment in the unit was also mentioned as a challenge where they often feel lonely because there is no television and radio for them to be updated on the current news of what is happening around the world. The MHCUs need to be well orientated to all spheres, hence, a radio or television for thm is needed in the mental health unit.

One participant said: (MHCU) “Ncuva they won’t do it because you see that there’s no enough space, because our space where we sleep is limited they do not want to keep us busy, because they must take us to church they give us topics.”

One participant said: (MHCU) “Actually here the problems that we encounter is that we are feeling lonely, because they do not take us out to get or receive energy from the sun(Sun basking), it’s only the issue of loneliness due to lack of television and radio, if they can try to provide us with them just to listen to the news, so that we will get to know what’s happening outside and take me out to get energy from the sun.”

4.3.1.2 Sub-Theme 1.2: Poorly Built Structures

The study participants indicated that structures for mental health units are poorly built. They indicated that the mental health units are dilapidated and old. The ceiling is not that high which makes it easier for the MHCUs to abscond through the ceiling by climbing up to the top, walk inside the roof and jump off the building. The burglar proofing of the unit was also cited as a concern as there is a huge gap between the wires and they are not serving any purpose because MHCUs use burglar bars on windows to escape. In one of the mental health establishments, the management at least promised to demolish the old structure and build the new mental health unit. It is evident that when the mental health units are poorly built, it is easy for the MHCUs to climb the wall or ceiling and abscond.

One participant said: “That building, if you go and check the ceiling where they use,

they use the ceiling to abscond, they just get inside the ceiling there and they walk from inside and that's when they get off on the other side of the room and that's when they get off, and they go out of the hospital and they sometimes they use to escape through burglar there, sometimes they can squeeze themselves there some they can go out through the burglar."

One participant said: "Structurally, the burglars are there but these burglars they are just for decorative purposes because the person can escape through the burglar, through the burglar and then those who can escape here you cannot touch them when they go out they run like no body's business so it…that's how they escape some they even (background noise) climb the…the…the through a ceiling, they jump isn't that there's a roof there yes they jump and then off to the roof then they jump down, off they go."

One participant said: "We just run our services here, and our building is dilapidated, but at least they want to build a new ward for us here, they are going to demolish the whole building in the old one, but let's not talk about it we have just heard it last week"

The MHCUs are also affected by the poorly built structure as they think that MHCPs do not want to occupy them because they expect to be given topics on how to control anger and attend a church service while admitted. But due to limited space, they are no activities that are provided to the MHCUs in the mental health establishment.

Another participant (MHCU) said "because our space where we sleep is limited they do not want to keep us busy, because they must take us to church they give us topics we talk and understand on how one should live to control anger we learn a lot when we are here and when we go home we would be changed when they give us treatment we will stay at home even the community will love us because of what they would be

teaching us here."

4.3.1.3 Sub-Theme 1.3: Lack of Privacy

The participants in the study indicated that the privacy of the MHCUs in their mental health unit is compromised as people can see through the windows of the unit. The windows of the mental health units are not all darkly painted and there are no curtains hanging on windows as MHCUs might use them to commit suicide or they can burn the ward using curtains.

One participant said: "The windows from the male room do not have the curtains, anyone can see from outside and it does not have, like we cannot hang curtains because they can burn or use them to commit suicide, they are visible it but like when someone tries to beat someone, like the mental health user is trying to be aggressive and as you know that they will be making sounds or noise, so when people are walking or passing by, they just come and watch us like from that side of the window so it's a bit of a challenge that one, privacy is compromised in this ward."

One participant said: "Yes there no privacy here, they can watch us from outside, you see is not painted dark, I think from the bottom of the window, but you can see, but by that time we were still busy trying to restrain the patient mmm we would say please move, the security would be assisting us by the time we say please can you please move they will have seen everything."

4.3.1.4 Sub-Theme 1.4: No Seclusion Rooms

The findings of the study also revealed there are no seclusion rooms for violent and aggressive MHCUs. This put the lives of the MHCPs in danger as they are prone to be assaulted by psychotic users and this leads them to resort to chemical restraints

by sedating aggressive patients. They indicated that they do have protocols to follow, but sometimes the MHCUs will not respond to the sedation, when they try to give more doses, doctors will get furious and not sign the treatment sheet of the patient. They further indicated that it is difficult for them to conduct their observations as they are always sedating the patients due to lack of a seclusion room.

One participant said: "We depend in sedation, if ever is violent someone is aggressive, sedation it's our only resort, we do not have a seclusion room, at least that room that…that is that side, it's like it's like allocated for us to do psychiatric patients"

One participant said: "Yes, so it makes it difficult to observe them, because if you keep restraining the person, keep sedating them you cannot see their behaviour"

One participant said: "When one start to be aggressive the other one follows and when they start to be aggressive, the dangers of me and the security to be injured is very much high and through we have got a… some protocols to sedate them because we do not have a seclusion room where we can seclude them when they are violent, we do follow this protocols but because these guys are here due to different triggers of mental illness some of the medication that we are giving them according to protocols they tend not to function well because of the drugs substances that they are using and when we give more doses to sedate them the doctors of the ward disagrees with us and say we are giving the medication that they did not prescribe if anything happen to the patient they won't be responsible, so we leave them being psychotic and give them medication a according to protocols because we do not want to face consequences when the doctors refuse to sign, then we have agreed with what he is saying even if the patient is not stable, we do not increases the doses for sedation so it's…it's a big challenge to us for not having a seclusion"

One participant said: "When the patient start to be psychotic we must use a man power, it means all of us who are within the ward we must catch that patient and sedate him if the ward is full we have to move someone who is on top of the bed to sleep on the floor so that the sedated one can be on the bed, and we can monitor him after sedation."

One participant said: "one other thing is that the structure, in which we are working on is not conducive for mental health care users some of the mental care users which are admitted here are still patients which they need sometimes they need a seclusion rooms we do not have seclusion rooms"

4.3.2 Theme 2: Inadequate Management of Mental Health Care Users When Admitted

The findings of this study showed that care, treatment and rehabilitation of MHCUs is not up to standard as sometimes there is a shortage of drugs or treatment for MHCUs. This makes it difficult for health providers to be able to provide good quality care to patients. Shortage of treatment also makes it difficult to manage or stabilise patients diagnosed with Substance-Induced Psychosis Disorders (SIPD). The results further indicated that there is a poor system of reviewing the MHCUs and MHCPs working in the institutions not keen or interested in caring for MHCUs. Protocols to manage MHCUs were also cited as very old or not being renewed by the psychiatrist as there is a shortage of psychiatrists in the province. The rights of MHCUs were also cited as a concern as other MHCPs do not observe or respect the rights of MHCUs when they are admitted to mental health institutions. MHCPs cited that for them to work with zeal in caring for users or provide care adequately to MHCUs, they must get danger allowance to serve as a motivation or recognition for working in a dangerous environment.

Five subthemes emerged: Poor reviewing system of patient's treatment and protocols, MHCPs not willing to work with MHCUs, Inadequate and ineffective treatment used to manage MHCUs, no danger allowances, and Rights of MHCUs not adequately observed.

4.3.2.1 Sub-Theme 2.1: Poor Reviewing System of Patient's Treatment and Protocols

The results of the study indicated that MHCUs are just given treatment without being reviewed after every six months of the first prescription by doctors. Mental health providers only continue to give the treatment as previously prescribed, this practice of not reviewing the treatment of MHCUs was alluded to as a shortage of psychiatrists in the province or district. MHCPs will try to contact the psychiatrist telephonically and s/he will prescribe or review the treatment via a phone call without seeing the patient.

One participant said: "They were not reviewed 2017 from yaa towards 2017 I think or 2018. and then they were not reviewed by the psychiatrist, they were not done, because apparently, the psychiatrists were not being paid until now. We have since last year, the whole of last year they were not being reviewed, so as mental health providers we just continue with the treatment that was being prescribed. I do not know for how long we are just continuing and yaa that's the thing and then normally we just contact the psychiatrist telephonically if we have a patient in the unit."

One participant said: "We used to have psychiatric who comes on a monthly basis to review the mental health users who were booked, maybe the medical practitioner thought is very important for the patient to be seen by the psychiatrist, but those who are booked for review of treatment, assessment by the psychiatrist is not done the whole of 2018 it was not done, so for reviewing the treatment, the medical practitioner they say they are not well trained, some just do not like it at all so it's, it's a bit of a

challenge to, you know when they come they just need to prescribe and that's it."

One participant said: "Because how can I admit the mental health users and I meanwhile the forms just do not end up with us, I mean all the forms need to be reviewed, if we did the right thing. Is it the right you know but now is like we just meet, and we just put the forms there eeh I do not know for how long this will continue? The treatment needs to be reviewed"

One participant said: "Is not like that good, I cannot say is good, because how can I admit the mental health users and I meanwhile the forms just do not end up with us, I mean all the forms for treatment need to be reviewed every six months."

Participants further mentioned that protocols for managing MHCUs are not being reviewed by the psychiatrist as they are still waiting for the psychiatrist to come and review them. The available protocols that they are following are very old, and the protocols can be regarded as invalid because the signature date by the psychiatrist has exceeded six months. Despite that, MHCPs cited that they continue giving treatment to the patients even though MHCUs experience side effects because in the whole district, there is no psychiatrist.

One participant said: "So, they are all aware, she also communicates with the province chief psychiatrist whom we are still waiting even today for those reviews isn't that the protocols must be reviewed, yes, we do not have the reviewed protocols that are signed by a psychiatrist."

One participant said: "The protocols that we have here is very old, very old protocols, for managing psychotic disorders and they were not being reviewed. So, we just follow it even though it very old and not valid because I think it is valid for a certain period

after being signed by the psychiatrist."

One participant said: "Oww I do not know because mental health is a broad problem currently is getting worse actually,I think, I thought maybe things were getting better from like last year, from last year it was just getting worse I mean how can a mental health user in the whole district not being seen by a psychiatrist in the whole district taking treatment without being reviewed exactly so they take treatment even when they are having side effects."

On the other hand, participants mentioned that they are experiencing side effects when using certain treatment. Some MHCUs said they explained to the doctor that the treatment they are taking is giving them challenges, but doctors are not reviewing or changing it. They cited that the injection or treatment that they are currently using makes them feel weak, that they sleep too much and get tired without doing anything or salivate a lot. Some participants indicated that the treatment makes them lose libido or experience erectile dysfunction.

Another participant (MHCU) said: "And myself have a problem they inject me with this injection they call it fluanxol, that injection it is not good for my health as it makes me release a lot of saliva, it makes me weak, it causes me to sleep I get tired without doing anything, they told me that the one I get is not available, and I do not like this one. It does not make me feel good and I told the doctor, he said he will change it."

Another participant (MHCU) said: "I take, I mix them, I take disipal, serenace in the morning, disipal and serenace in the afternoon disipal and serenace in the evening. Epilim arg I do not usually take it; it makes me to… I lose the libido and it has the effects on the erectile function when I'm with a woman I do not become active, but they do not want to change it for me"

4.3.2.2 Sub-Theme 2.2: Mental Health Care Practitioners Not Willing to Work with Mental Health Care Users

Findings of the study revealed that MHCPs sometimes are not willing to provide care to MHCUs—they leave them unattended even though they are being called to attend to them. The mental health coordinators at times had to reprimand them or talk to them that they need to provide care for the MHCUs rather than neglecting them. They further cited that there is a need for a doctor to be specifically allocated to the mental health unit because assessing MHCUs is a lot of work and requires more time and on top of that there are mental health forms that need to be completed. MHCPs also felt that caring for MHCUs is not falling under their scope of practice. This was also evident by medical doctors neglecting the MHCUs by not going to the ward and see the patients despite being called to come and see the patient in the ward by the nurse.

Furthermore, MHCPs indicated that some medical officers in mental health establishments are not keen or not willing to work with MHCUs when allocated in the mental health unit. The reason for medical officers not willing to be allocated in mental health units might be alluded to lack of knowledge as others indicated that they did not receive full mental health training, or the training was insufficient while they were doing their medical degrees.

One participant said: “So without you as a coordinator trying to talk to them and all that, then the mental health user will be left unattended so meaning that they are not willing to work with mental health care users.”

One participant said: “They do not like it, they do not have that thing for psychiatric, they feel like because someone, some other doctors also mentioned to me that they feel like there should be doctors specifically for psychiatric because is too much for them to assess the medical patients and as well as the mental health care users, for

mental health care user it takes time sometimes is a lot of work because they have to complete a form is a two hours assessment form and is just too much for them with 23 patients it will be two doctors and they still have to they feel like is and there should have a separate ward."

One participant said: "The other challenges that we have are that nurses sometimes they also feel like is too much for them like to nurse for psychiatric and also to nurse for medical, mental health users, they feel like why cannot there be a unit just like doctors sometimes neglect MHCUs by not necessary coming to see them, so we have to talk to them, just like please come and check the patient you cannot just leave a mental health user like that."

One participant said: "Like doctors sometimes they neglect MHCUs, not necessary coming to see them, so we have to talk to them, just like please come and check the patient mmm you cannot just leave a mental health user like that."

Participants also cited that MHCPs provide confusing services to the MHCUs, because it is either they are providing a good or poor service on different days. Furthermore, they felt that other MHCPs were being forced to work in the mental health unit.

One participant (MHCU) said: "Sometimes, they provide good services sometimes they provide you poor service, so I end up not understanding that what kind of services are they providing, today they will treat you well, tomorrow it's another story, the following day they treat you well, you see you end up not understanding it's like you today I greet you today then we have fun then tomorrow I greet you again you get angry so what would I say? It's like they are being forced to work here."

4.3.2.3 Sub-Theme 2.3: Inadequate and Ineffective Treatment Used to Manage Mental Health Care Users

The results of the study revealed that in most cases mental health units run out of stock of medication or drugs that are needed to control psychosis and this poses a challenge as they won't be able to manage the MHCUs well without treatment. However, participants were told to use alternative medication or drugs which sometimes fail to control the psychosis. In most cases, the drugs used were unable to stabilize the relapse psychosis to MHCUs who are using substances. Another serious challenge that was mentioned is that some institutions are still using drugs that have been phased out. MHCPs also indicated that when they place orders from the depo, in some instances, they do not receive the treatment ordered.

One participant said: "The medication part, there were times we were not having even the most important ones for anti-psychotics and we will be given the alternative drugs, but you find that they do not work at all. They said it was still in the system at the deport, you find that there are no antibiotics so you will have to go to Khensani and ask for medications."

One participant said: "Like other drugs, we use they are phased out already like etomine is no longer used but we still have etomine with us and we are using it when the patient is uncontrollable."

One participant said: "There is a shortage of treatment, like achuphase, rivotril. The sedative treatment. Sometimes we do not get it, the depo they do not deliver to us, If we do not have the achuphase, we just use other resources that we have at the moment, other alternative."

The participants further indicated that due to mushrooming of new drugs and

substances that are being used, it is difficult to control patients suffering from SIPD with the anti-psychotic drugs available in the mental health establishment and they end up not knowing what to give the patient. They also mentioned the growth of new street drugs like Nyaope, Cannabis, etc.

One participant said: "Because there are new drugs from streets that we do not know what they contain, and all these patients who come who are substance abuse they do not respond to the sedation. They do not respond well, so there's a higher risk because we normally end up not knowing what to give them to control their psychosis."

One participant said: "Most of them who are not responding they are using Nyaope and dagga it is even worse since the legalization of dagga, isn't that the government legalized the use of dagga openly."

4.3.2.4 Sub-Theme 2.4: No Danger Allowances

Participants cited that they need danger allowance to provide quality care to MHCUs and currently they are not getting it even though they are working in a hazardous situation whereby, at any time, they can be injured or assaulted by a patient while providing care. Furthermore, they cited that a nurse was killed by a MHCU in the mental health establishment while providing care to MHCUs, so they deemed working with MHCUs as a dangerous activity that needs to be recognized.

One participant said: "Danger allowance, we dealing with these dangerous patients and then, there's no danger allowance in the unit yet and people are not trained to care for them, dangerous as they are, because there's no danger allowance (background noise) so sometimes people feel like that…we are not recognised for the care that we are doing."

The participant further said: "Yes, because 'akir' de…despite the fact that we do not have a mental unit in the institution, but care is still provided to mental health care users hence danger allowance is needed so that we can work knowing that we are being cared for as nurses."

One participant said: "There is no danger allowance, we need danger allowance, our lives are in danger, not so long there was a nurse who died at a mental health care institution, a highly secured mental health institution here in our district, so if a nurse dies at a place like that where the nurses are supposed to be protected from the ones they are caring for, what about us who are having patients, who are not stable it means that anything can happen to us at any time."

One participant said: "I think danger allowance, there must be danger allowance for nurses …if a patient, from what I know if a patient injures a nurse get an injury on duty, I think the…the nurse who is caring for the patient must be compensated and I know that there are protocols which in which before they compensate, they must follow and look at it, but depending on the situation and the environment where we are working in, these people they know that it can happen at any time because of the environment where we are working, but yet they do nothing about it yah."

4.3.2.5 Sub-Theme 2.5: Rights of Mental Health Care Users Not Adequately Observed

Participants indicated that the rights of MHCUs are violated in mental health establishments. Furthermore, participants mentioned that MHCUs are being called by names of their illness or being disrespected. In other instances, MHCPs undermine the rights of MHCUs by telling them that they cannot do certain things because they are mentally ill. However, MHCUs have rights as stipulated by the MHCA. Participants cited the rights of MHCUs as right to basic life, to be respected, to be taken care of

and to have a supportive family.

One participant said: “Rights of the MHCUs are not observed in our hospital because they are given rotten food and meat. They cook a lot of meat in bulk and serve them because it has expired, sometimes they are not given water to bath because there is no water at the institution.”

One participant said: “Rights of mental health care users are not observed, others call them names like “Mpengo” which means that a mentally ill person or it is an insult to mental health care users and it is not good because everybody needs dignity and be respected and be called by their good names.”

One participant said: “They stigmatize them you find that the patients are called by the names of their illness and that it makes the patient not to be happy because everybody need to be respected so, that’s that about.”

One participant said: “Some Nurses are undermining the mental health care users by telling him that he cannot do one, two, three because you are mentally ill so by doing that you undermine that person, and that MHCU feels like he is nothing so he can destroy you.”

One participant said: “There are these, that they do not have rights, mental health care users are bewitched, mental health care users deserve to always admitted in the hospital, mental health care users do not have rights at all, mental health care users do not deserve to bath, mental health care users do not deserve to bath, to have partners those kinds of misconceptions about them.”

One participant said: “Yah, they, yes they have right to …to … to the proper medical care they… they…they have a right to supportive and caring family structure they also

have right to life and then they have right to basic, basic human needs yah!, like having…having a wife and being at home and, then they also have a right to be loved."

Results further indicated that MHCUs' rights are not observed adequately because MHCUs are being instructed to cut their hair, despite the hair being clean and well managed. Again, participants cited that MHCUs are being tied with steel wire, and not given food in the units. Furthermore, participants indicated that MHCUs are subjected to physical abuse, where they are beaten by MHCPs. The participants also said that they are treated like dogs and that the communication between MHCUs and MHCPs is not good.

Another participant (MHCU) said: "They are capable of let's take I made a simple mistake they slap you with clap a big clap, did you see, that one she came and check us by the door, she slapped me with a clap but I didn't hit her back I understand that I was slapped by sister and her and she is older than me, I didn't hit her back, but I didn't hold her in my heart. I just told myself that everyone got beaten, a big clap, that mother can slap, the one she opened and one check whether there's a person she hit me with a clap and fell down on the day, even now I respect her."

Another participant (MHCU) said: "It's like today I waked up and prepare my blankets, I waked up and wash my face and then I combed my hair, and then they told me that my hair has fallen on the blankets, and then I said I'm sorry, after that they told me that they want to cut my hair and then I told them that my hair is my choice I cannot cut it, I have a right to keep hair as long as it is neat and nicely combed."

Another participant (MHCU) said: "This other guy once escaped to go and earn social grant money, when he comes back and they say he is expensive, they beat him up until his teeth wear off and he was bleeding and they didn't care about his rights.

He was beaten by the securities."

Another participant (MHCU) said: "I was just thirsty I wanted to drink water because the tap water is there and say tie him with steels you see something like that, instead of telling me politely that we are busy be that side you will come back soon you see, so they tell me that hee, you, are mad, we will tie you with steels, go to the bed do you see how is it? Do not I have the rights to drink water when I'm thirsty? And I'm only looking for water to drink, without doing anything or making noise or causing chaos."

Another participant (MHCU) said: "Is that, that when you commit a simple mistake, they tie your legs, they tie your hands like a dog, like you are not a person and do not have rights and not being given food, not given even the medication up until 10 days or 7 days, that's where they untie me that's are the challenges that I have"

4.3.3 Theme 3: Improper Application of Safety Measures in the Wards

The results of the study indicated that safety measures in the wards are not well implemented in mental health establishments. The results further showed that there is the mixing of MHCUs with medical patients who are critically ill. Mixing the two categories might pose a danger to the lives of medical patients as they are weak and helpless, while MHCUs will be moving around the unit aimlessly and causing disruptions. Shortage of staff was also cited as a serious challenge as caring for MHCUs needs more staff in the form of male nurses who will be able to manage violent and aggressive patients. Three sub-themes emerged, and they are as follows; poor implementation of safety measures by security, mixing MHCU with medical patients and shortage of staff.

4.3.3.1 Sub-Theme 3.1: Poor Implementation of Safety Measures by Security

Participants cited that there is poor implementation of safety measures by security as in most cases security officers are stationed outside the mental health unit instead of inside. This kind of arrangement is not safe as it poses danger to MHCPs when the patient becomes aggressive as there will be no security to assist on the spot. In some instances, the restraints are not enough for all the patients and belts are used to restrain patients. Security officers from the main gate are sometimes called to assist in the mental health unit, but they have to travel for a long distance before they can reach the unit, when they arrive it is too late for the incidence that they have been called for.

One participant said: "Another challenge is that we have the security officer, the security officer that we have, if you have check they were sitting outside, they do not sit inside the unit. So if we need them that's where we call them to come inside the unit, they sit outside so anything can happen with the patient inside, if he is hanging himself no one is there to observe what is happening or the patient becomes aggressive start fighting."

The participant further said: "Oh security obviously security, The security need to be in the unit, at least we need to have one in the unit, we cannot have one outside its useless anyway because by the time mental health users try to do something it will be too late when they come inside to assist. So, it's better if they can station inside the unit not outside."

One participant said: "No, the…the…the…thing is that we, we respond quickly, because we know that we do not have much to restraint them, so we use restraining belts and they are few, we then use the security, so most of the time when they are

very aggressive, we call the security to come and help us."

One participant said: "Sometimes you find that another personnel is on lunch and the patient starts to be aggressive and you find that you are helpless and you have to depend on the security, sometimes we have to call the security officers from the main gate and you will have to wait for them to arrive here and its far for them to reach here."

Furthermore, MHCUs who are aggressive and violent pose danger to self and others, and they are secluded and monitored every 30 minutes for security reasons though securities officers are not available to guard them when they are in seclusions. When security measures are not well implemented in the mental health unit, MHCUs sometimes escape through the door in front of security guards.

One participant said: "Usually, it's us …it's us…it's us usually, if ever we are having a…a… patients who are not stable we check them every 30 minutes nee!? Every 30 minutes we go there by the door we look by the doors nee!! we lock the…the…the burglar door there, we lock the after every 30 minutes we…we…we can go and see them and then like we evaluate them every 30 minutes and then if ever we need the prescription of violent and very aggressive patient and then you find that he is posing a danger to self or others, we call the security guy, though they will say they cannot stay by the door because they are few, then we call the doctor, maybe the doctor will prescribe the sedation so we do sedate them."

One participant said: "If we are fortunate to see that the patient absconded immediately, when the patient escaped or some other patient when inform us hee! so and so is escaping, then we try to find him if the patient hasn't gone far as outside the hospital the security will help us to apprehend the patient to…to…to the ward but you

ask yourself how did the patient pass the security officer? if the patient is outside the gate or the hospital we report the case to the police station so and then we inform even the relatives so that if they see the patient at home they will be able to inform us and the police so that they can apprehend the patient to the ward."

4.3.3.2 Sub-Theme 3.2: Mixing Mental Health Care Users with Medical Patients

Results of the study found that there is a mixing of MHCUs and medical patients in the same unit. Mixing the two different categories sometimes brings fear to MHCPs as MHCUs might become aggressive and hurt medically ill patients who are lying on their beds helplessly. A participant mentioned that they are afraid to pen a burglar door for MHCUs because they might run away. Participants further cited that they do not have a choice, but to mix MHCUs and medical patients because they have been allocated one cubicle to keep aggressive users, when they are stable the gate is opened so that patients interact.

Another patient said: "And then by opening the burglar door, I always think about those other medical patients, if these psychiatric patients will not threaten or pose any danger to other medical patients? that's the question that always comes to mind and the other question is what if I open…open…and then they threaten to beat us (clapping hands) and then other question is what if I open for them, I open them and then they… they just they run and then…they…they…they go away of…of the hospital premises and then where will we get them so it's always a problem to open for them so when we open for them at least we call the security guards all the time so imagine every 15 minutes, they want to go out, they want us to open for them so I have to call the security guy every 15 minutes you see it becomes a problem."

One participant said: "We just mix those that are more stable, we mix them with the

male medical patients, we do not have a choice we just put them together and those that are more psychotic we just keep them in those cubicles with burglars."

One participant said: "Yes is not separated, like this is a mental health unit, is just a…a…a. seclusion room where we keep them for safety that they do not hurt other people and other patients. But the care is the same, yhaa they are cared by the same staff here. It is the same ward, where we only separate cubicle where we put burglars in case of emergency and when they are still aggressive, but when they are no longer aggressive, they are stable. Burglars they are opened they communicate; they are interacting with any other people or any other patients because they are still the patients of the medical ward."

One participant said: "Ok, like since you…you see this is a small hospital no ward for mental health care users and then in this ward is a medical ward mixed with a…a…a. psychiatric unit. I mean like it's a ward is …it's a medical ward but it has a special cubicle made specially to care for psychiatric patients, it's one and then sometimes we…we turn to have more than like it can accommodate three patients at the time but sometimes you find that the patients are more than three, then we have to take another patient to those other wards which is not right nee!!."

One participant said: "The issue is in general wards they do not have interest in mental health and they will not accept the patient who is aggressive, removing the drips of others they will say this is a psychiatric patient."

Furthermore, the participants mentioned a challenge of patient overflow because they only have a few beds to admit the patients. To confirm that there is the mixing of MHCUs and medical patients, participants also mentioned that different types of diagnosis are found in one ward which includes schizophrenia, meningitis, retroviral

diseases (RVD) and pulmonary tuberculosis (PTB).

One participant said: "We are allocated in one cubicle of the medical ward, so you find that in this cubicle we have got 7 beds you find that we have got an overflow of patients and people whom we are having were supposed to stay for 72-hours, so we mix them with general patients."

One participant said: "In one unit, when they say male medical ward Bela Bela hospital you must expect to find patients with meningitis, patients with substances induced psychosis, patients with schizophrenia, patients with meningitis patients with RVD, patients with PTB all these medical conditions combined, plus mental health care (background noise) users."

One participant said: ", They are admitted straight to medical ward then there, they will dis…the doctor from the male medical ward will discharge that patient according to his/her own observations at…at medical ward, then after discharge if the very same happened that the patient need to be admitted, the doctor admit him, will now be able to see that this pa…this patient is starting to be psychotic then he will a refer the patient at our unit."

4.3.3.3 Sub-Theme 3.3: Shortage of Staff

The participants cited that there is a shortage of staff in mental health establishments. Male nurses were regarded as staff and they are needed in the management of MHCUs because female nurses are afraid of aggressive MHCUs. Participants mentioned that they are short-staffed in terms of male nurses' allocation. Again, if there are no male nurses, or staff available in the unit, MHCPs usually depend on security guards to apprehend or manage the uncontrollable patients as female nurses are afraid even to open a burglar gate for MHCUs when there is no male nurse around.

One participant said: "We have got a challenge (clear her throat) we have got the challenge of human resources a…a as you know that in mental health care we need more man power, but here we do not have man power so as we are, we are very much short staffed."

One participant said: "Firstly, there have to be more posts, considering more male nurses, staff, if we are only females you can even see when the male patient is talking to you that you are just a female."

One participant said: "We only have three men, only three men, sometimes you find that another personnel is on lunch and the patient starts to be aggressive and you find that you are helpless, and you have to depend on the security."

One participant said: "Basically we do not have enough psychiatric nurses in the unit is only two psychiatric nurses in the male unit we only have one and in the female unit we do not have psychiatric nurses. So, we need more staff to manage the mental health care users."

One participant said: "We do not have a male nurse presently, when I talk about male nurses, I mean for man power, like now you will just find that we should have opened the male cubicle, but we have locked it, because they are moving around here, and we are only two and there is no male nurse. Us we are busy writing the files, and on the other side we are busy doing clinics."

Furthermore, participants mentioned that MHCUs sometimes threaten and promise to beat them as no security officer is stationed in the mental health unit to assist in case there is a violent patient. They further cited that more staff members are needed in the mental health unit as other nurses might be on leave, attending workshops while

others are working night duty. On the other hand, they are running an OPD clinic for MHCUs during weekdays and they are compromised.

One participant said: "The unit should be having more males than females as its need the man power some…sometimes so you find that for now, we are having, have got the, I think we have got five males and then we have got six or seven but we are not that much or many, you can see that on those staff members, somebody must have to go to leave, some attend the workshop the…others family responsibilities, the night duty, the day staff, you find that you sometimes you work, we work two by two during the day and where another one, we are also conducting a clinic on the daily basis, so the staff is so much short in such (background noise) in a way that it compromises the services that we provide though…it's poor services delivery because from Monday to Friday we have got the…the…the clinic OPD clinic so, in those staff imagine being four, we are being compromised in that one, we take into account the human resource."

One participant said: "We do not have enough male nurses allocated in the psychiatric units, and no security officer who is resident in the unit to assist with violent or aggressive patients as other patients they intimidate us, they promise to beat us, so we need more man power in the unit."

4.3.4 Theme 4: Poor Mental Health Care User Support

The results of the study showed that there is poor support of MHCUs by both the family members and the community, in general. The MHCUs sometimes hasve to stay for a longer period in the institutions even though they have been discharged because the community members do not want them to be released and be reintegrated into their communities. On the other hand, the family members do not visit their patients

after getting them to be admitted in the mental health establishments. Participants indicated that they do not get the full support from the government when it comes to mental health services, whereas other programmes are funded, or they are given enough budget to conduct campaigns. They also cited that people believe that mental illness is caused by witchcraft. Four sub-themes emerged as follows: Poor visitation by family members, Lack of support from the community members, Poor support by government, Poor awareness regarding mental health.

4.3.4.1 Sub-Theme 4.1: Poor Visitation by Family Members

Participants in the study indicated that family members do not visit their MHCUs when they are admitted to the mental health establishments—family members gave excuses like, being busy, not having money for transport to come and fetch MHCUs home or either no one at home will take care of the MHCU because they are working. They further cited that for MHCUs who reside far, it's difficult to get visitors and they stay for a period of three months without getting a visitor.

One participant said: "We are experiencing the problem with the relatives when we call them that their patient has completed the 72 hours, come and take them, usually they take…take 2-3 days to come, they always give the reason that they are busy or they do not have money for transport to come and take their patient or just to visit them, or maybe they do not have someone at home to look after them so, they always postpone of coming to fetch their patients here."

One participant said: "Most of the relatives who bring mental care users here, some of them they will deliver them and never comeback (background noise) we have to seek for them, sometimes they will just drop them on the first day they offered the admission then they are gone, then they will complain, no I cannot take care of him

I'm far away, I'm working far away I'm unable to care for them."

One participant said: "I meant that if the patient is maybe is from Thohoyandou, you find that he is taking almost three months, and nobody is coming to visit the patient. It is not all about giving food and medication, if the family members are coming it will be something, as a patient you can get discharged and live a normal life."

The MHCPs further mentioned that family members sometimes fail to attend the family session arranged by the social worker. They will visit few days after the 72 hours have elapsed. Other families who fail to visit MHCUs, cited that they are afraid of the MHCUs due to the things that they did while they were mentally ill because others have killed or raped, and they are state patients. Participants indicated that previously they used to take discharged MHCUs home with Emergency Medical Services (EMS) if the family members are not coming to fetch or visit.

One participant said: "Oh, and then another issue is that isn't this patient needs to be on within these 72-hour period ne! they need to be seen by OT, the psychologist and the social worker, and then sometimes the social worker ne! needs to assess the patient together with the family members, again it becomes a problem because the family members do not come for the…for the session with the social worker, they do not come we have to wait for them, we have to wait for 4 days for them to come and visit then you find that 72 hours has already elapsed."

One participant said: "Most of the family members do not come to collect their patients… Some say they fear them. Some say they fear them because most of them are state patients, they raped, and then they murdered. So they are afraid, Some promise to kill their members, some patients promise their family members to kill them, so they do not come to visit them here."

One participant said:" We have patients that when they are discharged because their family members are trying to reject them a…a they do not come and collect them yet we use to call the EMS to help us transfer these patients home usually on Wednesdays when other group members are coming back to work."

The MHCUs on the other hand, cited that family members are not coming to visit them in the mental health establishments. They further said that when family members are not coming to visit them, they feel that they are being rejected by their own family members. One participant indicated that he is discharged but his family members are not coming to fetch him. The MHCUs are supposed to be shown love by their family members through hospital visitation.

One participant said: (MHCU) "Ok, the problem I came across was being discharged here and my family members not coming to take me back home, they are not visiting me here at the hospital, I was discharged on the 07th of July and today is the 29th of October, they never came to visit me, maybe they are trying to reject me I do not know because it long since they brought me here at the hospital."

One participant said: (MHCU) "You will find that a person has been discharged today but they do not take him then result in overcrowding here in the ward. Some they do not visit them, like me, they never visited me since they brought me here at the hospital and I do want them to visit me to show that they love me."

4.3.4.2 Sub-Theme 4.2: Lack of Support from Community Members

Participants indicated that community members sometimes do not support families of MHCUs; instead, they aggravate the condition of the MHCUs by buying alcohol and drugs for them, whereas they were supposed to support the family. There are MHCUs who have been stabilized and are ready to go back to the community, those MHCUs

are forced to stay in mental health establishments because the community does not support their release from the institution.

One participant said: "You find that there are other people in the community and MHCUs go and ask for them for drugs and alcohol, they give them. I also observed in the community, there is a child, everyone can see that the child is not mentally stable but they buy him alcohol so it becomes painful if the community is not supporting the family members to manage that child so it is a challenge."

One participant said: "The community itself rejects that patient, so nothing can be done we must all continuously try to talk with those patients a…a with those communities through our social workers and the with those families we must engage it just takes a lesson for them to understand or to the point where we are to the point where they understand like this person committed this crime due to the nature of the illness, so it takes a lesson for them to, for the community to understand such language not unlike us we do understand it better yah, so the issue or reducing the number of…it's not gonna be easier at all yah."

The results of the study further showed that community members are rejecting MHCUs, especially those users who committed crimes in the community. Community structures like Chiefs, ward councillors and police officers were found to be afraid of MHCUs and family's members are supposed to run to them when the user has relapsed and causing harm to self and others, but they can help them as they also are afraid of the MHCUs.

One participant said: "The community members are afraid, even the police sometimes the police themselves you find that they are afraid…the family will call the police and the police will come and see that the person become aggressive then

the…the police would leave the patient and go back, you can see this person is very aggressive and they, then they might the…they might be helping the family…the family members must go where?. So, if the people who are the ones who are trusted to be providing the protection they are not providing, then who else, the neighbour won't do that, if the police cannot do that."

One participant said: "Sometimes when we admit them, we find that the chief does not want them back, and remember this is not a prison, they need to go back to the community when they are stable."

One participant said: "The ward councillors those whom the family must run to for support, but only to find that those are the people most of them they are afraid of them, they are afraid of MHCUs."

One participant said: "They still want to have their lives there, but you find them they are ready, they are ready, they are being stabilized everything. They are ready to go and live in the community, but the community does not want them, and you cannot blame the community."

4.3.4.3 Sub-Theme 4.3: Poor Support by Government

Participants of the study indicated that the mental health program is not taken seriously by the government as there is no budg*et* allocated specifically for mental health services. Lack of funding to the program results in MHCPs not being able to conduct awareness campaigns. Furthermore, participants mentioned that mental health services are not taken seriously as there is no medication for MHCUs. Mental health services are not supported by the government because managers have no interest in the program. Stigmatization was also cited to mental health services, where in some instances participants cited that government is not supporting them because

there is ward for mental health.

One participant said: "According to my personal view a…a…a mental health in our province Limpopo is not taken seriously a… its undermined, mental care users are undermined, the program itself is undermined that's why we do not even have the budget specifically for mental health to conduct campaigns."

One participant said: "Budget for mental health should be increased by the government so that we can be able to purchase enough medication for the patients because now they say our budget is finished and we do not have other medication that we normally use."

One participant said: "A… this…this, this problem that we are facing it is arising from the root, if we can fix it from the roots, most of the things we will sort them out the roots, I mean the ward, give us the ward, the government should give us the ward, if we get the ward we will be fine."

One participant said: "I think they do not take us seriously or they, they regard us a…as if we are just people or they cannot consider us to be like other people because if it wasn't the case they should at least take care of us they must make that the patient…our patients are happy and we are happy with them."

One participant said: "If we say we want money for something they say they do not have, but when you check for other wards, they are there, So the issue of stigmatization comes in, they do not have the interest in Mental Health Services."

On the other hand, participants cited that the government is not supporting mental health services, because they have legalized the smoking of dagga and MHCPs consider smoking of dagga as the primary cause of relapse psychosis for MHCUs.

Participants indicated that they often admit MHCUs with substance-induced psychosis disorders in the mental health units because of the legalization of dagga.

One participant said: "Because when you use substances you can relapse and come back but it is a challenge because the government has approved that you can smoke dagga anywhere and when I look at the stats we are admitting more MHCU with SIPD."

One participant said: "Most of them who are not responding are using Nyaope and dagga. Dagga Is legalised, I'm saying from the a…from all this type, before the legalisation of dagga. We had the same problem, that they were using this dagga and Nyaope and they were not, and they are not easily managed when they are using this."

4.3.4.4 Sub-Theme 4.4: Poor Awareness Regarding Mental Health

The results of the study showed that there is poor awareness of mental health both in media and in primary health care setting or clinic. The participants cited that mental health topics are not discussed on radio or news like other topics, except when there is a national crisis like what happened in the Life Esidimeni tragedy. They further mentioned that other programs are supported and funded, and they conduct door-to-door campaigns to make the community aware of the program or disease, but there is no such in mental health.

One participant said: "If you can open the news blog, or radio, the only disease they talk about is HIV/AIDS, TB and others. The only time we heard about mental illness being considered was Life Esidimeni tragedy, after that we are no longer hearing about mental illness."

One participant said: “They are not taking psychiatric serious but you will never miss HIV & AIDS, will never miss T.B, will never miss neonatal but mental health is nowhere to be funded, it does not have any budget now it’s about five years back we haven’t had any budget for the mental health to conduct campaigns.”

One participant said: “Another thing I am worried about is that, other clinics do not give community health education on how to manage a mental health care user because that is one of the reasons some of them relapses.”

One participant said: “Ehh, let me take you to another awareness which is most common in South Africa, which is HIV/AIDS, you find that their target is people who are positive and those educational go do door-to-door and talk about HIV but for mental illness there is no such meaning we will have more problems when there is somebody who is mentally ill. Or maybe, for example, if one has epilepsy and they do not know the symptoms, it means the patient can die”

4.3.5 Theme 5: Insufficient Knowledge Regarding Mental Health Care

The study findings revealed that MHCUs do not have an insight into their mental conditions. This was evident as some of them continue to smoke dagga, drink alcohol and forget to take their treatment. When MHCUs default treatment, they fall into a relapse psychosis. Furthermore, participants cited that MHCPs do not have enough knowledge regarding mental health, and the lack of knowledge implied a lack of training. MCHPs who are working in mental health units are being labelled mentally ill. People who are labelling MHCPs to be mentally ill are the ones who were supposed to have more knowledge on mental health because they are trained, unlike community members. Community members were found to lack mental health knowledge because others think that MCHUs must remain in mental health establishment despite their

improved mental condition. The results also revealed that the disability grant of MHCUs is being misused as it is being spent on alcohol. Furthermore, family members are taking advantage of the grant and use the money for their personal needs, not for the patient. Four sub-themes emerged: Poor insight regarding mental state by MHCUs, Insufficient knowledge about mental health care by MHCPs, Insufficient knowledge about mental health care by community members and Misuse of resources.

4.3.5.1 Sub-Theme 5.1: Poor Insight Regarding Mental State by Mental Health Care Users

The results of the study indicated that MHCUs lack insight regarding their mental condition as they do not agree that they are mentally ill. Some MHCUs usually take drugs and alcohol, forgetting to take their treatment which results in relapse psychosis. Participants also cited that MHCUs sometimes request to be released from the mental health establishment to go and consult their traditional healers as they think they cannot be cured while at the establishment.

One participant said: “Most of our mental health care patients do not agree or admit that they are have a mental illness, so it becomes a problem to us because we have three days to keep them so imagine on day 1 the patient is still…is…is having denial, that is having mental health illness now, how is he going to cope for 3 days obviously we will have to keep him on sedation for the next 3 days because when he is normal he is going to fight us.”

One participant said: “Because we were having another one who used to say we should discharge him so he could go to his traditional healer and take some herbs because he cannot be healed here.”

One participant said: "Most of them they do get the social grant, but after getting paid, they are not staying at home going around drinking the money, you ask them why are you coming back, they now got the grant, they spend the grant on alcohol…they do not take medication, they default treatment they comeback at once, it's a circle, they lack insight regarding their mental health."

One participant said: "We admit him now then now then because most of them when they become stable, we discharge them, they go home and they usually do, drink alcohol smoke dagga and either drugs which triggers their mental illness, then comes back because they do not have insight to their mental condition. We usually sometimes have; we can admit one person 3 times in one month if not twice."

On the other hand, participants believed that they were cuffed for no reason when they were brought to the mental health unit because they think they are not mentally ill. Participants confirmed that they smoke weed when they are outside the mental health establishment. Smoking weed might be the reason for users to be readmitted.

One participant said: (MHCU) "With myself I …I they do not, you know how they cuffed me because I'm not mentally ill, they only cuffed me first day when I come for admission, and they uncuffed me, when they uncuff me I even get discharged without being cuffed again, but I'm ok, not sick."

One participant said: (MHCU) "Some they do not know their stories, myself I do, I even take alcohol, when you made me stay here you helped me a lot I do not drink traditional alcohol, even the weed I do not smoke when I'm outside I smoke weed and cigarette, but traditional alcohol I do not touch. Further said I smoke weed when I'm out side, these days weed, they are not the same they are mixed with chemicals and other things so when I smoke weed and smoke that's you will see that now I'm high

because I do not talk too much”

4.3.5.2 Sub-Theme 5.2: Insufficient Knowledge About Mental Health Care by Mental Health Care Practitioners

The findings of the study revealed that MHCPs feel that they are not competent like those who are working in a specialized mental health establishment, because those who are in specialized mental health establishments only work with MHCUs on a daily basis and that might be the reason they have more knowledge than those who are working with general medical patients and mental health at the same time. Participants further cited that they were not trained to care for MHCUs.

One participant said: “It’s a bit of a challenge, they have that mind of that they are not trained, because I remember the other one said I’m not that trained to can care for the mental health care users, but we explained the basic needs does not need training, does not need you to be trained for psychiatric, basic needs are there as a scope of practice you are compelled to take care of mental health users.”

One participant said: “Yes because sometimes and also they feel like they are not that competent enough, for psychiatry, someone also mentioned to me that they are not that well trained and unlike Thabamoopo where they see patients every now and then but here it’s a bit of a challenge. They say,well she said (laughed)she said that at eeh ehh what is it, varsity they only do it I do not know is not that enough, Doing that training because they do not do it that much compared to the medical side of it, and after completion as long as you haven’t done it in a psychiatric hospital, like for a long time is a bit of a challenge, so if they find it difficult they have to sit down, call the Thabamoopo, it takes forever to reach the psychiatrist, so they just feel like is not within their scope of practice(voices of people).”

One participant said: "But those who are booked for review of treatment, assessment by the psychiatrist is not done the whole of 2018 it was not done so the treatment, the medical practitioner they are not well trained, some just do not like it at all so it's, it's a bit of a challenge to, you know when they come they just need to prescribe and that's it."

Participants further indicated that health care providers seem to know little about mental health whereas they are the ones who were supposed to have a better understanding because they are trained. In other instances, MHCPs were said to be affected by myths regarding the cause of mental illness, and it was suggested that they might need training regarding mental health issues.

One participant said: "Maybe my thinking is that they still have got those minds that mental illness is caused by super natural powers, but I would not think of them having such minds, because these are educated people, one should have the knowledge, to know what mental health is, but it is not the case."

One participant said: "They call us those ugly names you can think of like they use vulgar words towards us it just that sometimes I cannot say what they say mara!, but yah! Is not …is not like is not good to say to someone, like they should know what mental health entails because they are nurses and got training on mental health."

One participant said: "Other health professionals with psychiatric nursing, they think when we are working with mental health users, we end up like being like our patients, and they label us mentally ill because we are working in a psychiatric unit, I think they do not know about mental health, they still need to be trained."

4.3.5.3 Sub-Theme 5.3: Insufficient Knowledge About Mental Health Care by Community Members

Participants indicated that community members do not have knowledge on mental health issues, hence, in some instances they complain to the Chief that they do not want the patient to be released to the community because they still lack understanding of what mental health is. Only a few in the community were said to understand mental health. Other community members feel that the patients need to stay for the rest of their lives in mental health establishments, not to be discharged.

One participant said: "Community members do not understand mental illness, not at all, only few specific people, the rest, but majority they do not know, and they do not care about mental health care …they do not have knowledge about mental health care users."

One participant said: "If you are a chief, you as chief have experienced the bad things done by the patient in the community, so it is only the community members who are seeing that, so for you to keep the community safe you should include the community members. The decision also involves them so that they can understand mental health because they do not understand at all."

One participant said: "Ehh, mostly I am also part of the community, I stay in the village. The things we get from the interviews or the reports, it tells you that the community do not know about mental health, they do not understand how mental health care users behave or what makes them behave that way."

The participant further said: "You find that the community does not like the patient, and they complain to the chief, they still have that mentality that the institution must be privatised and let the patient stays here for life. They are still practising that. That

is a reason why a patient must be kept here for a long time, because the community does not want them."

Findings of the study further revealed that community members still believe that mental illness is caused by witchcraft or MHCUs are cursed, this was evident when other relatives of MHCUs go to the mental health establishment and demanding to take the patients to consult the traditional healers for alternative treatment while MHCUs are still under 72-hour observation.

One participant said: "I do not know if because they still have the olden believe about mental health care users that these people are mentally ill, they are cursed and whether is the illness of witchcraft or what, but I do not know."

One participant said: "Some of the relatives just come to demand their patients before 72 hours elapsed, they come and fight the nurses, demanding the patients believing that they are bewitched."

One participant said: "There are these, that mental health care users are bewitched, mental health care users deserve to always be in the hospital, mental health care users do not have right, mental health care users do not deserve to bath, mental health care users do not deserve to bath, to have partners those kinds of misconceptions about them."

One participant said: "Because some think mental illness is caused by witchcraft, they think they have been bewitched."

4.3.5.4 Sub-Theme 5.4: Misuse of Resources

The study results showed that the MHCU grant is not well handled, as others are using

the grant money to buy drugs and alcohol. Family members are said to be abusing the grant of MHCUs for their own personal use and not for the needs of the patient. They can even try to get the patient to be admitted so that they spend the grant of the MHCU while the patient is away. Furthermore, participants further said that for the grant to be managed well, the money needs to be administered by someone as the MHCUs might use it to buy drugs and alcohol.

One participant said: "Eix… on the issue of the grant I think maybe the SASSA grant …no! it is not used properly, is not used according to law, but maybe like the patient, the psychiatric patient does not need to be given the grant or not…not like that it must be given to somebody who is going to look after them, it must not directly be given to them because they…they say they are going to spend it on alcohol on a daily basis so, if ever it can be given to somebody who is a guardian a legal guardian to that patient."

One participant said: "Most of them they do get the grant, but they are staying alone at home you ask them why are you using the grant to buy alcohol…but they spend the grant on alcohol not buying what it was supposed to help them, like food and clothes."

One participant said: "Their relatives will explain to us that this one has relapsed because he is busy taking drugs, smoking and drinking excessive alcohol, immediately when he gets paid, he takes money to buy drugs and alcohol."

One participant said: "Most of them its grant they are on social grant and is not being used well at home, some of them they do not even get the money that's why they prefer that…usually they come here before let's say, when the month, when it is 2 days after he gets the social grant he comes here, so that the family members will surfer and because they want the money they will visit him each time, and keep saying

we can see that he is fine you can discharge him, after discharging him, he goes home with the money and they take it and then they just let him surfer until next month."

Furthermore, participants said that family members get the MHCUs admitted to mental health establishment so that they can remain to enjoy their money while they are away. Others withhold the SASSA card, so that they can withdraw all the grant money and not give it to the owner—they only submit the ID book when asked about the belongings of the user.

Another participant (MHCU) said: "I was not even told I was getting the grant but my SASSA Card was with my family members and when the social workers asked about the whereabouts of my card they said they did not know about my card, they only had my ID book."

Another participant (MHCU) said: "Other patients here they get the grant but they do not see their money, they brought them here to the hospital for admission so that they can remain at home using their money, spending it on their personal needs not on the patient."

4.3.6 Theme 6: Strategies to Improve the Management of Mental Health Care Users

Strategies to improve the management of MHCUs were suggested by the participants as: Decentralization of mental health services, Halfway houses for MHCUs, NGOs (home-based carers), Health education regarding mental health issues, Mental health advocacy, Workshops on new information regarding mental health and Infrastructure improvisation.

4.3.6.1 Sub-Theme 6.1: Decentralization of Mental Health Services

The results of the study showed that decentralization is a good strategy in the management of MHCUs because users will be cared for in the mental health establishments near their homes. Participants further mentioned that the benefits of decentralization will include that the patients to be cared for, near their homes and there will be no need to travel long distances by family members to visit the MHCUs. Treatment will also be collected at the nearest clinic or community health centre close to where the MHCUs stays.

One participant said: "Isn't that when the, they explained how they go do the decentralisations of this patients a… isn't it start from…from… national, because it is the…the…the… mandate was given by the minister to say, as the minister of health of health, there should be those hospitals in terms of managing mental care users, that the mental health care users must be nursed and managed near to their home, yes, so now they are not, it is not done because we have to take them to 'Evuxakeni' sometimes as far as 'Hayani' where…where some cases we…we… cannot handle especially those who cannot even have their families so now you find that some of them we take them to Thabomoopo or their original home is Venda or maybe they are working this side we admit them here now the family must come from home most of the time those who come we did admit we find that the parents are grown up they are old age. They cannot manage to be travelling long distances and then their families who are not working they do not have money to travel so those are the challenges that we end up not finding the family them we communicate with them telephonically and then so the decentralisation it was gonna wok well because we would have patients closer to their home and then having them closer to their home. We have the cooperation of the family members it will be easier to…to let the family adapt on how to care for their patients, then another thing is that it's easier to reintegrate the patient

back to the community."

One participant said: "When we discharge, we sit with them down and say that now you see we give them the discharge forms, the Form 3, then we give them 2 ne! one original one copy we…we…we. state clearly that they must go to their nearest clinic and submit the…the…those forms there so that when their medication is finished, they go to the same clinic and then collect their medication."

4.3.6.2 Sub-Theme 6.2: Halfway Houses for Mental Health Care Users

Participants mentioned that establishing halfway houses might assist in the management of MHCUs as other users do not have anyone to take care of them when discharged from the mental health establishment. The halfway houses or places need to be licenced in to be able to provide care treatment and rehabilitation to the MHCUs.

One participant said: "They are going, yes because we…we do not have those halfway houses and all those other places where like in other provinces they have, where people can stay there and be taken care of or maybe they go there during the day, they are providing services so we do not have such facilities."

One participant said: "Some of the places a…like there are this other one yah!!, another thing is that if we can have the easier way to licence institution like the… those… those institutions like places where people volunteer to have places where they can manage the mental care users especially who do not have anyone to take care of them. Because people are working some are working far way and they do not have anyone to take care of them at home. So, there are those kinds of places where people will just build a place, rent the place where there's many rooms where they keep them there so we know that there are expected standards, if you want to keep a number of a…a patients there, so now if we have such places can be helpful and be

licenced so that they meet standards and be licenced then we would have (background noise) more places to be able to take these people but the challenge is that we do not have such licenced places in our Province."

4.3.6.3 Sub-Theme 6.3: Non-Governmental Organizations (Home-Based Carers)

Participants mentioned that community home-based carers can be delegated by MHCPs to go and check or monitor if MHCUs are complying with the treatment as carers are attached to the community mental health facilities. However, participants acknowledged that there are MHCUs who are difficult to be managed, or who are aggressive, and the carers might find it difficult to monitors those.

One participant said: "Here we refer them to the clinic and then at the clinics that's where they get their treatment monthly, then there's are home base carers, carers who are helping in the community. But is difficult for them to deal with the mental care users because there are those who are kind of aggressive, they are aggressive."

One participant said: "We are having the home-based carer, so these should be the ones who should be delegated to go check the MHCU to make sure they take their medications, because checking on them, they will understand they have the support from us."

4.3.6.4 Sub-Theme 6.4: Health Education Regarding Mental Health Issues

Participants cited education as a powerful tool to empower the community and family members about mental health issues. They indicated that family members need to be educated regarding the signs and symptoms of mental illness so that they can see if the MHCU have relapsed and been able to shout for help. Furthermore, participants

mentioned that if family members accept the MHCU's condition, it will be easier for the community to follow suit and accept the mental health condition of the user.

One participant said: "So, but family education will be very necessary so that even whenever they experience problems, they know, and then we can educate them about signs and symptoms of mental health illness. So, that when they see patient acting in this way, they can call someone close, they can call the police, or they can call someone for help."

One participant said: "Yes, the family members will be assisted because some do not understand the condition of their children so the community will try to educate them, they must accept their children. The community will also accept them."

One participant said: "First one, education about if ever, those!, a…I want to…to…to…like to emphasize the issue of compliance, family members or….even the community members like they should (clapping hands) like they should help one another in making sure that the patient is complying to treatment."

Participants indicated that educating the community members regarding mental health is needed so as to inform them that they need to include MHCUs in the community activities and stop side-lining people with mental illness. They further said that community education might go a long way as a way of dispelling the misconceptions about mental illness. Again, in certain months, mental health must be prioritised and conduct awareness campaigns.

One participant said: "Like educating the community members, must not to mock, not to mock or side-line mental health care users. They should inform them like as they should …. they should engage with them in issues relating…I mean in issues

relating the community, when the community is having a community meeting regarding issues of like water and electricity, mental health care users should also be included to take part."

The participant further said: "I wanted to say that we do need to conduct some community outreach about mental health and then clean all the misconceptions perceptions about mental health."

One participant said: "Yah! so I think it will go long way in, like I think educating them. If ever we can do community prog…programs about Mental health care. Most of the people at least they would have light, and most of the people maybe they will know about these mental health care users. Because biggest issue it needs to be clarified and then it might be respected."

One participant said: "Yes, they have access to information. For the community part, there must be this institution and the Department of Health providing education about mental health, more especially around September because it is a mental health month."

One participant said: "When you consume alcohol that MHCU will relapse, they will know we are not supposed to give him drugs or alcohol because he may relapse or education may work to the community members, so I think knowledge is power, these people should be educated about mental health issues."

Participants cited that community members need to be taught about the rights of MHCUs. The MHCA protects the rights of MHCUs. Some of the rights that they thought the community members need to be taught about include: right to the proper medical care, right to supportive and caring family structure, the right to life, basic

human needs, like having…having a wife, being at home and right to be loved.

4.3.6.5 Sub-Theme 6.5: Mental Health Advocacy

Participants believe that if the program has a person who is advocating for it, people tend to listen to the complaints raised by activists. They further indicated that when the program has an advocate or activists, the mental health program might be allocated the budget or funds to conduct awareness campaigns.

One participant said: "I just think there are no, should I say activists, people who speak out for mental health program, because if the program has got people who speak for it, there's someone who is listening, they listen."

The participant further said: "Isn't that activists will be there, they speak for the program, if they cry, their voice is heard, the intervention will be there and then it will lead us having own budget to be able to do such outreach such as campaigns."

4.3.6.6 Sub-Theme 6.6: Workshops on New Information Regarding Mental Health

Participants mentioned that information is changing on a daily basis and they need to be updated on the recent developments in mental health because they depend on the internet to get recent information about mental health. They further indicated that workshops regarding the management of MHCUs need to be conducted so that they can know how to manage them. When it comes to the management who usually not consider the mental health unit when allocation budget, they suggested that the managers be in-serviced so that they can understand mental health.

One participant said: "Updating courses where we hope for updating ourselves and the likes…because the information is changing every time, now and again, so people

should be having workshops and then updated on the recent information, because recently for us to get anything we are using the internet."

One participant said: "In case of the shortage of materials and medications, the management has to be given some in-services training so that they must understand mental health and the importance of those patients. Training is need so that they know what mental health is"

One participant said: "Ehh, I do not know. Maybe if we can have a lot of workshops regarding mental health, where they will teach us about how to care for these patients, how to manage aggressive patients because we need more training when working with these patients."

4.3.6.7 Sub-Theme 6.7: Infrastructure Improvisation

Participants mentioned that they are providing mental health services though they do not have a fully-fledged mental health unit, they have improvised one of the cubicles that were allocated to them in either male or female medical ward, have it secured with burglar bars so that they can contain those MHCUs who are aggressive. Although they suggested that if MHCUs can be allocated one ward with its staff compliments might be a good idea so that they can provide quality care to the MHCUs.

One participant said: "we improvise, room on room that is a normal room for medical patients, and we just improvise and converted it be a separated room we use it as a seclusion room and say that admission separate unit for them, so is the only one, has got four beds, so that if the one that we use, we put some burglar proofs, burglar doors, because if ……an open, so we put burglars so that we can be able to keep our aggressive mental health care users there."

One participant said: “Yes, it is very same ward we are conducting 72-hour observations here in the same ward, but we have a specific …specific cubicle ward for them which is which has a battler door yah! It’s there at the corner I will show you when we are finished here, we only have it’s only accommodating 3 psychiatric patients, like it’s problem like when we have 4 psychiatric patients, one will be forced to be mixed with other medical patients.”

One participant said: “Infrastructure suggestion, but if ever you can, one ward can be allocated for only mental health care users with its own staff members, with its own patients and nurses so that we can provide care to our patient.”

4.4 Summary

The results of the study pointed out several challenges in the care and management of MHCUs in mental health establishments. Challenges includes; structural related, inadequate management of MHCUs when admitted, improper application of safety measures in the wards, poor MHCUs support and Insufficient knowledge regarding mental health care. Furthermore, MHCPs suggested the strategies to improve the challenges they face in their daily work

CHAPTER 5

PRESENTATION OF THE QUANTITATIVE DATA

5.1. Introduction

The previous chapter dealt the qualitative research findings. In this chapter, the quantitative research findings will be presented which include the Demographic characteristics of the respondents, Views of mental health care providers (MHCPs) regarding the care being provided to mental health care users (MHCUs) in their hospitals/facilities, Views on the provision of mental health services and MHCPs relationship with MHCUs, Knowledge of MHCPs regarding the rights and privileges of MHCUs during admission and stay in a mental health establishment, Challenges faced by the MHCPs during their daily work activities in mental health establishments in Limpopo Province and a summary thereof.

The main objectives of the quantitative research strand was to investigate the views and experiences of MHCPs caring for MHCUs in Limpopo Province. The specific objectives of Phase 2 were to describe the views of mental health service providers regarding the care being provided to MHCUs in their hospitals/facilities in Limpopo Province, to determine knowledge and awareness of MHCPs regarding the rights and privileges of the patients during admission and stay in mental health establishment, to describe the challenges faced by the MHCPs during their daily work activities in Limpopo Province and to discuss the views of the MHCPs on how these services rendered to MHCUs can be improved. Self-administered questionnaires were used to collect data in the selected mental health establishments.

Three hundred and thirty-nine (339) questionnaires were distributed and 314 were returned. However, only 305 questionnaires were fully completed, and the response rate was 93%. Data were analyzed using the Statistical Package for Social Sciences (SPSS) version 26.0. Tables and charts were used to present the data.

5.2. Demographic Characteristics of the Respondents

Three hundred and five (305) respondents participated in the study, where 228 were Professional Nurses (PN) with Psychiatric Nursing Science qualifications, 37 were clinicians (Medical Doctors; Dr, Clinical Psychologists and Psychiatrists) and 40 respondents were allied health workers (Social Workers (SW), Physiotherapists, Occupational therapists (OT) and Dieticians). Limpopo Province is divided into five districts. Figure 5.1 shows the distribution of respondents according to district. The district with the highest number of respondents was Capricorn District (n=76; 24.9%), followed by Sekhukhune District (n=66; 21.6%), then Vhembe and Waterberg Districts each with (n=61; 20.0%). The district with the least respondents was Mopani which accounted for 13.4% (n=41).

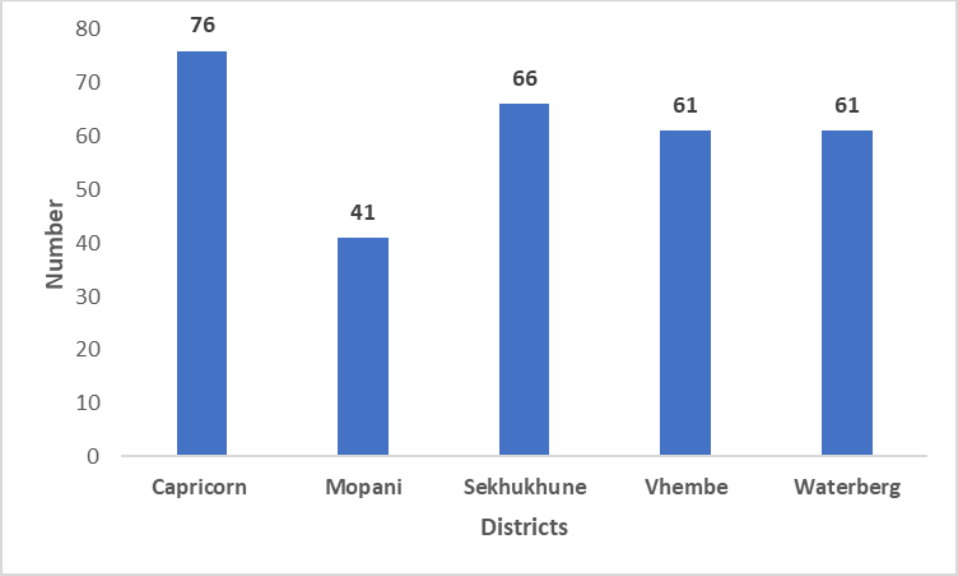

Figure 5.1: Distributions of the respondents according to district

Table 5.1 presents the gender, age and years of experience of the respondents. More females (n=179; 58.7%) participated in the study. The reason for females being higher than males can be attributed to the fact that nursing is predominantly a female profession. The age groups of respondents ranged from 20 to 65 years old. Mental health care practitioners aged between 20 to 30 years old were the highest in number (47.3%; n=144), while those aged 51 years old and above were the lowest in number (5.2%; n=16). In Limpopo Province, more young people or youth were found to be working in the mental health units than older people. The experience of the respondents was also considered with majority years of experience ranging inclusively from 1-20 years.

Table 5.1: Gender, age and years of experience of the respondents (n=305)

Item	Attributes	Frequency	(%)
Gender	Male	126	41.3
	Female	**179**	**58.7**
Age	20-30	**144**	**47.3**
	31-40	108	35.4
	41-50	37	12.1
	51 and above	16	5.2
Years of experience	1 to 10 yrs.	**111**	**36.4**
	11 to 20 yrs.	**111**	**36.4**
	21 to 30 yrs.	65	21.3
	31 and above	18	5.9

Figure 5.2 shows the respondents' occupations. The majority of the respondents were nurses (n=228; 74.8%), followed by medical doctors (n=31; 10.2%), then occupational therapists (n=20; 6.6%), and social workers (n=15; 4.9%), whereas psychologists made up the less represented group (n=6; 2.0%) and, as such, they are regarded as

a scarce skill in the province. Other allied health professionals were only found in specialized mental health establishments, including physiotherapists and dieticians who only accounted for 1.6% (n=5) which is the lowest number as in general mental health establishments they do not form part of the care, treatment and rehabilitation (CTR) of MHCUs.

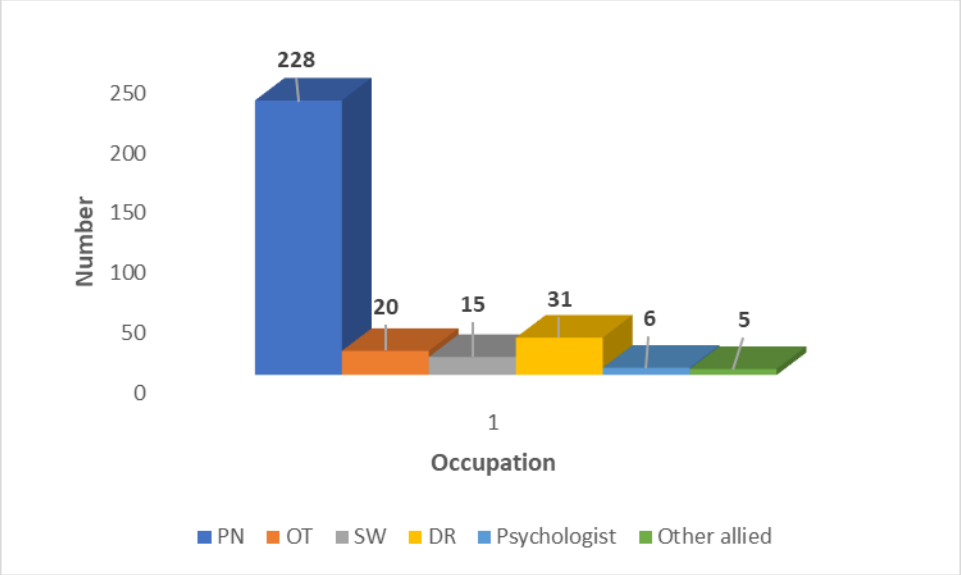

Figure 5.2: Occupation of the respondents. **PN:** professional nurses; **OT:** occupational therapists; **SW:** social workers; **DR:** medical doctors; **Psychologist:** clinical psychologists and psychiatrists; **Other allied:** physiotherapists and dieticians.

5.3. Views of Mental Health Care Providers Regarding the Care Being Provided to Mental Health Care Users in Their Hospitals/Facilities

This section entails the views on the assessment, admission and treatment, and rights of MHCUs, the provision of mental health services, MHCPs' relationship with MHCUs, as well as the therapeutic setting and availability of resources. Table 5.2 depicts the views of MHCPs regarding the assessment that is being provided to MHCUs before they are admitted to the mental health unit. Slightly more than half of the respondents (n=166; 54.4%) reported that they know how to conduct the assessment before

admitting MHCUs in their respective units.

Table 5.2: Views on the assessment of mental health care users

Items	DNK	D	A
MHCPs know how to conduct an assessment of MHCUs before admission.	10 (3.3)	129 (42.3)	166 (54.4)
MHCPs have the knowledge and the skills required for assessment of MHCUs	12 (3.9)	205 (67.2)	88 (28.9)
I doubt the efficiency of the assessment conducted by MHCPs	11 (3.6)	184 (60.3)	110 (36.1)
Assessment of MHCUs is done in a convenient venue	13 (4.3)	194 (63.6)	98 (32.1)
All MHCPs have been trained on the assessment of MHCUs	8 (2.6)	203 (66.6)	94 (30.8)

Key: DNK: Do not know; D: Disagree; A: Agree; Values outside brackets=n; values inside brackets=%

When respondents were asked whether they have knowledge and skills required in conducting the assessment of MHCUs, the majority of them (n=205; 67.2%) indicated that they disagreed with the statement, implying that they do not have the knowledge and skills required, and only 28.9% (n=88) of them agreed that they have the necessary knowledge and skills required to conduct the assessment. A considerable number of respondents (60.3%, n=184) also reported that they doubt the efficiency of the assessment conducted by MHCPs in their mental health establishments. When MHCPs were asked about the convenience of the assessment venue, more than half of the respondents (63.6%, n=194) said that the venue that they are using is not convenient.

Lastly, on the assessment of MHCUs, respondents were asked if they have been trained on how to conduct the assessments, most of the respondents (66.6%, n=203) indicated that they had never received training on how to conduct the assessment of MHCUs. Almost half of the MHCPs in the study in all mental health establishments

cited that they do not know how to conduct assessments of MHCUs. Furthermore, most of the MHCPs cited they lack the knowledge and skills to conduct such assessments. This suggested that there is a lack of training in the assessment of MHCUs. Knowledge and skills can be regarded as key in the proper management of MHCUs in mental health establishments.

5.3.1. Views on Admission and Treatment of Mental Health Care Users

Views on admission and treatment of MHCUs in mental health establishments are shown below in Table 5.3.

Table 5.3: Views on admission and treatment of mental health care users

Items	DNK	D	A
MHCPs know the procedure to be followed during MHCUs admission.	5 (1.6)	225 (73.3)	75 (24.6)
MHCPs know all the forms to be completed during admissions	6 (2.0)	195 (63.3)	104 (34.1)
Treatment of MHCUs is paid for by the family members	7 (2.3)	112 (36.7)	186 (61.0)
All MHCPs have been trained on the completion of all admission forms of MHCUs	8 (2.6)	199 (65.2)	98 (32.2)

Key: DNK: Do not know; D: Disagree; A: Agree; Values outside brackets=n; values inside brackets=%

The majority of the respondents (n=225; 73.3%) said that MHCPs do not know the procedure to be followed during the admission of an MHCU in their mental health establishments. Furthermore, with knowledge regarding the Mental Health Care Act (MHCA) forms that need to be completed during the admission of the MHCU, the majority of the respondents (n=195; 63.3%) said that they do not know all the forms. However, when asked if the treatment of MHCUs is being paid by family members, most of the respondents (n=186; 61.0%) indicated that the treatment of MHCUs is not paid by family members.

The majority of the respondents (n=199; 65.2%) indicated that they were not trained on the completion of all admission forms when admitting a patient. Lack of training on how to complete MHCA forms was noted as a serious challenge, as in almost all mental health establishments MHCPs were not aware of the procedures to be followed and forms that need to be completed when admitting MHCUs in their mental health units. The lack of training by MHCPs in the completion of MHCA forms and procedure of MHCU's admission might compromise the service that is being provided in mental health establishments.

5.3.2. Views on the Rights of Mental Health Care Users

Views on the rights of MHCUs, when admitted to a mental health establishment, is illustrated in Table 5.4.

Table 5.4: Views on the rights of mental health care users

Items	DNK	D	A
The rights of MHCUs are being observed in the institution	2 (0.7)	216 (70.8)	87 (28.5)
The MHCUs are taught about their rights in the units by MHCPs	3 (1.0)	188 (61.6)	114 (37.4)
There is a chart displayed on the wall or notice board about the rights of MHCUs	0 (0)	161 (52.8)	144 (47.2)
The MHCUs know their rights while admitted to the unit.	9 (3.0)	205 (67.2)	91 (29.8)
Family members are also taught about the rights of their relatives in the unit	11 (3.6)	195 (63.9)	99 (32.5)

Key: DNK: Do not know; D: Disagree; A: Agree; Values outside brackets=n; values inside brackets=%

When respondents were asked if the rights of MHCUs were being observed in their mental health establishments, most of the MHCPs (n=216; 70.8%), indicated that the rights of MHCUs are not being observed in their institutions. Moreover, 61.6% (n=188) of the respondents cited that MHCUs are not taught about their rights when admitted

to the mental health establishments. More than half of the respondents (n=161; 52.8%) mentioned that there is no chart displayed on the wall or notice board about the rights of MHCUs in their mental health establishments. Furthermore, the majority of the respondents (n=205; 67.2%) disagreed that MHCUs know their rights while admitted to the mental health unit. Most of the respondents (n=195; 63.9%) held a view that family members are not taught about the rights of their relatives in the unit as they frequently visit. MHCA clearly stipulate the rights of MHCUs when admitted to mental health establishments, however, the results of the study found the opposite as rights of MHCUs were not observed and they are violated by those who were supposed to uphold them. Furthermore, the results showed that MHCPs are not teaching MHCUs and family members about the rights when admitted and visiting their patient in the unit. This might mean that the MHCA is not implemented fully in mental health establishments whereas the act is the core business of the mental health unit.

5.3.3. Views on the Provision of Mental Health Services and Mental Health Care Providers' Relationship with Mental Health Care Users

Views on the provision of mental health services and MHCPs' relationship with MHCUs in the mental health establishment are summarized in Table 5.5. Slightly more than half of the respondents (n=208; 68.2%) indicated that MHCPs provide quality care to MHCUs. However, an equal proportion of the respondents (n=206; 67.5%) mentioned that the service provided to MHCUs is not according to the MHCA 17 of 2002. A few numbers of respondents (n=182; 59.7%) said that MHCPs always collaborate with multidisciplinary teams when providing mental health care services to MHCUs. As many as 43.3% (n=132) of the respondents said that MHCPs sometimes display a negative attitude while providing care to MHCUs. The relationship between the MHCUs and MHCPs was said to be disquieting in the mental health unit, whereby

the majority of respondents (n=227; 74.4%) confirmed that the relationship between the MHCPs and MHCUs is not good.

Table 5.5: Views on the provision of mental health services and mental health care providers' relationship with mental health care users

Items	DNK	D	A
The MHCPs provide quality care to MHCUs	4 (1.3)	208 (68.2)	93 (30.5)
Services provided to MHCUs are according to the MHCA 17 of 2002	6 (2.0)	206 (67.5)	93 (30.5)
The MHCPs always collaborate in providing mental health service to MHCUs	4 (1.3)	182 (59.7)	119 (39.0)
The MHCPs sometimes display a negative attitude while providing care to MHCUs.	10 (3.3)	132 (43.3)	163 (53.4)
The relationship between MHCUs and MHCPs is good in the unit	5 (1.6)	227 (74.4)	73 (24.0)

Key: DNK: Do not know; D: Disagree; A: Agree; Values outside brackets=n; values inside brackets=%

As seen from the results, the service provided to MHCUs is not up to standard or of good quality as it is not provided according to the MHCA which guides the care, treatment and rehabilitation (CTR) of MHCUs in mental health establishments. Poor quality of service might be due to the lack of collaboration between the multidisciplinary team members because caring for MHCUs needs the entire multidisciplinary team to be involved to provide good quality care. On the other hand, the attitudes of MHCPs towards the MHCUs must be positive to strengthen the good nurse-patient relationship.

5.3.4. Views on Therapeutic Milieu and Availability of Resources

Table 5.6 shows the views on the therapeutic milieu and the availability of resources. Respondents were asked if their mental health establishment provided a therapeutic milieu to MHCUs, and more than half of the respondents (n=170; 55.7%) said that their mental health establishment does not provide such an environment. Most of the

respondents (50.4%; n=154) cited that there is the mixing of MHCUs of different categories, which include state patients, 72-hour or forensic observation and chronic users in the same unit. The majority of the respondents (n=201; 65.9%) mentioned that they do not have enough beds for MHCUs to sleep on when admitted. Furthermore, the majority of the respondents (n=199; 65.2%) mentioned that the paint used in the mental health unit is not bright and the unit is not renovated frequently.

Table 5.6: Views on therapeutic milieu and availability of resources

Items	DNK	D	A
The hospital environment provides a therapeutic milieu to MHCUs	5 (1.6)	170 (55.7)	130 (42.7)
There is a mixing of MHCUs of different categories (SP, Observation, and chronic users) in the same unit	2 (0.7)	149 (48.9)	154 (50.4)
There are enough beds for MHCUs to sleep when admitted	3 (1.0)	201 (65.9)	101 (33.1)
The paint used in the mental health unit is bright and renovated frequently	16 (5.2)	199 (65.2)	90 (29.6)
There is a separate unit designated solely for observation of MHCUs before transferred to the mental health unit.	19 (6.2)	187 (61.3)	99 (32.5)

Key: DNK: Do not know; D: Disagree; A: Agree; Values outside brackets=n; values inside brackets=%

Respondents were asked if there is a separate unit designated solely for observation of MHCUs before transferred to the mental health unit, and majority of the respondents (n=187; 61.3%) indicated that they do not have a separate unit designated solely for observations of MHCUs before they are transferred to the mental health unit. Speedy recovery of MHCUs, when admitted in mental health establishments, depends on the therapeutic milieu provided by MHCPs. However, this study showed that there is a mixing of different categories of patients which might result in some MHCUs being assaulted physically and sexually by those who are not severely psychotic. Patients who are in their first episode of illness are subjected to stigma and sometimes wrongful

labelling as mentally ill because they are being observed for 72 hours in the mental health unit and the practice is not correct according to the MHCA. This section asserts that MHCPs do not know how to conduct the mental health assessment to MHCUs who need admission and that they never receive any training on how the assessment is conducted. On the contrary, MHCPs seem to doubt the efficiency of the assessment conducted by each other in their mental health establishments. Another worrying or burning issue that emerged was that in all the mental health establishments, MHCPs reported that they do not have a venue that is convenient for them to conduct 72-hour observations and the majority of MHCPs also reported that they were not trained on the completion of MHCA forms before the MHCU can be admitted.

5.4. Knowledge of Mental Health Care Providers Regarding the Rights and Privileges of Mental Health Care Users During Admission and Stay in a Mental Health Establishment

This section mainly deals with the knowledge of MHCPs regarding the rights and privileges of MHCUs during admission and stay in the mental health establishment. This section will thus discuss the Views on rights of MHCUs when admitted in the mental health establishments, Views on the rights of MHCUs, MHCA forms to be completed during the admissions of MHCUs, drugs that are used to control psychosis of MHCUs, Forensic/72-hour observation, discharge procedure and availability of psychosocial rehabilitation.

5.4.1. Views on Rights of Mental Health Care Users When Admitted in the Mental Health Establishments

Table 5.7 shows the views on the rights of MHCUs when admitted to mental health establishments. The majority of respondents (n=197; 64.6%) mentioned that the rights of MHCUs are not being observed in their mental health establishments. Reasons

cited for rights of MHCUs not being observed include MHCUs not taken seriously (n=32; 10.5%), rights of MHCUs not observed by MHCPs in their mental health unit (n=31; 10.2%), attitudes of MHCPs towards MHCUs being negative (n=1; 0.3%), and the most of the respondents (n=133; 43.6%) mentioned that MHCUs are seen as users or people who are mentally ill.

Table 5.7: Views on the rights of mental health care users

Item		Yes	No
In your opinion, the rights of mental health care users are being observed in the institution?		108 (35.4)	197 (64.6)
Reasons for indicating "No"	The MHCUs not taken seriously		32 (10.5)
	Rights of MHCUs not observed		31 (10.2)
	The MHCUs are seen as Users or Mentally ill		**133 (43.6)**
	Attitudes of Mental Health providers		1 (0.3)
Values outside brackets=n; values inside brackets=%			

Respondents were asked if MHCUs are taught about their rights in the mental health unit (Table 5.8). The majority of respondents (n=217; 71.1%) indicated that MHCUs are not taught about their rights in the mental health establishments. Out of 88 of those who indicated that they are taught, 46 (52.3%) mentioned the right to be treated in a clean and safe environment, 20 (22.7%) the right to refuse treatment, 14(15.9%) the right to be respected and treated with dignity, 5 (5.7%) the right to be referred to the next level of care and few respondents (n=3; 3.4%) indicated that confidentiality of MHCUs needs to be respected. The main objectives of the promulgation of the MHCA 17 of 2002 were to protect the rights of MHCUs as the previous MHCA did not. However, this study found the opposite whereby the rights of MHCUs are not observed, respected or taught by MHCPs. Furthermore, respect, human dignity and privacy were not shown towards MHCUs in mental health establishments even though MHCPs know their rights.

Table 5.8: Mental health care users' rights taught in mental health units

Item		Yes	No
Do you think MHCUs are taught about their rights in the units by MHCPs?		88 (28.9)	217 (71.1)
If YES, Explain the rights that MHCUs while in the mental health establishment	Right to be treated in a clean and safe environment	46 (52.3)	
	Right to refuse treatment	20 (22.7)	
	Right to be referred to the next level of care	5 (5.7)	
	Right to be respected, treated in dignity	14 (15.9)	
	The confidentiality of MHCU need to be respected	3 (3.4)	
Values outside brackets=n; values inside brackets=%			

5.4.2. Mental Health Care Act Forms That Need to be Completed During the Admissions of Mental Health Care Users

The Mental Health Care Act (MHCA) forms that need to be completed during the admissions of MHCUs is shown in Table 5.9. In response to knowledge of the forms that MHCPs should complete during the admissions of MHCUs, the majority of respondents (n=242; 79.3%) indicated four forms (MHCA 04, MHCA 05, MHCA 07 and MHCA 22) as the relevant forms that need to be completed. The findings revealed that 4.6% (n=14) knew three forms, 4.3% (n=13) knew two forms, 6.9% (n=21) knew only one form, whereas 4.9% (n=15) did not have knowledge of any forms that need to be completed during the admission of MHCUs. Those who knew MHCA 04 were greater in number (n=282; 92.5%). The majority of respondents (n=275; 90.2%) knew MHCA 05. Again, most respondents (n=254; 83.3%) mentioned that they know MHCA 07. Those who knew MHCA 22 were 82.3% (n=251). Apart from the knowledge of the forms mentioned above, only a few respondents knew other MHCA forms that are used during the transfer and admission of MHCUs from other institutions or mental

health establishments.

Table 5.9: Mental Health Care Act forms to be completed during the admissions of mental health care users

Items		**Attributes**	**Frequency/n (%)**
Which MHCA forms should MHCPs complete during admission of MHCUs?		Do not know	15 (4.9)
		1 Form	21 (6.9)
		2 Forms	13 (4.3)
		3 Forms	14 (4.6)
		4 Forms	**242 (79.3)**
Form	**Yes**	**No**	**Do not know**
MHCA 04	282 (92.5)	5 (1.6)	18 (5.9)
MHCA 05	275 (90.2)	12 (3.9)	18 (5.9)
MHCA 07	254 (83.3)	30 (9.8)	21 (6.9)
MHCA 22	251 (82.3)	34 (11.1)	20 (6.6)
Other MHCA Forms (Number of other forms)		None	292 (95.7)
		1 Form	6 (2.0)
		2 Forms	3 (1.0)
		3 Forms	4 (1.3)
Key: MHCA: Mental Health Care Act Form; Values outside brackets=n; values inside brackets=%			

Those who indicated three MHCA forms were 4 (1.3%) and those who mentioned 2 MHCA forms were 3 (1.0%) and those who cited 1 MHCA form were 6 (2.0%). Moreover, most of the respondents (n=292; 95.7%) did not mention the forms used when transferring MHCUs. All MHCA forms are filed in mental health establishments, yet surprisingly few MHCPs knew the forms that are supposed to be completed before transferring MHCUs from one institution to another. This might mean that MHCPs do not give themselves time to go through the MHCA forms that need to be used when working in mental health units and this kind of practice can be regarded as ignorance.

5.4.3. Drugs used to Control Psychosis of Mental Health Care Users

Drugs that are used to control psychosis of MHCUs in mental health establishments are listed in Table 5.10.

Table 5.10: Drugs used to control psychosis of mental health care users

Item	Attributes	Frequency (%)
Which are the drugs used to control psychosis of MHCUs in the unit?	None	13 (4.3)
	1-3 drugs	47 (15.6)
	4-6 drugs	30 (9.8)
	7-9 drugs	**234 (76.7)**
Serenace	Yes	**273 (89.5)**
	No	18 (5.9)
	Do not know	14 (4.6)
Ativan	Yes	**270 (88.5)**
	No	15 (4.9)
	Do not know	20 (6.6)
Clonazepam	Yes	**269 (88.2)**
	No	18 (5.9)
	Do not know	18 (5.9)
Clozapine	Yes	**260 (85.2)**
	No	27 (8.9)
	Do not know	18 (5.9)
Resperidone	Yes	**252 (82.6)**
	No	32 (10.5)
	Do not know	21 (6.0)
Epilim	Yes	**240 (78.7)**
	No	43 (14.1)
	Do not know	22 (7.2)
Lithium Carbonate	Yes	**239 (78.4)**
	No	42 (13.8)
	Do not know	24 (7.9)
Clopixol achuphase	Yes	**209 (68.5)**
	No	72 (23.6)
	Do not know	24 (7.9)
Clopixol depot	Yes	75 (24.6)
	No	**208 (68.2)**
	Do not know	22 (7.2)
Fluanxol	Yes	39 (12.8)
	No	**247 (81.0)**
	Do not know	19 (6.2)
Other drugs	Disipal	2 (0.6)
	Etomine	1 (0.3)
	Do not know	3 (1.0)

The majority of respondents (n=234; 76.7%) mentioned seven to nine drugs that are being used to control psychosis of MHCUs in the mental health units. Those who mentioned 4 to 6 drugs were 9.8% (n=30), and those who mentioned one (1) to three (3) drugs were 15.6% (n=47). The drugs that were mostly mentioned by respondents are Serenace (n=273; 76.7%), Ativan (n=270; 88.5%), Clonazepam (n=269; 88.2%), Clozapine (n=260; 85.2%), Risperidone (n=252; 82.6%), Epilim (n=240; 78.7%), Lithium Carbonate (n=239; 78.4%), Clopixol achuphase (n=209; 68.5%).

Clopixol depot and Fluanxol were found to be not known by many respondents. Out of 305 respondents, 75 (42.6%) knew Clopixol depot and 39 (12.8%) knew Fluanxol. Other drugs that were mentioned include Disipal (n=2; 0.6%) and Etomine (n=1; 0.3%). MHCPs providing care, treatment and rehabilitation are expected to know the drugs that are frequently used to control the psychosis of MHCUs so that when side effects develop, they will know how to manage them. As shown by the results, it seems as there are MHCPs who do not know the drugs that are used by their patients and this might mean that they do not read patients' files or ask them if the medication that they are taking is making them feel well.

5.4.4. Forensic 72-Hour Observation, Discharge Procedure and Psycho-Social Rehabilitation

Forensic/72-hour observation, discharge procedure and availability of psychosocial rehabilitation is depicted in Table 5.11. The majority of the respondents (n=238; 78.0%) cited that they do not have a forensic or 72-hour observation unit in their institutions. The respondents (n=67; 22.0%) who said they have the forensic or 72-hour observation unit in their institutions cited that they do or conduct the 72 hours observation in the Male Medical Unit (n=215; 70.5%). Most respondents (n=51; 16.7%) mentioned that they conduct the observations in the mental health unit

(psychiatric unit), while few respondents (n=8; 2.6%) indicated that they conduct their forensic observations in the maximum-security unit.

Table 5.11: Forensic/72-hour observation, discharge procedure and psychosocial rehabilitation

Item		Yes	No
Do you have a forensic/72-hour observation unit in your institution?		67 (22.0)	**238 (78.0)**
If YES, how is the observation conducted	Conducted in the Medical Unit		**215 (70.5)**
	Conducted in a Mental Health Unit		51 (16.7)
	Conducted in Maximum security unit		8 (2.6)
	Do not know		31 (10.2)
And where is it conducted	Medical ward		**207 (67.9)**
	Mental Health Unit		65 (21.3)
	Maximum security ward		12 (3.9)
	Do not know		21 (6.9)
Discharge procedure of MHCUs at institution, and the referral procedures	Seen by MDT, Form 3 completed, Health education is given, follow-up date is given		**261 (85.6)**
	Not all process mentioned		18 (5.9)
	Do not know the procedure		26 (8.5)
Community based mental health services available in the District	Psychosocial rehabilitation centres available		30 (9.8)
	None		**255 (83.6)**
	Do not know		20 (6.6)
Values outside brackets=n; values inside brackets=%			

The discharge and referral procedures in the institution were known by the majority of respondents (n=261; 85.6%) who mentioned that the MHCU is seen by the Multidisciplinary Team (MDT), then the MHCA form 03 is completed, health education is given to the MHCU and the family members informed regarding the treatment and follow-up date is given to the MHCUs. Out of 305 respondents, 56 (18.4%) did not

have any knowledge of the discharge or referral procedures for MHCUs in mental health establishments.

When it comes to community-based mental health services available in their districts, almost all of the respondents mentioned that there is none (n=255; 83.6%), those who did know if psychosocial rehabilitation exist were 20 (6.6%) and few respondents 30 (9.8%) cited that they have the psychosocial rehabilitation, meaning that majority of MHCUs are not supported after their discharge in the community. As seen from the results, almost all of the MHCPs were conducting 72-hour observations in the mental health unit, which is not the best practice, especially when the patient is not mentally ill, but is displaying signs and symptoms of mental illness due to other underlying medical conditions. After 72 hours when the team have concluded that the person is not mentally ill, the shame and stigma will remain with the patient as s/he was admitted to the mental health unit.

Psychosocial rehabilitation plays a significant role in the lives of MHCUs, however, in this study the results revealed that there are no available psychosocial rehabilitation centres to be used by MHCUs after discharge to keep them busy and contain them in the community rather than mental health establishments. The psychosocial rehabilitation centres can serve as a platform to prevent relapses from MHCUs, but they will remain in the community functioning well and making some living from what they produce in the centres.

Rights of MHCUs were found not to be observed by MHCPs in the mental health establishments, though in all the mental health units the rights of MHCUs were pasted in their notice boards and it can be regarded as a white elephant as they are not being taught or practised—this was evident by majority MHCUs not knowing their rights while admitted in the mental health establishments. When it comes to the completion

of legal forms (MHCA), most respondents indicated four forms (MHCA 04, MHCA 05, MHCA 07 and MHCA 22) as the relevant MHCA forms that need to be completed by MHCPs when admitting the MHCUs. They also indicated more than seven drugs that can be used to control psychosis of MHCUs in mental health establishments. Furthermore, the majority of the respondents cited that they do not have a forensic or 72-hour observation unit in their institutions, they just improvise and assess the MHCUs in medical units.

5.5. Challenges Faced by the Mental Health Care Practitioners During Their Daily Work Activities in Mental Health Establishments in Limpopo Province

This section highlights the challenges that are faced by MHCPs during caregiving in their mental health establishments. The challenges include shortage of staff, no suitable structure for MHCUs, no budget or funds and shortage of treatment. Table 5.12 shows the challenges faced by MHCPs while providing care in their mental health establishments. The respondents cited several resource challenges that they face in their mental health establishments, including human resource, structural resource, financial resource and treatment. Some of the challenges that they have mentioned also include no trained psychiatric nurses (n=34; 11.1%), shortage of staff (n=57; 18.7%), no suitable structure for MHCUs (n=52; 17.0%), no budget or funds for mental health units (n=105; 34.4%) and shortage of treatment (n=38; 12.5%). Those who did not know any challenges experienced accounted for 5.9% (n=18). Out of 305 respondents, the majority 217 (71.1%) indicated that there are no clinical risks involved for staff working at the mental health units or observation units. Of those who said there are clinical risks involved 88 (28.9%) also cited the risks that are involved, viz., being attacked, raped or injured by MHCUs (n=38; 43.2%), abscondment of MHCUs from the mental health establishment (n=19; 21.6%), medico-legal hazards

(n=2; 2.3%), contracting infection like TB and HIV (n=20; 22,7%), being killed by the MHCUs during nursing care (n=9; 10.2%).

Table 5.12: Challenges faced by the mental health care practitioners while providing care

Item	Attributes	n (%)
Resource challenges experienced at work (Human resource, Structural, Financial and Treatment)	No trained Psychiatric Nurses	34 (11.1)
	Shortage of staff	57 (18.7)
	No suitable structure for MHCUs	52 (17.0)
	No budget or funds	**105 (34.4)**
	Shortage of treatment	38 (12.5)
	Do not know	18 (5.9)
Availability of clinical risks involved for staff working in mental health/ observation unit?	**Yes**	88 (28.9)
	No	**217 (71.1)**
Types of clinical risks involved	Being attacked, raped, injured by MHCUs	38 (43.2)
	Abscondment of MHCUs	19 (21.6)
	Medico-legal hazards	2 (2.3)
	Contracting Infection (HIV, TB)	20 (22.7)
	Being Killed by MHCUs during nursing care	9 (10.2)
Ways to minimize the clinical risks	Training of staff	30 (34.1)
	Employing male nurses in the Mental Health Unit	11 (12.5)
	Employing more security officers	16 (18.2)
	Installing CCTV Camera	8 (9.1)
	Construction of proper mental health unit	13 (14.8)
	Increasing recreational facilities	1 (1.1)
	Buying more resources	5 (5.7)
	SAPS to guard MHCUs	4 (4.5)

/Continued …

Table 5.12: Challenges faced by the mental health care practitioners (MHCPs) while providing care (continued)

Item	Attributes	n (%)
Clinical staff safety and protection in the units	**Yes**	**214 (70.2)**
	No	91 (29.8)
Safety issues	Lack of security officers	36 (39.6)
	Lack of Police Guard	7 (7.7)
	No CCTV Camera	6 (6.6)
	Shortage of staff	9 (9.9)
	No danger allowances	6 (6.6)
	Unpredictable behaviour of MHCU	6 (6.6)
	No material resources	7 (7.7)
	Staff can be assaulted and killed	14 (15.3)
Ways to promote safety	Training psychiatric nurses	25 (27.5)
	Construction of a mental health unit	15 (16.5)
	Implement proper security measures	41 (45.1)
	None	10 (10.9)
Work-related stress experienced by MHCPs	Burnout and stress	45 (14.8)
	Overworked	**217 (71.1)**
	Poor support from management, MDT & other departments	18 (5.9)
	Fear of being killed	25 (8.2)
Experience stigma & discrimination in working with MHCUs	Yes	86 (28.2)
	No	**219 (71.8)**
Types of stigma and discrimination experienced	Called names and labelled mentally ill	50 (58.1)
	The MHCUs rooms not cleaned sometimes	6 (7.0)
	Structural stigma (No funds allocation, giving them old linen)	30 (34.9)
Withdrawal of social grants from MHCUs affecting their well-being	Yes	63 (20.7)
	No	**242 (79.3)**
Possible ways to reinstate their social grant	Ward Doctor to be involved in deciding on the issuing of grant for MHCUs	23 (36.5)
	Engage SASSA Doctor and refer to a social worker	20 (31.7)
	Conducting test for drugs before approval of the grant	3 (4.8)
	Encourage compliance to treatment	2 (3.2)

Of the respondents, 88 (28.9%) suggested the strategies that can be employed to minimize the risks in the mental health establishments such as: training of staff (n=30; 34.1%), employing male nurses in mental health units (n=11; 12.5%), employing more security officers (n=16; 18.2%), installing CCTV cameras (n=8; 9.1%), construction of proper mental health units (n=13; 14.8%),increasing recreational facilities (n=1; 1.1%), buying more resources (n=5; 4.5%) and few respondents (n=4; 4.5%) recommended that SAPS need to guard their MHCUs coming for 30 days forensic observations.

Out of 305 respondents, the majority (n=214; 70.2%) cited that the clinical staff is safe and protected when in the mental health units. Those who indicated that the clinical staff is not safe in the units (n=91; 29.8%) cited different reasons why the staff members are not safe, including lack of securities (n=36; 39.6%), lack of police guard (n=7; 7.7%), no CCTV cameras (n=6; 6.6%), shortage of staff 9 (9.9%), no danger allowance 6 (6.6%), unpredictable behaviour of MHCU (n=6; 6.6%), No material resources (n=7; 7.7%), and staff can be assaulted and killed (n=14; 15.3%). The challenges that MHCPs encounter daily are enormous. Other challenges affect the day-to-day functioning of the mental health unit, like the mental health unit not being allocated a budget or lack of medication used to control the psychosis of MHCUs.

The MHCUs might stay for a prolonged period in the mental health establishment which, in turn, may increase the spending by the government towards the recovery of the patient. Once more, working in mental health units has its own challenges like being harmed or killed by psychotic MHCUs. Given the danger of the environment that MHCPs find themselves working in, it is vital to allocate more security officers who will serve as staff and assist when MHCUs becomes violent or aggressive because female nurses are afraid of the MHCUs. Training of MHCPs can be regarded as a good strategy so that they have the knowledge and proficiency how to protect themselves while working with violent and aggressive patients.

Suggestions were given on what needs to be done for the clinical staff to be safe. Most of the respondents (n=41; 45.1%) mentioned that there is a need to implement proper security measures, 25 (27.5%); also cited was training of psychiatric nurses (n=15; 16.5%) and the construction of a proper mental health unit (n=15; 16.5%).

The majority of respondents (n=217; 71.1%) indicated that they experience work-related stress, while 45 (14.8%) cited that they experience burnout and stress, 18 (5.9%) cited poor support from the management, MDT and other departments and 25 (8.2%) indicated that they fear to be killed by MHCUs during caregiving. Furthermore, the majority of the respondents (n=219; 71.8%) cited that they do not experience stigma and discrimination when working with MHCUs. Approximately 28% (n=86) of those said they do experience stigma and discrimination in their mental health establishments. Most of the respondents indicated that they are called and labelled being mentally ill (n=50; 58.1%), MHCU rooms not being cleaned sometimes 6 (7.0%), and other respondents 34.9% (n=30) mentioned that they experienced structural stigma, where they are not allocated funds and being given old linen to use for MHCUs.

The majority of respondents (n=242; 79.3%) said that withdrawal of social grants from MHCUs does not affect their well-being. More than half (n=63; 20.7%) of the respondents who said the withdrawal of social grants affect their well-being went further and gave suggestions on what needs to be done to reinstate their social grants. The suggestions include ward doctors to be involved in deciding on the issuing of grants for MHCUs (n=23; 36.5%), engaging with the SASSA Doctor (n=20; 31.7%), referring to the social worker (n=15; 23.8%), conducting tests for drugs before approval of the grant (n=3; 4.8%) and encouraging MHCUs to comply with their treatment (n=2; 3.2%). Stress and burnout can be experienced when working in mental health units, especially when hospital management does not provide support

to the MHCPs working with MHCUs. Working in the mental health unit is a challenge on its own as one might be killed by MHCU during the provision of nursing care. It is, therefore, significant that MHCPs working in mental health units are supported by management to reduce the stigma and discrimination they experience and also raise awareness of mental health in mental health establishments. The awareness might curb the stigma directed to MHCPs working with MHCUs. As seen from the results of the study, withdrawal of social grants affects the well-being of MHCUs, hence, the mental health units and SASSA doctor must collaborate when issuing grants to MHCUs. The reason for collaboration is that MHCUs are well-known by the MHCPs because they work with them on a monthly basis, unlike the SASSA Doctor who only gets to meet the patient once during the day of assessment and decide if the user deserves to get the grant or not.

5.6. Summary

This chapter presented the quantitative results where tables and graphs were used to present data. Demographic characteristics of respondents were discussed, then the researcher discussed the Views of MHCPs on the assessment of MHCUs, on admission and treatment of MHCUs, on rights of MHCUs, on the provision of mental health services and MHCPs relationship with MHCUs, Views on therapeutic milieu and availability of resources. Assessment of MHCUs before admission is key as it provides a preliminary diagnosis of the user so that s/he can be managed well and given the proper treatment. In this study, it was found that most of the respondents reported that they knew the procedure of how to conduct the assessment before admitting MHCUs in their respective units. However, the respondents indicated that they do not have the knowledge and skills required in conducting the assessment of MHCUs before admission, this was due to the fact they were not trained.

The MHCPs also reported that they doubt the efficiency of the assessment conducted by MHCPs to their mental health establishments. The majority of the respondents said that the venue that they are using to conduct the 72-hour assessments or forensic observations is not convenient and it is not in accordance with the MHCA. The MHCA protect the rights of MHCUs, however, the majority of respondents indicated that the rights of MHCUs are not being observed in their mental health establishments and they further indicated that MHCUs are not taught about their rights when admitted in the mental health units. Furthermore, the majority of the respondents cited that they do not have forensic or 72-hour observation units in their institutions—they just improvise and asses the MHCUs in maximum security or medical units. However, caring for MHCUs who are still psychotic might pose risks and can be seen as dangerous and life-threatening to MHCPs.

CHAPTER 6

COMPARISON, INTEGRATION AND INTERPRETATION OF THE QUALITATIVE AND QUANTITATIVE RESULTS

6.1 Introduction

Chapters 4 and 5 presented the qualitative and quantitative results, respectively. This chapter compares, relates and provides an interpretation of the study findings. When two data sets, i.e., qualitative and quantitative, are integrated, it can be described as mixed methods (Creswell & Clark, 2018; Pluye, Bengoechea, Granikov, Kaur & Tang, 2018). Mixed methods integration was chosen as the approach for this study as it would aid in answering questions that could otherwise not be answered by quantitative or qualitative approaches alone. The researcher chose the convergent parallel mixed methods to merge the two data sets using a table to compare different perspectives drawn from the qualitative and quantitative data strands (Creswell & Clark, 2018).

The two data sets are considered independent as collection and analysis were done separately. The findings of the qualitative and quantitative approaches showed convergence when compared. The population for qualitative study component consisted of 34 MHCPs (Professional Nurses with Psychiatric Nursing Science qualifications) and 19 MHCUs. However, for quantitative component, 305 respondents participated in the study, where 228 were Professional Nurses (PN) with Psychiatric Nursing Science, 37 were clinicians (Medical doctors (Dr), Clinical Psychologists and Psychiatrists) and 40 respondents were allied health workers (Social workers (SW), Physiotherapists, Occupational therapists (OT) and Dieticians).

The discussion is sequenced according to the study objectives, consequently, the chapter begins with a discussion of findings related to the views and experiences of MHCUs related to the provision of care, treatment, rehabilitation, rights of MHCUs in the mental health care establishments in Limpopo Province, followed by the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province, challenges faced by the MHCPs during their daily work activities in mental health establishments in Limpopo Province, then the strategy to improve the management of MHCUs, plan for implementation, evaluation plan and summary.

6.2 Comparison and Integration of the Qualitative and Quantitative Strands of the Study

In this study, the convergent parallel mixed method was employed as it enabled the researcher to compare and integrate the findings of the two data sets (qualitative and quantitative strands). Therefore, data were merged by following the procedure of side-by-side comparison where qualitative and quantitative data were combined in a single presentation (Table 6.1).

6.3 Interpretation and Meta Inference

Interpretation and meta inference of the study findings are discussed to fully understand the views and experiences of MHCUs and MHCPs related to the provision of care, treatment, rehabilitation, rights of MHCUs in the mental health care establishments in Limpopo Province and challenges that MHCPs faced with during their daily work activities in mental health establishments in Limpopo Province. Results from merging the two data sets, both qualitative and quantitative provide a clear definition of how the data perfectly match or fit well together as divergence or convergence. Convergence refers to the comparison of results in order to see if the findings confirm each other, while divergence means that the two data sets contradict

Table 6.1: Side by Side comparison of qualitative and quantitative findings

Qualitative findings		Quantitative findings
Theme	**Sub-theme**	**Statistics**
1. Structural-related challenges	1.1 No wards for MHCUs	Most of the respondents (n=187; 61.3%) indicated that they do not have a separate unit designated solely for observations. Furthermore, the majority of the respondents (n=238; 78.0%) cited that they do not have a forensic or 72-hour observation unit in their institutions
	1.2 Poorly built structures	Only a few of the respondents said that there is no suitable structure for MHCUs (n=52; 17.0%)
	1.3 Lack of privacy	When MHCPs asked about the convenience of the assessment venue, more than half of the respondents (63.6%, n=194) said that the venue that they are using is not convenient
	1.4 No seclusion rooms	
2. Inadequate management of MHCU when admitted	2.1 Poor reviewing system of patient's treatment and protocols	
	2.2 MHCPs not willing to work with MHCUs	Most of the respondents (n=208; 68.2%) indicated that MHCPs provide quality care to MHCUs. About 43.3% (n=132) of the respondents said that MHCPs sometimes display a negative attitude while providing care to MHCUs and 74.4% (n=227) confirmed that the relationship between the MHCPs and MHCUs is not good. only 25 (8.2%) indicated that they fear being killed by MHCUs during caregiving
	2.3 Inadequate and ineffective treatment used to manage MHCUs	Only 12.5%(n=38) of the respondents indicated that they experience a shortage of treatment
	2.4 No danger allowances	Only 6.6% indicated that there is no danger allowance
	2.5 Rights of MHCUs not adequately observed	Most of the respondents (n=197; 64.6%) mentioned that the rights of MHCUs are not being observed in their mental health establishments, 61.6% (n=188) said that rights are not taught to MHCUs and about (n=161; 52.8%) mentioned that there is no chart displayed on the wall

3. Improper application of safety measures in the wards	3.1 Poor implementation of safety measures by security	Out of 91 of the respondents who indicated that clinical staff is not safe, some cited lack of securities (n=36; 39.6%), lack of police guard (n=7; 7.7%), no CCTV cameras (n=6; 6.6%). Most of the respondents (n=41; 45.1%) mentioned that there is a need to implement proper security measures, Furthermore, only 8.2% (25) indicated that they fear being killed by MHCUs during caregiving
	3.2 Mixing MHCU with medical patients	About 50.4% (n=154) respondents cited that there is the mixing of MHCUs of different categories, which include state patients, 72 hours or forensic observation and chronic users in the same unit
	3.3 Shortage of staff	Some of the challenges that they have mentioned include, no trained psychiatric nurses (n=34; 11.1%), shortage of staff (n=57; 18.7%)
4. Poor MHCUs support	4.1 Poor visitation by family members	Most of the respondents (n=195; 63.9%) held a view that family members are not taught about the rights of their relatives in the unit as they do not frequently visit.
	4.2 Lack of support from the community members	When it comes to community-based mental health services available in their districts, the majority of respondents 255 (83.6%) mentioned that there is none, meaning MHCUs are not supported after their discharge in the community.
	4.3 Poor support by the government	As few as (n=105; 34.4%) respondents said that there is no budget or funds for mental health units and, 18 (5.9%) cited poor support from the management
	4.4 Poor awareness regarding mental health	
5. Insufficient knowledge regarding mental health care	5.1 Poor insight regarding mental state by MHCUs	Respondents mentioned that there is a need to encouraging MHCUs to comply with their treatment, only (n=2; 3.2%) respondents thought it is vital to encourage MHCUs to comply. Majority of respondents (n=261; 85.6%) indicated that health education is given to the MHCU and the family members regarding the treatment and a follow-up date is given to the MHCU
	5.2 Insufficient knowledge about mental health care by MHCPs	Most of the respondents (n=205; 67.2%) indicated that they disagree with the statement indicating that they do not have the knowledge and skills required. Furthermore, most of the respondents indicated that they are called and labelled as being mentally ill (n=50; 58.1%).

Insufficient knowledge regarding mental health care (*continued)*	5.2 (*continued)*	Most of the respondents (66.6%, n=203) indicated that they never receive training on how to conduct the assessment of MHCUs, furthermore, most of the respondents (n=199; 65.2%) indicated that they were not trained on the completion of all admission forms that need to be completed when admitting a patient. Out of 305 respondents, about 56 (18.4%) respondents cited that they didn't have any knowledge of the discharge or referral procedures for MHCUs in mental health establishments. About 88 (28.9%) respondents suggested the strategies that can be employed to minimize the risks in the mental health establishments such as; training of staff (n=30; 34.1%)
	5.3 Insufficient knowledge about the mental health care by community members	
	5.4 Misuse of resources	Respondents mentioned that there is a need to conducting tests for drugs before approval of the grant (n=3; 4.8%)
6. Strategies to improve the management of MHCUs	6.1 Decentralization of mental health services	
	6.2 Halfway houses for MHCUs	
	6.3 NGOs (Home-based caregivers)	
	6.4 Health education regarding mental health issues	
	6.5 Mental health advocacy	
	6.6 Workshops on new information regarding mental health	
	6.7 Infrastructure improvisation	Only (n=51; 16.7%) mentioned that they conduct the observations in the mental health unit (psychiatric unit), while few respondents (n=8; 2.6%) indicated that they conduct their forensic observations in the Maximum-security unit.

each other or there is incongruency between the data sets (Creswell & Clark, 2018). The stronghold of the study findings was qualitative, where it was supported by quantitative findings.

6.3.1 Structural-Related Challenges

The study findings revealed that several institutions are experiencing structural-related challenges such as a lack of suitable infrastructure to admit MHCUs to provide good quality care to MHCUs. It was found that there is either no mental health unit, or it is poorly built in such a way that it is not convenient to admit MHCUs. Four sub-themes emerged as, No wards for MHCUs, Poorly built structures, Lack of privacy and No seclusion rooms.

The study found that in some of the institutions they do not have wards to admit MHCUs and the MHCUs are referred to the nearest institution for care, treatment and rehabilitation (CTR). In some instances, MHCPs would improvise by using a cubicle in a medical unit and convert it to mimic a mental health unit where they will admit MHCUs for a short stay. It was confirmed most of the respondents (n=187; 61.3%) do not have a separate unit designated solely for observations. Furthermore, the majority of the respondents (n=238; 78.0%) cited that they do not have a forensic or 72-hour observation unit in their institutions.

The quality of care provided to MHCUs might be compromised due to the lack of designated mental health units as providing care to MHCUs necessitates a standalone unit so that they can be monitored constantly by MHCPs. Family members can be hesitant in taking their significant others to institutions where there is no mental health unit as they already know that their MHCUs will be transferred to the nearest facility for treatment. Lack of a mental health unit can be described as a barrier to accessing

mental health services as some MHCUs might not want to be referred to the nearest facility due to long travelling distances and it can be seen as unrealistic (Adu-Gyamfi, 2017; Foye, Simpson & Reynolds, 2020; Haddad *et al*., 2020; Petersen, Campbell-Hall & Mjadu, 2009). Again, MHCUs might be hesitant to go and receive care in the nearest facility due to other commitments or lack of transport or money.

The lack of mental health units poses a risk to MHCPs as they are admitting more patients, and this results in an overflow of MHCUs in one unit, in this case, others are forced to sleep on the floor. Congestions of patients in a mental health unit equally present a danger to both staff and MHCUs as there are always fights among patients. Inadequate mental health facilities were also cited as a challenge by several studies where different authors found that mental health establishments often have too few beds to accommodate mental MHCUs and this resulted in congestion (Adu-Gyamfi, 2017; Haddad *et al*., 2020; Petersen & Lund, 2011)

The MHCUs easily abscond from mental health establishments when there is no proper mental health unit in place. This means that after they captured the MHCU, the treatment that was in place needs to be restarted again to stabilize the user because when MHCUs abscond, they do not take treatment and they are regarded as dangerous to self and others in the community. Results showed that mental health establishments are experiencing several abscondments due to a lack of proper and secured mental health unit. The MHCUs who abscond are deemed dangerous as they can cause harm to self and others, while others can commit suicide. Moreover, males were found to abscond more in mental health establishments (Gerace, Oster, Mosel, O'Kane, Ash & Muir-Cochrane, 2015; Hunt, Clements, Saini, Rahman, Shaw, Appleby, Kapur & Windfuhr, 2016; Gowda, Thamby, Basavaraju, Nataraja, Kumar & Math, 2019; Verma, Khanra, Goyal, Das, Khess, Munda & Ram, 2020). However, in other studies (Gowda *et al*., 2019; Hunt *et al*., 2016), it was found that the rate of

MHCU abscondment was less when they were compared to results reported worldwide, and of those who have absconded, many were from low socio-economic settings, either diagnosed with schizophrenia or mood disorder with comorbidity of alcohol use disorder (Gerace *et al*., 2015; Gowda *et al*., 2019; Verma *et al*., 2020). In most cases, those who abscond had been diagnosed with alcohol use disorder and were difficult to contain in the community as they usually revert to alcohol use and forget to take treatment which will, in turn, make them relapse and get readmitted to the mental health establishment.

The MHCPs sometimes discharge the patient prematurely before they are stable due to a lack of space in the mental health units. The discharge of MHCUs from the unit was found to be based on the fact that there is no unit to accommodate MHCUs and discharging MHCUs before they are stable does not add value to the quality life of the users as in few days, they are back for readmission. The same results were reported in other studies where MHCUs were discharged without looking unto the reasons why they were brought to the mental health unit in the first place, meaning that MHCUs are discharged before they are stable or their problems of being admitted been resolved (Clibbens, Harrop & Blackett, 2018; Garriga *et al*., 2020; Petersen & Lund, 2011). Moreover, MHCUs who are discharged are at a high risk for early psychiatric relapse and they are candidates for readmissions as they would have been discharged before they are mentally stable (Garriga *et al*., 2020; Lund *et al*., 2012).

Poorly built or constructed mental health units makes it easier for MHCUs to abscond as security is not tight. The facility where MHCUs are being cared for needs to be constructed in such a way that it restricts MHCUs from absconding. The unit needs to be properly built, taking into consideration that users are vulnerable or high risks for absconding because of their mental instability. Again, this makes it easy for patients to abscond from the mental health establishment as they can easily climb through the

ceiling and escape without being seen. The results were confirmed by only a few of the respondents who said that there is no suitable structure for MHCUs (n=52; 17.0%). Infrastructure challenges in mental health units were also cited as a serious challenge as other mental health establishments were found not to have a designated mental health unit or, even if one existed, it was poorly built (Haddad *et al*., 2020; Petersen, Campbell-Hall, *et al*., 2009).

Privacy of MHCUs in mental health establishments is considered important as everyone has a right to privacy, regardless of mental status. However, the study findings revealed that in mental health establishments there is no privacy for MHCUs due to structural challenges. Lack of a convenient venue to treat and care for MHCUs can be regarded as disrespecting human rights as everyone is entitled to privacy regardless of their social status or mental state. This was confirmed when MHCPs were asked about the convenience of the assessment venue—more than half of the respondents (63.6%, n=194) said that the venue that they are using is not convenient. The study results are in line with the findings by Noohi *et al.* (2020), where the majority of participants indicated that the general hospital does not provide an appropriate venue to manage MHCUs with comorbidity because they are managed by different mental health providers and the environment itself is not convenient, and they have also referred to the environment being chaotic (Noohi, Kalantari, Hasanvandi & Elikaei, 2020).

Sharing a seclusion room by many MHCUs can be regarded as a challenge because their privacy is compromised. Some MHCUs might get violent and hurt those with whom they are sharing the room, hence, privacy is vital for secluded MHCUs as it the constitutional right for everyone to have his/her privacy. When MHCUs are secluded in one room where there are three or four beds, providers indicated that in such cases there is a lack of confidentiality. Compromised privacy of MHCUs is evident when

there are more beds in one room as it creates overstimulation and they indicated that there is also an increase in violent behaviour in locked mental health units (Stolker, Nijman & Zwanikken, 2006; Ulrich, Bogren, Gardiner & Lundin, 2018). Reduction of aggressive behaviours and crowding stress can be minimized when the privacy of MHCUs is ensured. It can also be ensured by creating a single bedroom with bathrooms for patients as those who are sharing a room are more prone to aggressive behaviours and display social withdrawal (Ulrich *et al*., 2018).

Lack of privacy was also cited as a challenge in a study that was done in the United States where participants indicated that the curtains and doors of the units were purposely left open for the protection and observations of MHCUs by MHCPs. The practice was said to cause discomfort to MHCUs, especially when it was done without engaging them, they felt that their privacy was violated (Harris, Beurmann, Fagien & Shattell, 2016). Curtains and doors left open in mental health units compromise the privacy of MHCUs as they are being exposed to everyone who is passing by, although providers are justifying the practice as protecting the MHCUs. Furthermore, when privacy is compromised, MHCPs are unable to carry out their duties well because people always come and watch what is happening in the unit through the windows.

Aggressive MHCUs need to be managed well in mental health establishments by being put in a safe place or seclusion room as they can be dangerous to self and others. Moreover, they also put the lives of the MHCPs at risks as they can assault them when they become aggressive. Lack of a seclusion room was cited as a challenge in the study by participants and leaves MHCPs with no option but to sedate the aggressive patient. Sedating of patients continuously may hinder the 72-hour observations by MHCPs as users will always be sleeping. This simply means that MHCPs might fail to carry an assessment until the user is awake and it increases the average length of stay for MHCUs in the mental health unit.

However, for MHCUs to be sedated, a doctor must authorize the sedation of the patient by prescribing the drugs that need to be injected. In quantitative findings, there were no questions asked about availability or unavailability of seclusion rooms in a mental health establishment, hence, no data confirm or contradict the subtheme.

Moreover, the use of seclusion and restrain was said to cause harm to the MHCUs. On the other hand, it protects both MHCUs and MHCPs against harm when users become violent and aggressive. Several studies discussed the impact of the use of seclusion and restrain by MHCPs as dehumanizing, traumatic, controlling and disrespecting human rights (Brophy, Roper, Hamilton, Tellez & McSherry, 2016; Muir-Cochrane, O'Kane & Oster, 2018). Some MHCUs indicated that they sustained trauma while secluded and this is a breach of human rights because there was no accountability. However, MHCPs felt that the use of seclusion needs to be justifiable to protect their safety while providing care to aggressive MHCUs (Muir-Cochrane *et al*., 2018).

6.3.2 Inadequate Management of Mental Health Care Users When Admitted

Findings of the study revealed that the care that MHCPs are providing is not of good quality due to the shortage of medication used to control psychosis and they are experiencing a shortage of staff, especially psychiatrists in their mental health establishment or district. The MHCUs are given treatment without being reviewed which results in the development of side effects. Results also showed that MHCPs are not willing to work with MHCUs and they are not taking the rights of MHCUs seriously. The following sub-themes emerged: Poor reviewing system of patient's treatment and protocols, MHCPs not willing to work with MHCUs, Inadequate and ineffective treatment used to manage MHCUs, No danger allowance, and Rights of MHCUs not

adequately observed. The study found that treatment for MHCUs is not being reviewed by the psychiatrist on a six-monthly basis and MHCPs continue giving the treatment using the old prescription, even though patients are experiencing side effects. They further indicated that the protocols that they are using are not signed by the psychiatrist. No questions were asked regarding the review of treatment and protocols for the management of MHCUs. A longitudinal model to the management of MHCUs was found to be a barrier to the provision of mental health services. The model is about the provision of care to MHCUs by several providers as MHCPs are changed every month where in six months, the MHCUs would have been seen or cared for by several MHCPs, and it is difficult for the current MHCPs to advocate for change or review of treatment because they are not aware of the side effects the MHCUs experienced in the past. Mental health was described as an ongoing process that needs to be monitored bi-annually by MHCPs (Ganz, Curry, Jones, Mead & Turner, 2018).

MHCPs are not willing to work with MHCUs when allocated in mental health units and, as a result, they display a negative attitude towards caring for MHCUs. A negative attitude can be associated with poor quality of services provided to MHCUs as MHCPs feel that it is not their responsibility to care for MHCUs. In support of this, participants cited that there is a need to allocate a doctor specifically to the mental health unit because there is a lot of work involved in the CTR of MHCUs. This was also confirmed by most of the respondents (n=208; 68.2%) who indicated that MHCPs provide quality care to MHCUs. About 43.3% (n=132) of the respondents said that MHCPs sometimes display a negative attitude while providing care to MHCUs and 74.4% (n=227) confirmed that the relationship between the MHCPs and MHCUs is not good. The results of the study were in line with the studies done in London, China and other countries where tit was found that MHCPs felt that caring for MHCUs is not part of

their job, and it is something that they were not prepared for in their role (Foye *et al*., 2020; Reed & Fitzgerald, 2005; Xu, Li, Xu & Wang, 2017). When MHCPs are not committed or prepared to work with MHCUs, it compromises the quality of care provided because providers feel that it is too much for them and they neglect the provision of care to the users and, as a result, they provide poor service to MHCUs.

A study conducted by Canadian psychiatrists found that both residents and psychiatrist had negative attitudes towards caring for schizophrenic patients (Dabby, Tranulis, Kirmayer & Laurence, 2015) and they wanted to be distant from the MHCUs socially, even though MHCUs were found to be stable and controllable (Hsiao, Lu & Tsai, 2015). On the contrary, the explicit attitudes towards caring for MHCUs were seen to be fading away or becoming positive when MHCPs are constantly in contact and assisting the MHCUs on a weekly basis, and they tend to have a more positive implicit attitude towards the MHCUs (Dabby, Tranulis & Kirmayer, 2015). The positive attitude towards caring for MHCUs might allude to knowledge in the issues relating to mental health as the more you are exposed to something, the more you develop zeal, passion and a positive attitude.

This also led MHCPs to be resistant and showing disengagement or avoidance to care for MHCUs. The lack of support by government sectors has led to the poor delivery of mental health services in mental health establishments (Adu-Gyamfi, 2017). A negative attitude towards MHCUs can allude to a lack of skills and knowledge in the issues relating to mental health and it contributes to providers not being willing to give care to MHCUs when admitted in the mental health unit (Alexander, Ellis & Barrett, 2016). In contrast to what the researcher found and other study findings, not all MHCPs have negative attitudes towards caring for MHCUs. In a study conducted amongst MHCPs, it was observed that, generally, MHCPs have positive attitudes and were showing sympathy and concern when assisting MHCUs.

The majority of the MHCPs were always willing to assist them when admitted to their mental health establishments, although younger nurses and those without mental health training show fear while caring for these patients and the fear can be attributed to lack of knowledge, less practical and lack of awareness in mental health issues (Ihalainen-Tamlander, Vähäniemi, Löyttyniemi, Suominen & Välimäki, 2016). The fear young nurses have can be allayed by conducting in-service training so that they become well-conversant with mental health issues.

The MHCPs revealed that drugs that are used to control psychosis in the mental health units are not effective because sometimes drugs fail to control or stabilize MHCUs who are using substances. They further cited that occasionally mental health establishments run out of treatment that is used to manage MHCUs, however, they are told to use alternative drugs even though the drugs are not effective, especially to those who are diagnosed with substance-induced psychosis. South Africa and other countries have been affected by the use of drugs like Nyaope and others, the use of drugs is not an exception for MHCUs, and it is difficult to manage or control the relapse psychosis of a person who has a history of using such drugs. This was supported by only 12.5%(n=38) of the respondents who indicated that they experience a shortage of treatment. Shortage of treatment in mental health establishments affects the care and management of MHCUs as non-drug management for users cannot work without psychotropic drugs.

The results of the study were in line with the reported challenges by MHCPs in the management of MHCUs in mental health establishments, where the majority of respondents said that they are experiencing a shortage of drugs that are used to manage MHCUs (Adu-Gyamfi, 2017; Al-Ruthia *et al*., 2017; Haddad *et al*., 2020). Study findings revealed that MHCPs are working in a dangerous environment by caring for MHCUs, and they also cited that they are not getting danger allowances or

rewards for putting their lives at risk while caring for MHCUs in mental health units and they regarded the mental health units as unsafe. It was confirmed by only 6.6% of respondents that they receive no danger allowance. MHCPs work with zeal when they know that they will be compensated for the job that they are doing, especially when caring for MHCUs as their lives are in danger. However, it is not the case as there is no danger allowance given to MHCPs by the management even though they were providing care to MHCUs. They were told that they do not qualify because their mental health establishment only admits MHCUs for 72 hours, then after they must transfer to the next level of care. This was also found not to be the case as they will be keeping MHCUs for a longer period whereas they are not getting danger allowance (Netshakhuma, 2016).

The rights of MHCUs were found not to be respected and fully observed by MHCPs in mental health establishments. Participants of the study revealed that the rights of MHCUs were violated in mental health units where users are subjected to both physical and emotional abuse when admitted. This was supported by most of the respondents (n=197; 64.6%) who mentioned that the rights of MHCUs are not being observed in their mental health establishments, 61.6% (n=188) said that rights are not taught to MHCUs and about 52.8% (n=161) mentioned that there is no chart displayed on the wall. MHCA 17 of 2002 clearly stipulates how the rights of MHCUs can be protected and promoted (DoH, 2013) and violation of human rights is regarded as a total failure in the implementation of the MHCA (Adu-Gyamfi, 2017).

The national mental health policy framework and strategic plan indicated that by 2014 the human rights of people living with mental illness would have been protected and promoted through the active implementation of the MHCA 17 of 2002 as promulgated and the DoH was tasked to closely monitor the implementation of the Act (DoH, 2013). However, it seems that the rights of MHCUs are not taken seriously by both health

care providers and the community in general due to a lack of understanding of mental health issues. Moreover, people with mental illness are abused by their significant others and also by MHCPs in mental health establishments where they were supposed to be protected and taken care of. In a study that was conducted in India, the majority of participants reported having suffered emotional, physical and sexual abuse (Bhatia, Srivastava, Khyati & Kaushik, 2016). There was also a significant association between abuse and the type of psychiatric diagnosis, where a high percentage of those who experienced abuse were mostly diagnosed with a psychotic disorder, followed by obsessive-compulsive disorder, anxiety disorder, and those who were diagnosed with the sexual disorder (Bhatia *et al*., 2016).

The MHCPs were said to be violating the rights of MHCUs by not respecting them, they talk to them as they wish and regard them as just crazy people without considering the feelings of users. The MHCUs were said to be given names and labelled by MHCPs because of their mental health conditions and sometimes they are held in mental health units against their will (Harris *et al*., 2016).

Furthermore, knowledge about the rights of MHCUs can be associated with the level of education that both the MHCPs and MHCUs have (Danilakoglou, Nikolopoulou, Filippiadou, Garyfallos, Bozikas & Papazisis, 2019; Alburquerque-Sendín, Ferrari, Rodrigues-de-Souza, Paras-Bravo, Velarde-García & Palacios-Ceña, 2018). MHCPs who have a higher level of education were found to have exceptional positive attitudes towards caring for MHCUs. Moreover, the study also found that there is a strong correlation between the type of profession, whether the provider is a psychiatrist or a nurse, and the attitudes towards MHCUs (Danilakoglou *et al*., 2019). Lack of knowledge regarding the rights of MHCUs has a negative impact on the treatment of people living with mental illness, hence, there is a need for people to be taught about the rights of MHCUs.

6.3.3 Improper Application of Safety Measures in the Wards

Safety in mental health units needs to be regarded as a priority for both MHCUs and MHCPs, because when a person feels safe in an environment, s/he can function optimally and provide excellent services to people they are serving. However, the study results revealed that there is an improper application of safety measures by security personnel and mental health establishments were found to be mixing different categories of users (MHCUs and medical patients) in the same unit. Shortage of staff was also cited as a challenge as participants indicated that they need more male nurses to manage aggressive patients in the unit. Three sub-themes emerged as follows: Poor implementation of safety measures by security, Mixing MHCU with medical patients, and Shortage of staff.

Security officers are not allocated in mental health units and this practice endangers the lives of both MHCPs and MHCUs because without proper implementation of safety measures in mental health units, providers become afraid while carrying out their duties. Moreover, in some institutions, security officers are stationed outside the unit. Participants raised the unavailability of security officers inside the mental health unit as a risk because one cannot predict the behaviour of MHCUs. Likewise, when MHCUs becomes aggressive, it becomes a challenge if there is no security officer inside the unit to assist in calming the user. Participants also indicated that the lack of securities in the units poses a danger to both staff and patients as they have to call for help from the security guards from the main gate and they said it is far because they have to travel for a long distance before they can reach the unit and assist. Poor implementation of security measures was also confirmed—out of 91 respondents who indicated that clinical staff is not safe, some cited lack of securities (n=36; 39.6%), lack of police guard (n=7; 7.7%), no CCTV cameras (n=6; 6.6%). Most of the respondents (n=41; 45.1%) mentioned that there is a need to implement proper security measures.

Furthermore, only 25 (8.2%) indicated that they fear being killed by MHCUs during caregiving. Fear of mental health or caring for people with mental illness were also reported in several studies in that MHCPs expressed their fear towards people with mental health problems where they felt that they are unable to control certain situations in mental health units and regard people with mental illness as dangerous (Brinn, 2000; Brunero, Buus & West, 2017; Foye *et al*., 2020; Morgan, 2016; Muir-Cochrane *et al*., 2018; Reed & Fitzgerald, 2005; Ross & Goldner, 2009).

The findings of the current study were in line with the results of the research done in New York on the use of security officers for MHCUs admitted in the mental health unit. The study found that security officers were frequently called when MHCUs are displaying violent and aggressive behaviours towards staff and patients. MHCPs had to give treatment to MHCUs who were refusing to take treatment in the presence of the security officers as the behaviour of the user cannot be predicted (Lawrence, Perez-Coste, Arkow, Appelbaum & Dixon, 2018).

However, the scenario of the built environment mentioned above were an indication or characteristic of a forensic mental health care unit where the setting can be described as panoptical security because everything that MHCUs are doing in the mental health unit must be seen through surveillance cameras and windows barely opened and MHCPs will use panic buttons in case there is an emergency (Tomlin, Bartlett & Völlm, 2018). A study on the experiences of MHCPs who were assaulted by MHCUs while working in mental health units found that MHCPs were mostly concerned about their safety. Furthermore, MHCPs felt unsafe in the work environment and their fear was attributed to lack of supervision, hectic workdays and poor administration. The fear that MHCPs had led to emotional responses such as anger, fear, trauma and avoidance (Bonner, 2012).

Participants of a study done in England indicated that the use of body-worn cameras by MHCPs is feasible as it put the mind of MHCUs at ease while reducing the incidence of violence and aggressive behaviours because MHCUs know that everything happening in the unit is being recorded by the camera (Hardy, Bennett, Rosen, Carroll, White & Palmer-Hill, 2017). Both the MHCPs and MHCUs accepted the use of body-worn cameras as it reduces the complaints and the number of restraints in the mental health unit dropped (Hardy *et al*., 2017). The MHCUs are afraid to act inappropriately or violently because they want their behaviour to be regarded as good so that they can get an early discharge from the mental health establishment, hence the use of the camera is recommended in the mental health unit.

There is a challenge of mixing medical patients and MHCUs in the same unit. The challenge of mixing the two categories of patients has alluded to lack of infrastructure for MHCUs where they indicated that they do not have a specific mental health unit, hence, there is mixing. The MHCPs cited a serious concern when the two categories have been mixed as there are medically ill patients who are helpless, and there is a risk that psychotic MHCUs might remove drips from the patients and cause disruption in the unit and this will put the lives of medical ill patients in danger because some are critically ill and bedridden. Th results also confirmed that there is the mixing of MHCUs of different categories, which include state patients, 72-hour or forensic observations and chronic users in the same unit. About 50.4% (n=154) of respondents cited that there is the mixing of MHCUs of different categories, which include state patients, 72-hour or forensic observations and chronic users in the same unit.

To confirm that there is a mixing of MHCUs with general medical patients, challenges faced by MHCPs caring for MHCUs in a surgical ward were discussed and the study found that there is a need to work toward improving the quality of care provided to MHCUs when admitted in the unit as in many cases users are not provided with quality

services, moreover, MHCUs are regarded as vulnerable (Foye *et al*., 2020; Reeves, Henshall, Hutchinson & Jackson, 2018) and it was further indicated that MHCUs with severe mental illness receive a low quality of care in general institutions than when they are admitted in a mental health establishment. The mixing of different categories in, general, results in the provision of poor-quality care to MHCUs as they will not be taken seriously even though they are presenting with a life-threatening situation. MHCPs will always choose to attend to medical patients first before attending to the MHCUs and this compromise the quality of care provided to MHCUs as they are attended to last.

Zolnierek & Clingerman (2012) revealed that is difficult to provide care to both MHCUs and general medical patients at the same time because caring for MHCUs is demanding and needs more time than caring for general patients. Participants cited that they tend to get frustrated because when providing care to MHCUs, they are disrupted from the task or fall behind time for giving medication to other general medical patients and MHCUs were the last ones to be seen after all other patients have been attended to (Zolnierek & Clingerman, 2012). Mixing of forensic observation and chronic MHCUs might pose a risk in mental health establishments as chronic users can be assaulted by forensic observation clients as some of the observation clients are regarded as dangerous based on what they did previously in their communities—some committed rape, murder and arson (Hoptman *et al*., 1999).

The shortage of staff in the form of male nurses is a serious challenge in mental health establishments. The MHCPs cited that female nurses are afraid of MHCUs as others do threaten to assault them physically and suggested that they need more staff to be allocated in mental health units, especially males to assist whenever MHCUs become aggressive or violent. When there is no male nurse available in the mental health, female MHCPs indicated that they are afraid to open even a burglar gate for MHCUs

to go out as there would be no one to assist if a situation might arise. MHCPs confirmed some of the challenges they experience in mental health units to include no trained psychiatric nurses (n=34; 11.1%) and shortage of staff (n=57; 18.7%). Several studies also found that there is a shortage of staff or MHCPs in mental health establishments (Adu-Gyamfi, 2017; Haddad *et al*., 2020; Petersen, Campbell-Hall, *et al*., 2009; Petersen & Lund, 2011; Sim, Ahn & Hwang, 2020; Xu *et al*., 2017).

Female MHCPs are expected to provide care to male patients who can get aggressive and overpower them due to their masculinity and this has a negative impact on the quality of care provided to MHCUs as females are afraid to provide care to male MHCUs. Studies conducted in Korea and South Africa in mental health units found that few male nurses (MHCPs) participated in the studies meaning that female MHCPs were higher in numbers (Alburquerque-Sendín *et al*., 2018; Sim *et al*., 2020). Participants cited that they are afraid of unexpected physical violence by MHCUs and some were threatened by angry patients with a knife and they always felt threatened whenever the MHCU get angry in the unit (Sim *et al*., 2020).

Allocation of staff in mental health units is not proportional as management does not have interest in mental health. Also, there is a gap or shortage of staff which have been brought on by staff turnover and retirement in mental health units. The fewer the staff allocated in mental health units, the poorer the quality of care that will be provided. Shortage of health workforce, especially MHCPs, was found to be the main contributory factor for delivering poor services to mental health establishments. The shortage sometimes is attributed to the uneven allocation of the available resources in mental health units and due to ageing population, which results in major shortages as many posts are not filled after registered nurses have retired from the health system (Buerhaus, Skinner, Auerbach & Staiger, 2017).

Support of MHCUs by both their significant others and community members can be regarded as an important factor towards the speedy recovery of relapsed MHCUs. However, the findings found that there is poor support of MHCUs by family members and the community in general. Four sub-themes emerged as follows: Poor visitation by family members, Lack of support from the community members, Poor support by government, and Poor awareness regarding mental health.

Study findings revealed that family members of MHCUs do not visit their patients in the mental health establishments after being admitted. Family members were said to always come with an excuse when they are supposed to visit MHCUs in the mental health establishment like being busy with no time to visit them and lack of money for transport. Others cited that there is no one to take care of MHCU at home as they are working. The findings were confirmed by statistics where most of the respondents (n=195; 63.9%) held a view that family members are not taught about the rights of their relatives in the unit as they do not frequently visit MHCUs in the unit. The MHCUs who are supported by their family members often stays longer at home or in the community without relapsing, it also reduces the admission rate in mental health establishments and increases the quality of life to MHCUs.

Support from family was cited as a very important component for patient recovery and staying in the community for long-time avoiding readmission (Ådnanes, Cresswell-Smith, Melby, Westerlund, Šprah, Sfetcu, Straßmayr & Donisi, 2018; Gouveia, Massanganhe, Mandlate, Mabunda, Fumo, Mocumbi & de Jesus Mari, 2017). Many participants indicated that peer and professional support need to be complementary while family support was described as an important factor since MHCUs felt safer rather than being abandoned by their relatives in the mental health establishments (Ådnanes *et al*., 2020). However, family members of MHCUs face several challenges that may hinder them to support their significant others when admitted to the mental

health establishment, including financial, interpersonal, emotional and social relationships. These factors affect the day-to-day activities of family members and also their occupation (Seshadri, Sivakumar & Jagannathan, 2019). By contrast, in a study done in China and other countries, family members of MHCUs were found to be very supportive to their patients as they were frequently visiting and staying near the bedside, bringing them food from home and paying hospital bills. Furthermore, support received from family members was described as vital because it plays a very important role in patient care as alluded by the psychiatrist who was interviewed in the study (Gouveia *et al*., 2017; Seshadri *et al*., 2019; Yu, Kowitt, Fisher & Li, 2018).

Community members are not supporting MHCUs, instead they reject them based on the things that users committed due to mental illness like raping, killing and assaulting community members. Community members were also found to be the ones giving MHCUs substances. When it comes to community-based mental health services available in the district, almost all of respondents 255 (83.6%) mentioned that there is none, meaning MHCUs are not supported after their discharge in the community. Lack of support from community members was also found in a study done in Kwazulu-Natal, where community members were showing signs of neglect of MHCUs and stigmatizing family members of users where, in some instances, family members will be banned from attending community meetings because they might bring their MHCUs who will cause disruptions in the meeting.

Other family members were asked to pay damages for what the MHCUs did, whereas sometimes those MHCUs are wrongfully accused of stealing, breaking windows (Nxumalo & Mchunu, 2017). For MHCUs and their families to feel safe, loved and accepted in a society, community members must show support to MHCUs and their family members. Barriers that hinder MHCUs from seeking mental health assistance is due to social judgement and labelling or name calling such as being crazy and

sometimes MHCUs suffer rejection from society or community members. However, the findings of the study found that stigma was having a small to moderate impact on health-seeking behaviour when it comes to mental health issues (Clement *et al*., 2015).

Families of MHCUs experienced high emotional costs\ when it comes to caring for their loved ones as mental health establishments have shifted the role of caring of MHCUs to the family members through deinstitutionalization of services. Families are experiencing several challenges such as high burden, blame and guilt for being unable to recognize the early signs of mental illness from their MHCUs. In addition, lack of day-care facilities or psychosocial rehabilitation centres and shortage of treatment to control the psychosis of their patients were noted as challenges by the family members caring for MHCUs (Caqueo-Urízar, Rus-Calafell, Urzúa, Escudero & Gutiérrez-Maldonado, 2015).

Lack of knowledge regarding mental health issues and treatment of mental illness was raised as a major challenge by the family members who are supposed to take care of the MHCUs. Participants in a study conducted on the challenges of family members caring for MHCUs revealed that family members experience financial constraints, lack of resources like treatment and do not have information or knowledge regarding mental illness and sometimes they tend to isolate themselves socially in the process (Leech & Dolamo, 2016).

Furthermore, insufficient support from the community members to the family of MHCU, exclusion from societal activities, emotional distress, lack of funds to support the user, stigma and discrimination of MHCUs by the community, shortage of decentralized mental health establishments, were found to be other challenges faced by family members caring for MHCUs (Naslund, Aschbrenner, Marsch & Bartels, 2016).

Communities that are not supportive of MHCUs create fear of disclosure of mental diagnosis as MHCUs and their family members are afraid to be discriminated against. This might hinder the early health-seeking behaviour by MHCUs because they will be afraid of stigma and discrimination in the community. The MHCUs fear stigma from the community members, hence, many didn't feel the need to disclose their mental conditions to the community members. The MHCUs would rather lie about mental health admission by saying that they are going for a vacation. Furthermore, community members were describing MHCUs diagnosed with depression as abnormal, crazy and unfit (Yu *et al*., 2018).

Findings revealed that there is poor support by the government for mental health services. Participants mentioned that mental health programs are not taken seriously like other programs, e.g., the HIV and AIDS program was cited as being given greater attention in terms of funding and support than mental health. The findings were supported by some respondents (n=105; 34.4%) who said that there is no budget or funds for mental health units and, 18 (5.9%) cited poor support from the management. When there is poor or no support from the government, MHCPs provide substandard service to MCHUs, hence, many people, including providers, do not have an interest in mental health.

The findings were in line with the study conducted by (Haddad *et al*., 2020), in that 79% of participants agreed that there is a lack of support from government and institutional funding and neglect of the mental health unit. Furthermore, the study conducted in Ghana found that the government pays little or no attention to mental health services, and this has led to poor service delivery in the field of mental health in the country (Adu-Gyamfi, 2017). Lack of institutional or government support can be attributed to the poor service delivery by MHCPs as providers felt that they are not recognized or appreciated for the work that they are doing by compromising their life

to provide care to MHCUs and most of them were dissatisfied with their work (Alburquerque-Sendín *et al*., 2018). Moreover, investing in mental health services was described as a very important factor in mental health management where the government needs to support the move by employing more staff (MHCPs) and training frontline workers (Sharma, 2020).

Findings of the study further revealed that there is poor awareness of mental health services as compared to other programs. Participants cited that other programs have planned campaigns because they are conducted door-to-door. Other health topics were said to be taught at the clinic, but mental health topics are not covered. They also mentioned that the media does not cover issues related to mental health, worryingly, mental health is discussed only when there is a national crisis like Life Esidimeni. During mental health or mental illness awareness month, the media does not cover the topics and this results in poor understanding of mental health. There was no question regarding awareness of mental health in quantitative research.

Mental health awareness is very important in developing a healthy nation because there is no physical health without mental health (Kolappa, Henderson & Kishore, 2013). Moreover, awareness of mental health can reduce stigma and discrimination against MHCUs and strengthen prevention and early identification of mental illness in the community (Srivastava, Chatterjee & Bhat, 2016). The MHCUs are frequently negatively described by the media, and they associate them with a negative image. They are often described as dangerous, unpredictable, unable to work or function independently and incapable of doing certain things due to their mental illness. This kind of stereotype perpetuates stigma and discrimination against people living with mental illness in the community and users are aware of the views that the general public hold towards them (Xu *et al*., 2017).

Stigma and discrimination against MHCUs and their families can be dispelled through the conduction of awareness campaigns in the community as people will be given more information pertaining to mental health issues. In a study conducted in India, mental health awareness was found to have produced positive results because stigma and discrimination for people living with mental illness by family and community members were dispelled. The use of media and celebrities was also found to have a positive impact on mental health awareness as the media play a vital role in people's lives (Srivastava *et al*., 2016). Once more, making mental health content easily accessible to a journalist is another way of strengthening mental health awareness as they can write positive things regarding mental health issues in their blogs. Moreover, training of teachers can assist in dispelling misinformation about mental illness (Parikh, Parikh, Vankar, Solanki, Banwari & Sharma, 2016)

6.3.4 Insufficient Knowledge Regarding Mental Health Care

Study results found that there is insufficient knowledge regarding mental health by both the MHCUs and MHCPs. For MHCUs to lack insight on their mental condition was cited as a challenge by MHCPs because when users deny that they are mentally ill, they will default treatment that could result in relapse psychosis. However, insufficient knowledge for MHCPs has been alluded to as a lack of training regarding mental health issues. Four sub-themes emerged, and they are as follows: Poor insight regarding mental state by MHCUs, Insufficient knowledge about the mental health care by MHCPs, Insufficient knowledge about the mental health care by community members, and Misuse of resources. The study found that MHCUs do not have insight into their mental health condition and it results in treatment default. When they default treatment, they relapse and need to be readmitted to a mental health establishment, and as a result there will be overcrowding. Participanst also cited that MHCU takes alcohol, get drunk and forget to take treatment.

Respondents mentioned that there is a need to encouraging MHCUs to comply with their treatment—only few (n=2; 3.2%) respondents thought it is vital to encourage MHCUs to comply. The majority of the respondents (n=261; 85.6%) indicated that health education is given to the MHCU and the family members regarding the treatment and a follow-up date is given to the MHCUs.

The MHCUs are sometimes difficult and do not adhere to antipsychotic drugs prescribed by doctors and thus, a high number of MHCUs end up being readmitted to the mental health establishment (Dixon, Holoshitz & Nossel, 2016). Several factors are leading to treatment default or treatment disengagement for MHCUs like thinking that the antipsychotic drugs are not effective. The MHCUs feel that significant others are forcing them to take treatment which can also be regarded as a negative attitude towards the treatment regimen or unable to access the treatment due to users always being in a hurry when they go to collect their treatment at primary health care facilities or outpatient departments (OPD) (Dixon, Holoshitz & Nossel, 2016).

Poor education of MHCUs contribute to poor treatment compliance as MHCUs do not understand the reason for taking the treatment. A study done on a nationwide Danish prevalence of substance use among MHCUs found that there is high usage of substances by MHCUs with a different diagnosis. They further indicated that most of the substance users were males who were receiving disability grant to buy substances. The contributory factor for the users to use drugs can imply a lack of education as the results further showed that the MHCUs had fewer years of educational training (Toftdahl, Nordentoft & Hjorthøj, 2016). Other patient-related factors contributing to poor management of MHCUs include lack of trust in MHCPs, lack of insight into their mental illness condition and the use of treatment, especially the first episode users. Homeless MHCUs are often not able to follow the treatment regimens as they do not have a stable place to stay and always move around.

Other factors include the culture of the users which makes it difficult for them to adjust to the treatment, poor peer support and substance abuse by the MHCUs which, in turn, have a negative impact on the psychosocial functioning of the user and those with substance abuse disorders are frequently readmitted in the mental health establishment (Dixon *et al*., 2016).

In most cases, the reason for MHCUs not complying with treatment is that they look down upon themselves and have self-blame for being mentally ill. Self-stigma was also reported as another factor that contributes to poor management of MHCUs as they tend to internalize stigma based on the views held by society about the treatment of mental health or visiting a psychiatrist to seek assistance regarding mental health issues. The MHCUs may opt not to visit a psychiatrist as they feel embarrassed, this tends to impact negatively to health-seeking behaviour for mental health services as they delay seeing the psychiatrist (Angermeyer, van der Auwera, Carta & Schomerus, 2017). In another study on disclosure of mental illness, the condition was found to be a contributing factor or a barrier to mental health-seeking behaviour amongst MHCUs (Clement, Schauman, Graham, Maggioni, Evans-Lacko, Bezborodovs, Morgan, Rüsch, Brown & Thornicroft, 2015).

Participants indicated that MHCPs have insufficient knowledge regarding mental health issues. The insufficient knowledge suggests a lack of proper training in mental health while others were said to be shrouded in myths pertaining to mental health. This was confirmed by most of the respondents (n=205; 67.2%) who indicated that they disagree with the statement that they do not have the knowledge and skills required. Furthermore, most of the respondents (n=50; 58.1%) indicated that they are called and labelled as being mentally ill. Most of the respondents (66.6%, n=203) indicated that they never receive training on how to conduct the assessment of MHCUs. Furthermore, most of the respondents (n=199; 65.2%) indicated that they

were not trained on the completion of all admission forms when admitting a patient. Out of 305 respondents, about 56 (18.4%) cited that they didn't have any knowledge of the discharge or referral procedures for MHCUs in mental health establishments. About 88 (28.9%) respondents suggested strategies that can be employed to minimize the risks in the mental health establishments such as training of staff (n=30; 34.1%).

The findings were in line with the studies where participants were afraid to care for MHCUs and the fear was due to lack of knowledge and skills to care for people with mental illness (Foye *et al*., 2020; Reed & Fitzgerald, 2005). They further indicated that with ongoing education, they can overcome the fear of caring for MHCUs. Lack of training in the issues pertaining to mental health and lack of self-confidence in identifying and early diagnosing of mental illness by MHCPs was also cited as another challenge that might hinder the providers to render appropriate care to the users (Foye *et al*., 2020; Petersen *et al*., 2016).

The MHCPs who have more experience in caring for MHCUs have more knowledge when it comes to mental health issues than those with less year of experience. Furthermore, literature review on the health care professionals' knowledge regarding the eating disorder, eight papers found that there is a lack of knowledge on the diagnosing of eating disorder amongst health professionals. The lack of knowledge differed according to professions, those who have more experience in working with the patients were found to be having more knowledge as compared to others (Seah, Tham, Kamaruzaman & Yobas, 2017).

Providers working in mental health units need to be highly trained in mental health issues to provide uncompromised care to MCHUs. Mental health is a specialized field of care that needs special techniques, knowledge and skills. Mastering these skills were said to be challenging even to those nurses who are experienced, hence, there

is a need to provide training on mental health issues to MHCPs working in mental health establishments (Alexander *et al*., 2016; Forsdike, O'Connor, Castle & Hegarty, 2019).

Participants indicated that community members have insufficient knowledge when it comes to mental health issues. They cited that community members still believe that mental illness is caused by witchcraft, or supernatural powers, and people with mental illness are supposed to be institutionalized. Community members sometimes will go to the Chief and complain that they do not want a certain MHCU to be discharged from the institutions, and the Chief will have no say because people would have spoken that they do not want the MHCU in the community. No question was asked on the knowledge of the community regarding the care of MHCUs. Several studies corroborate the findings in that there is a lack of knowledge regarding mental health issues by the community members, which results in stigma toward people with mental illness (Nordt, Rössler & Lauber, 2006; Parikh *et al*., 2016; Xu *et al*., 2017). For MHCUs to be reintegrated into the community, there is a need to first deal with stigma and discrimination by community members towards people with mental illness (Xu *et al*., 2017).

Moreover, in a study that was conducted in the Ga-Dikgale community, they found that there is a greater level of positive attitude towards people diagnosed with mental illness by older participants compared to younger ones. Furthermore, they also found that the reintegration of MHCUs into the community is difficult as community members lack knowledge regarding mental illness (Tshoga, 2019). The belief that mental illness is caused by a person's bad thinking was found in several studies (Yu, Kowitt, Fisher & Li, 2018; Shah, Wheeler, Sessions, Kuule, Agaba & Merry, 2017). Moreover, community members still believe that mental illness is caused by an evil spirit, punishment by god, witchcraft and jealousy for someone's achievements (Madzhie,

Mashamba & Takalani, 2014; Shah *et al*., 2017; Yu *et al*., 2018). Findings of the study revealed that the Disability Grant (DG) for MHCUs is not well utilized as in most cases the money is not used for what it is intended like providing social support to the users as others who cannot work. The DG was said to be misused through spending it on substances. Family members sometimes send the MHCU to the mental health establishment for admission so that they can remain to spend the DG of the user. This was also confirmed by s respondents who mentioned that there is a need to conduct tests for drugs before approval of the grant (n=3; 4.8%) as they believed that the DG is being misused by the MCHUs because they buy substances.

The MHCUs diagnosed with a major depressive disorder on temporary disability grant were perceived as those ones taking more sick leave (Daigre, Granell, Grau-López, Fadeuilhe, Calcedo-Barba & Roncero, 2016). However, other patients diagnosed with adjustment disorders would rather prefer to be sent back to work than to get a temporary disability grant as prolonged issuing of the grant was associated with low quality of life, high death and increased morbidity (Daigre *et al*., 2016).

Abuse of MHCUs is prevalent, but in most cases such abuse is not reported by the users because they are afraid or depend on the abusers for accommodation and care. Emotional abuse was reported in a study done to MHCUs in India and the authors emphasize the issue of campaigns to curb such abuse of the MHCUs (Bhatia *et al*., 2016). Social support for families caring for MHCUs is important because the family has to take care of the MHCUs who need more care (Iseselo, Kajula & Yahya-Malima, 2016). When social support through DG is received and managed well by family members, they can support the MHCUs to take treatment and make all necessary follow-ups for the user. This makes the MHCU to not relapse because they are supported. However, the misuse of resources is due to substance use where the DG is no longer used for what it is intended for, and this behaviour results in treatment

non-adherence (Toftdahl *et al*., 2016) and most of the MHCUs abuse alcohol which makes it difficult for them to comply with treatment.

6.3.5 Strategies to Improve the Management of Mental Health Care Users

Participants suggest that relevant strategies be implemented in mental health establishments to mitigate the challenges they are experiencing in the care of MHCUs. Seven themes emerged as follows: Decentralization of mental health services, Halfway houses for MHCUs, NGOs (home-based careers), Mental health advocacy, and Workshops on new information regarding mental health.

6.3.5.1 Decentralization of Mental Health Services

Decentralization of mental health services is a good strategy in the management of MHCUs because users will be nursed near their homes to enable their significant others to visit them in the mental health establishment. The findings were supported by several studies that describe the advantages of decentralizing mental health services (Fernando, Suveendran & de Silva, 2018; Gurung *et al*., 2017; Kigozi, Ssebunnya, Kizza, Cooper & Ndyanabangi, 2010; Kilonzo & Simmons, 1998).

However, there are challenges in the decentralization of mental health services such as lack of trained specialist and stigma towards mental health (Fernando *et al*., 2018; Frashëri, 2016). Decentralization of mental health services has become the focus globally as MHCUs need support from their families. Due to the reduced average length of stay for MHCUs in mental health establishments, people with severe mental illness like schizophrenia experience several difficulties like repeated relapse psychosis, recurrence of the disease and poor cognition by the users (Cheng, Huang, Lin, Wang & Yeh, 2018).

6.3.5.2 Halfway Houses for Mental Health Care Users

Halfway houses may be significant in the management of MHCUs as there are those users who are not wanted by either the community or family members. All MHCUs who are stable will be discharged to the halfway houses while the social worker is still busy engaging the family and community members to accept the MHCU back into the community. The findings were in line with the study conducted in Taiwan, where halfway houses were cited as a beneficiary to both the MHCUs and government as the long-term institutionalization was avoided and resources were saved (Shen, Hsu & Ly, 2020).

Halfway houses were also cited as a better place to discharge MHCUs with a dual diagnosis from the mental health establishment. The reason mentioned in support of the establishment of halfway houses was MHCUs with dual diagnosis are discharged prematurely before they can recover from the conditions they were suffering from when admitted and the halfway houses need to have space to cater for such cases (Manyedi & Dikobe, 2016).

6.3.5.3 NGOs (Home-Based Carers)

Community home-based carers were cited as an extended hand for MHCPs as they are the ones who can be sent to go and monitor if MHCUs are complying with treatment. Although some are difficult to manage or handle because they are aggressive, the home-based carers might come in handy as they are assigned to certain households in the community. Visitation by caregivers to the families of people living with mental illness or MHCUs contribute positively in the community and it have several benefits. The outcomes of home-based carers' visits were noted as valuable since they have improved MHCUs adherence to treatment and reduced the hospitalizations of the users.

Furthermore, the family as a whole benefit as they will be taught about the signs and symptoms of mental illness and prevention of relapsed psychosis (Acri, Hooley, Richardson & Moaba, 2017). Community home-based carer intervention was found to be effective in reducing mental health problems to people living with HIV and Aids in a study that was conducted in Nepal (Pokhrel, Sharma, Pokhrel, Neupane, Mlunde, Poudel & Jimba, 2018). The presence of community home-based carers in the visitation of MHCUs is of paramount importance as it increases treatment adherence and reduces unnecessary relapse psychosis and hospital readmission (Pokhrel *et al*., 2018). People living with mental illness or MHCUs are not immune to any other infectious diseases like COVID-19. Support to MHCUs is needed and can be provided by carers in their respective homes. Home-based carers are expected to support people living with severe mental illness by visiting them at home, giving them appropriate information on the prevention of the virus and when to seek medical care (Druss, 2020; Peritogiannis *et al*., 2011)

6.3.5.4 Health Education Regarding Mental Health Issues

The study found that health education to both the family and community members can serve as the basis for providing knowledge about mental health. Participants indicated that the community, in general, do not understand mental health, hence, there is a need for MHCPs to provide health education to the general community. When the community at large understand mental health, stigma and discrimination will be reduced as they will know how mental illness is prevented and treated. Health education to the family and community members can reduce the stigma towards MHCUs and improve mental health access by the people affected and their immediate family members. To achieve this, there is a need to educate individuals, groups, the general public and family members of MHCUs about the causes of mental illness, signs and symptoms, how mental illness can be treated or controlled and prevention

of mental illness (Xu *et al*., 2017). For the community and family members to fully understand mental illness, intervention through intensive mental health education is required. Awareness campaigns need to be conducted regarding mental health issues—this will reduce the incidence of abuse of MHCUs in the community because they will be knowledgeable (Bhatia *et al*., 2016). Anti-stigma campaigns need to be conducted to the general public where MHCPs will teach them how to identify and differentiate mental health disorders. They also need to teach them about their rights. However, MHCPs need to do self-introspection regarding their attitudes towards MHCUs (Nordt *et al*., 2006).

6.3.5.5 Mental Health Advocacy

Participants in the study indicated that there is a need for a mental health program to have advocacy so that the person will be able to speak on behalf of the MHCUs. They further cited that other programs have advocacy, hence, their issues are attended to very fast, but with mental health, no person fights for their rights publicly like people living with HIV and AIDS, for example. The results were supported by a study that was conducted in Zimbabwe about mental health advocacy, where respondents indicated that until a mental health program can have a spokesperson, there will be no change in the way services are rendered in mental health establishments (Hendler, Kidia, Machando, Crooks, Mangezi, Abas, Katz, Thornicroft, Semrau & Jack, 2016).

They further cited that people who are managing the budget in government do not have an interest in mental health, hence, it is not funded like other programs (Hendler *et al*., 2016). Advocacy in mental health can improve the outcomes of service delivery to MHCUs as there will be the empowerment of service users to be able to stand and defend their rights. It will change the way things are currently done in the care of MHCUs and treatment they receive in the mental health establishments and also have

a direction or impact on the policy which is the MHCA (Hendler *et al*., 2016; Ridley, Newbigging & Street, 2018). Moreover, community education was described as the central goal of advocacy in mental health service delivery. Furthermore, the goals of mental health advocacy are to increase community awareness about mental health issues, lobby for external donors so that the budget may be enough, caution the government to prioritize mental health, motivate for human resources in mental health units and convince people that mental health is also important like other programs so that stigma and discrimination towards MHCUs can be reduced (Hendler *et al*., 2016).

6.3.5.6 Workshops on New Information Regarding Mental Health

Findings of the study revealed that training MHCPs with new and developing information is very important as things are changing daily. Participants indicated that they need refresher courses to update them, as well as in-service training and workshops in new drugs that are used in the management of MHCUs in mental health establishments. When MHCPs have information about mental health, they can diagnose mental illness early and make proper referrals where necessary and this will reduce the number of undiagnosed mental illness. Providers with high knowledge will diagnose MHCUs properly and this means that quality care is provided to the users. This was in line with several studies where the authors suggested the importance of educating MHCPs to recognize and diagnose mental illness effectively (Alburquerque-Sendín *et al*., 2018; Alexander *et al*., 2016; Haddad *et al*., 2020; Reed & Fitzgerald, 2005; Uwakwe, 2000; Xu *et al*., 2017). Furthermore, in-service training and workshops were also cited as the best strategy to empower or upgrade the knowledge and skills of MHCPs caring for MHCUs in mental health establishments. In-service training provides insight to MHCPs, and knowledge in mental health issues and new developments in the field. It is envisaged that in-service training will provide good quality care as MHCPs would have been empowered (Manyedi & Dikobe, 2016).

6.3.5.7 Infrastructure Improvisation

Participants indicated that to provide quality care to MHCUs, there is a need to improvise the cubicles that they have been allocated and burglar proofing to be installed to manage patients well. Although they suggested having a stand-alone or separate ward for MHCUs to provide quality care, only few (n=51; 16.7%) mentioned that they conduct the observations in the mental health unit (Psychiatric Unit), while fewer respondents (n=8; 2.6%) indicated that they conduct their forensic observations in the Maximum-Security Unit.

Poor infrastructure to accommodate and observe MHCUs for 72 hours in district hospitals was cited as a challenge. The poor infrastructure might compromise the care delivered to MHCUs as the care will not be aligned to the MHCA. However, at the specialized level, there must be proper infrastructure to accommodate and care for MHCUs (Lund *et al*., 2012). Infrastructure was a challenge in a study conducted in Nigeria where the strategy was that the government needs to improve the mental health facilities for MHCPs to provide quality mental health services. Furthermore, when the infrastructure has been improved, there is a need for the government to hire more staff to work in the mental health units (Haddad *et al*., 2020).

Provision of quality care to MHCUs need MHCPs who are willing, dedicated and highly trained in dealing with mental health issues because caring for users who are not stable in a poorly designed mental health structure poses a risk to both the users and providers. Health education regarding mental illness to the community is key in dispelling myths, misconceptions about the causes of mental illness. Also, stigma and discrimination against MHCUs can be dispelled through knowledge. Workshops and in-service training for MHCPs must be frequently organized to bridge the gap by providing new and recent information on how to manage MHCUs and the attitudes of

MHCPs might change through such knowledge acquisition. Mental health establishments must make it a point that they order enough treatment for MHCUs as the shortage of drugs used in psychiatric units poses a danger to the mental state of users. Support of MHCUs by family members and community is key because users will feel loved and accepted in the community, and this will make them stay longer without relapsing. Furthermore, security in mental health establishment needs to be taken very seriously as MHCPs will feel protected and valued by the management.

The converged findings of the study imply that there is a need to provide information or in-service training to MHCPs to improve the care provided to MHCUs in mental health establishments. The MHCUs must be empowered or motivated to understand and accept their mental conditions as this will make them comply with the treatment regimen and not relapse. When MHCUs have been empowered, they will avoid people who feed them with drugs and alcohol as when drunk they tend to forget to take treatment. Furthermore, the rights of MHCUs must be emphasized and taught to both the users and family members. Mental health education in the community needs to be prioritized through mass campaigns and use of media as the community members were found to be lacking information regarding mental health issues.

The decentralization of mental health services might improve the services rendered to MHCUs as users will be provided with care near their homes and it will be easy for family members to visit them when admitted to the mental health establishment. There is a need to revive or establish halfway houses in all provinces to cater for MHCUs who have been rejected by their family members or community. MHCUs will be discharged to the halfway houses rather than being confined in mental health establishment even though they are stable. Lastly, the media coverage of mental health issues is poor and there is a need to increase the communication of mental health topics so that people will understand mental health and at least there must be

a person talking on behalf of the MHCUs, advocating for their needs. If MHCUs are well managed, they will stay in the community without relapsing and being admitted to mental health establishments will, in turn, improve the management of MHCUs as they will be complying with treatment. There is a need to establish sheltered employment for MHCUs as others will be attending psychosocial rehabilitation where they will be working and contributing to the economy of the country.

6.4 Summary

This chapter discussed the findings where the converged results were presented using side-by-side comparison in a table format. Quantitative results were used to support qualitative findings followed by a literature control for the results. The study findings were representative of the objectives outlined in Chapter 1 and the objective was achieved as the results are convergent. The themes from qualitative findings and transcripts from quantitative findings yielded the same results. The findings revealed several challenges faced by MHCPs while caring for MHCUs in mental health establishments, including Structural-related challenges, Inadequate management of MHCUs when admitted, Improper application of safety measures in the wards, Poor MHCUs support and Insufficient knowledge regarding mental health care. Furthermore, MHCPs suggested the strategies to overcome the challenges they face in their daily work.

CHAPTER 7

STRATEGY DEVELOPMENT

7.1 Introduction

The previous chapter focused on the comparison and interpretation of the study findings using the convergent mixed methods research paradigm, wherein both qualitative and quantitative research methods converged and authenticated that the service provided to MHCUs in mental health establishments is not of good quality. Therefore, there was a need to develop a strategy to promote effective management of mental health users in mental health establishments in Limpopo Province. This chapter is centred on the second phase of the study, which is the development of the strategy, validation and develop a of a pilot plan.

7.2 Strategy Development

The development of a strategy was based on the findings of Phase 1 of the study, which was convergent mixed methods research. The implementation of care in the mental health care services was explored looking at the views and experiences of MHCUs and MHCPs in relation to the provision of care, treatment, rehabilitation (CTR), and rights of MHCUs in the mental health care establishments in Limpopo Province. The assessment also included the investigation on the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province. Furthermore, the researcher consulted guidelines and policies in mental health care as aligned to administration and policy assessment of the PRECEDE-PROCEED model.

7.2.1 A Workshop with the Vhembe District Mental Health Forum

A day's workshop was secured with the Chief Director of Health in Vhembe District to present the findings to the Vhembe District Mental Health Forum (VDMHF). The forum consists of a Psychiatrist, Psychologist, Occupational Therapist, Social Worker, Medical Doctors, and Psychiatric Nurses from both the mental health establishments and primary health care, District and Sub-District Mental Health Coordinators. The members were invited on the basis that each has a unique perspective on the problem and certainly what may be required to solve them. Secondly, the forum was invited as the prospective adopters and implementers of the developed strategy to ensure acceptability and sustainability.

According to Roger (2010), identifying the adopter categories could form a strong basis from which to design and implement innovation. The meeting was held in the Vhembe District health boardroom and attended by 12 out of 18 participants from the VDMHF. Based on the findings, the factors affecting implementation of mental health services were found to be a cluster of challenges related to MHCUs, family/community, providers and institution-linked factors. The summary of the findings was presented to the forum as briefly presented in Table 7.1.

7.2.1.1 Patient | Mental Health Care User-Related Challenges

MHCUs' challenges include lack of insight about their mental health conditions, abused substances and alcohol and this might be the contributory factor for them to forget taking treatment because they are drunk, they will not think of going home to take treatment on time. Mental health establishments were found to be admitting one MHCU more than once in a month due to them defaulting treatment. When MHCUs default treatment, they relapse and get readmitted to mental health establishments.

Table 7.1: Summary of challenges hindering the delivery of quality mental services

Patient related challenges (MHCUs) ❄ Poor mental health insight ❄ Substance abuse ❄ Treatment default / non-adherence to treatment regiment ❄ Frequent readmission in MHE ❄ Irregular taking of treatment
Family/Community related challenges ❄ Lack of knowledge in mental health issues ❄ Rejection of MHCUs ❄ Stigma and discrimination of MHCUs ❄ Lack of support of MHCUs ❄ Fear of MHCUs
Providers related challenges (MHCPs) ❄ Poor knowledge and skills in the management of MHCUs ❄ Not willing to work MHCUs ❄ Negative attitudes towards MHCUs ❄ Fear of MHCUs ❄ Poor implementation of MHCA
Institutional related challenges ❄ Poor infrastructure for MHCUs ❄ Poor supply of treatment ❄ Poor reviewing system of MHCUs ❄ Mixing of MHCUs with medical patients ❄ Lack of dedicated budget for mental health program ❄ Legalization of dagga by government

7.2.1.2 Family/Community-Related Challenges

Rejection of MHCUs by family members or relatives was identified as a major challenge as some MHCUs were found to have been dumped in the mental health establishments by their relatives and there will be no one visiting the user while admitted. Lack of support by family members and community was also discovered as a contributory factor that makes MHCUs to be admitted frequently in mental health

establishments. Furthermore, stigma and discrimination of MHCUs by community members were found to be prevalent, and this allude to a lack of knowledge in mental health issues. Moreover, family members and the community at large were found to be afraid of MHCUs, hence, there little or no support is given to them. People who are supposed to provide care to MHCUs at home or support them in the community are afraid of users, implying that MHCUs will not be supported and this is a serious challenge because they need more support to remain stable in the community without relapsing.

7.2.1.3 Mental Health Care Provider-Related Challenges

Challenges related to MHCPs include negative attitudes towards MHCUs and this compromise the service provided to users as they do not treat them with the respect and dignity they deserve. Furthermore, other MHCPs were not willing to work directly with MHCUs citing personal and safety reasons. Knowledge and skills in the management of MHCUs were also found to be poor in MHCPs and this alluded to lack of training or in-service education.

7.2.1.4 Institutional Related Challenges

Poor mental health infrastructure contributes to the service that is provided to MHCUs, where in other instances there is no mental health unit at all. Users were complaining of not being seen by an occupational therapist as there is no space to engage in activities. The premature discharge of MHCUs was cited as a contributory factor for users to relapse as they were discharged before they are stable. Other mental health establishments were found to be mixing MHCUs and medical patients in the same unit and this creates safety concerns. Poor supply of treatment in mental health establishments contributes to the high number of MHCUs being readmitted because without treatment users cannot be stabilized.

Staff shortage has a negative impact on the care of MHCUs. Again, poor implementation of security measures was of great concern as in other mental health establishments there were no security officers allocated in mental health units. Six-monthly reviews of the treatment of MHCUs were found not to be done due to shortage of psychiatrists or doctors dedicated to the mental health units. There is no budget dedicated to the mental health program, and this affects the service delivery to MHCUs as MHCPs are unable to plan for awareness campaigns and excursions. Following the presentation of the integrated results, the participants confirmed the findings as what is happening in the implementation of mental health services in Limpopo Province. The findings were further discussed in order to identify the main problem as well as the behavioural factors contributing to the problem. The forum identified the main challenge as the “revolving door”, which is frequent relapses and readmissions in mental health establishments by MHCUs. The following question was posed to the forum.

> *“Based on the results, what should be included in the strategy to promote the effective management of mental health services in Limpopo Province”?*

Then the researcher and the forum checked the guidelines and policies that are used in the care and management of MHCUs. A Logic Model of the Problem was developed with the stakeholders and the forum then worked on the proposed Logic Model of Change. The researcher also used the Behaviour Change Techniques (BCTs) that were relevant to the behaviour identified and applied in the development of the strategy.

7.2.2 Logic Model of the Problem

To develop strategies, the main problem needs to be stated in terms of negative

conditions. After a lengthy debate, the team reached a consensus that the main problem is the 'revolving door' due to frequent relapses and readmissions of MHCUs in mental health establishments. The MHCUs as described above were always admitted to the facilities. The forum was then guided on developing a Logic Model of the Problem (Figure 7.1). Working from the right to the left, relapses and frequent admissions were identified as the main problem.

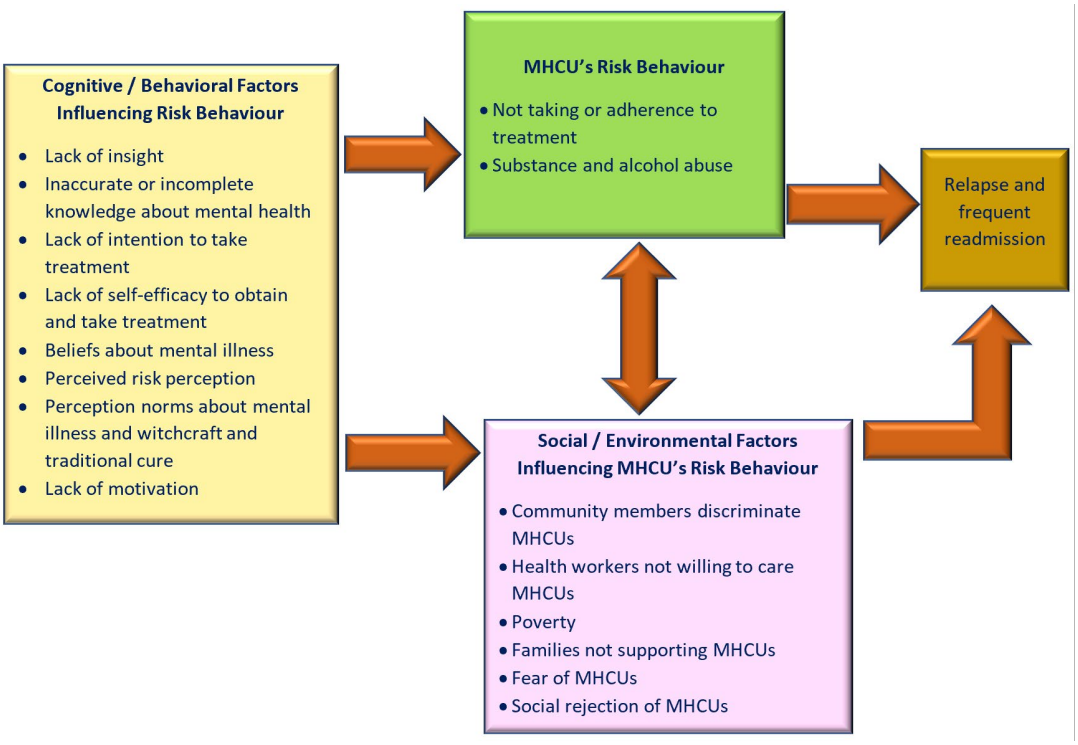

Figure 7.1: Logic Model of the Problem: health risk behaviour among mental health care users in Limpopo Province

Looking at the behaviour of the MHCUs, substance and alcohol abuse were the two main factors that contributed to the 'revolving door'. The social and environmental factors influencing the behaviour of the MHCUs were discrimination, fear, and rejection by family and community members. Health care workers were also not willing to provide care to MHCUs. Lastly and very important are the cognitive and behavioural factors influencing risk behaviours. These behaviours included lack of insight,

inaccurate knowledge, lack of intention to take treatment, lack of self-efficacy, risk perception, beliefs in witchcraft including cultural norms, traditional cure and lack of motivation. Addressing some of the cognitive/behavioural factors may results in the reduction of relapse psychosis and frequent readmissions by MHCUs in mental health establishments.

7.2.3 Proposed Logic Model of Change

After the development of the Logic Model of the Problem as described above, the researcher and the forum then worked on the proposed Logic Model of Change (Figure 7.2) which is from the left to right where the ultimate goal is to achieve low relapses and frequent readmissions of MHCUs in mental health establishments.

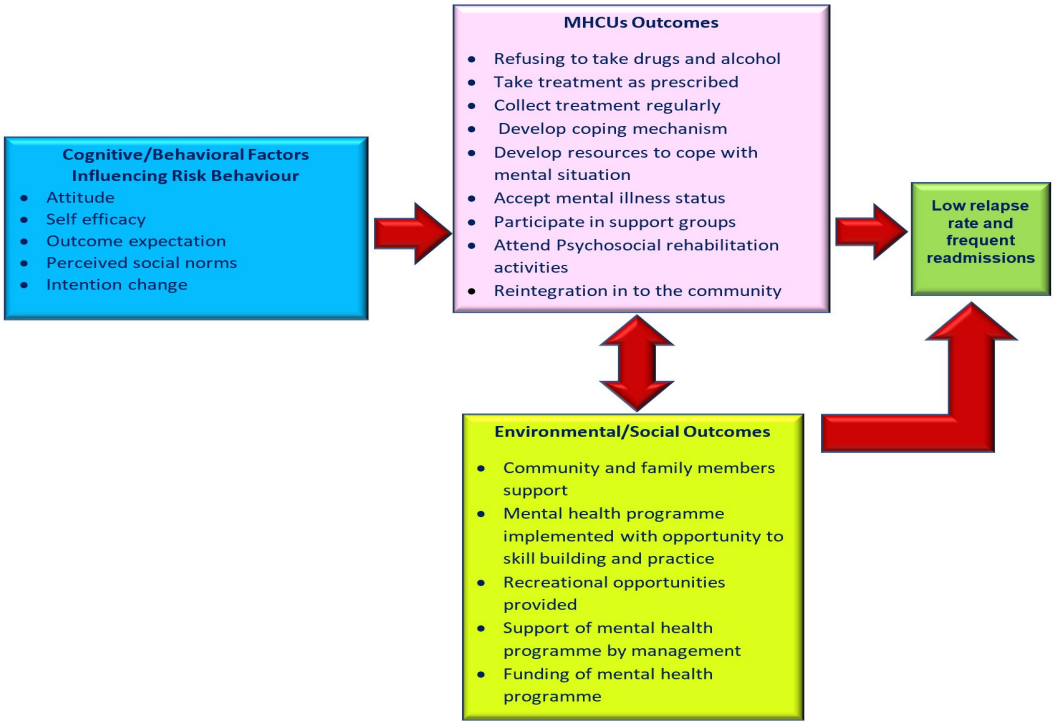

Figure 7.2: Proposed Logic Model of Change

Some of the cognitive/behavioural challenges include attitude, self-efficacy, outcomes

expectations, perceived social norms and intention to change. To achieve low relapse rate and frequent readmissions, the MHCUs must be motivated to change the behaviour. According to the Proposed Logic Model of Change, the MHCUs outcomes include refusing to take drugs and alcohol, taking treatment as prescribed, collecting treatment regularly, developing resources to cope with the situations they face on daily basis, accept mental illness status, participate in support groups, attend psychosocial rehabilitation and reintegration into the community. Furthermore, environmental outcomes may also assist in reducing the number of relapses and frequent readmission where support is fundamental to MHCUs and mental health programme.

7.2.4 Strategy to Improve Mental Health Care Services in Limpopo Province

The behavioural change techniques suggested by (Abraham & Kools, 2012) address various cognitive processes and behaviours. Based on the proposed Logic Model, the forum was introduced to the Diffusion of Innovation Theory (DIT) (Rogers, 2010). According to the theory, for the innovation to be acceptable and sustained, the innovation should meet certain criteria. The following were then followed when developing the draft strategy:

- **Relative Advantage Checks** if the innovation is better than what was there before. The forum was to check what is available now then come up with a strategy to better address the relapses rate of MHCUs in mental health establishments.

- **Compatibility Checks** if the innovation fit with the intended audience. The forum was to check if the suggested strategy will suit the delivery of services to MHCUs in Limpopo Province, including the implementation thereof.

- **Complexity Checks** if the innovation is easy to use. The forum had to check if the strategy will be easy to implement within the available budget

- **Trialability Checks** if the innovation can be tried before deciding to adopt it. The forum had to check if the developed strategy can be experimented with on a limited basis and easy to implement without any challenges with no additional staff members and can be regarded to be cost-effective.

- **Observability Checks** if the results of the innovation are visible and measurable. The forum had to check if the developed strategy will be visible and measurable (Rogers, 2010).

Four components to constitute the strategy were identified and described with the stakeholders.

▲ ***Name of the Strategy***

- Strategy to improve mental health care services in Limpopo Province

▲ ***Aim of the Strategy***

- To reduce mental illness relapses and frequent readmission by MHCUs in Limpopo Province.

▲ ***Objectives***

- To influence individual and interpersonal level of antecedents of MHCUs decision making and risk taking.

- To influence health care providers, family and community members regarding supporting MHCUs.

7.2.4.1 Component 1: Increase Knowledge and Encourage a Healthy Attitude About Mental Health

This component will help MHCUs make healthy decisions about mental illness. This focus can also influence other levels of care to change community social norms and perceptions, strengthening institutions that care for MHCUs and encouraging adults to communicate effectively with MHCUs. Community and family members, and specifically MHCUs need clear and accurate information regarding mental illness and the importance of taking treatment. Health education activities can affect many of the factors that influence MHCUs and other stakeholders' decision-making.

Myths, beliefs and misconception regarding the causes of mental illness can be dispelled through organizing mass media campaigns and give mental health education regarding causes of mental illness to dispel myths, beliefs and misconception. Traditional leaders, in collaboration with the Department of Health, Department of Social Development, Department of Justice, South African Police Services (SAPS) and local community structures will spearhead the mental health campaigns in the community. Community members will be allowed to voice their beliefs about mental health or mental illness and health professionals will be able to clarify and give extensive health education during the village meetings or indaba. The involvement of traditional healers and faith-based organization leaders can assist in dispelling the myths, beliefs and misconceptions about the causes of mental illness and they are the first contact with the family or users when there are mental illness relapses.

7.2.4.2 Component 2: Improve Social Environment

Support of MHCUs by either the immediate family members, MHCPs and community members forms the basis of improved quality mental health services. This component

will make MHCUs feel accepted when experiencing challenges where they can consult freely without any fear of being judged in mental health establishments. Community members can also contribute to supporting both the families of MHCUs and users by accepting and including them in all decision-making in the community. Traditional leaders can also play a role by making the environment conducive where there are MHCUs and reduce stigma and discrimination of people living with mental illness so that they can feel free and accepted.

Encouraging or requesting MHCUs to select a buddy at home, getting support from community health care workers and local spaza shops owners will remind the MHCUs to take the treatment regularly. Establishing mental health advocacy leaders in all mental health establishments starting from the national level to community or primary health care facilities is key in this regard. Furthermore, the established mental health advocacy groups will assist in fighting for the rights of MHCUs and lobbying for funds to be used during mass media campaigns; also, the advocacy group will fight inequalities in health programs as all health programs are important. Establishing a relationship with the municipality and developing home visit schedules for those who need constant supervision will reinforce compliance to treatment.

7.2.4.3 Component 3: Improve and Develop Social Skills of Mental Health Care Users

In most cases, MHCUs are regarded as being violent and aggressive towards family and community members. The reason for the community to label MHCUs as being aggressive might allude to the way MHCUs behaved during the psychotic phase as some do display aggressive behaviour towards people. MHCPs can provide training to MHCUs regarding the control of their anger and negotiate not to be called ugly names like being crazy or mad. The training can include how to be assertive, fighting

for their rights as MHCUs without violating other people's rights. Furthermore, MHCUs may also be encouraged to avoid people who drink alcohol or smoke dagga as this behaviour can make them take drugs or drink alcohol and forget to take treatment which will result in relapse psychosis and getting readmitted to mental health establishments. Skills can be achieved through training workshops for mental health users.

7.2.4.4 Component 4: Improve Self-Efficacy to Obtain and Take Treatment by Mental Health Care Users

This component will boost the self-confidence of MHCUs that they can still lead a normal life with mental illness in the community being stable by going to the clinic or hospital to collect treatment and follow the Doctor's prescription. It can also be achieved by giving a similar example of some MHCUs who are on treatment, but are leading a normal life or occupying high positions in their workplace. The MHCUs can be given instructions on how to take treatment on specific time schedules, storage of treatment can serve as a vital element whereby the users will be instructed to store the psychotropic drugs away from direct sunlight and closing the lid tightly.

Monitoring of MHCUs can be done by family members as they will be able to check if the behaviour of users has changed and when they observe any signs of relapse or mental illness, they must report to the nearest facility. Family members can easily identify if the behaviour of MHCU has changed as they stay with the user on daily basis. When MHCUs are maintaining a stable condition in the community, positive feedback should be provided regarding their good behaviour which is compliance to treatment. The MHCPs must tell the MHCU that s/he is doing great by taking treatment; this will increase motivation to continue taking treatment because positive feedback was received.

Referral of MHCUs to community home-based care workers will assist in monitoring the treatment compliance to MHCUs as they visit homes of users on a daily basis and they can serve as an extended hand for the government where there is a shortage of MHCPs to conduct home visits. The strategy used in TB for Directly Observed Treatment (DOT) can also be applied for MHCUs who are not complying with treatment in their homes, spaza shops or primary health care facilities to strengthen compliance.

7.3 Validation of the Developed Strategy

Following the draft, the strategy components were again sent to 18 members of the forum by email for final review, using the same criteria which were expounded during development. Members of the DMHF were given two weeks to complete the review and send their inputs back to the researcher. Constant reminders were given after every three days to all the members. Only 10 (55%) members of the forum returned the validation forms and the results are shown in Table 7.2 below. Inputs suggested by members of the mental health forum were incorporated in the main final strategy.

- ***The relative advantage which checks if the innovation is better than what was there before***. All respondents confirmed that the developed strategy components are better as there is no strategy in place specifically that deals with the mental illness relapse reduction in mental health establishments. However, one member of the forum (10%) suggested that strategy components must include action verbs.

- ***Compatibility checks if the innovation fit with the intended audience***. All respondents confirmed that the developed strategy components will fit the intended audience.

Table 7.2: Validation of developed strategy by the stakeholders

Criteria	Question	Strategy Components	Remarks
Relative advantage	Is the strategy better than the present?	Component 1	10 (100%) said there is no strategy in place to reduce mental illness relapses and frequent readmission rates.
		Component 2	10 (100%) said the strategy is good.
		Component 3	10 (100%) confirmed that the strategy is better.
		Component 4	10 (100%) confirmed that the strategy is good.
Compatibility	Does the strategy fit with the intended audience?	Component 1	10 (100%) confirmed that it fit the intended audience.
		Component 2	10 (100%) confirmed it as fit for the MHCUs
		Component 3	10 (100%) confirmed it with inclusion of spiritual and traditional healers.
		Component 4	10 (100%) confirmed it as it is.
Complexity	Is the innovation easy to use?	Component 1	10 (100%) agreed that it is easy to use.
		Component 2	10 (100%) confirmed it is simple to use
		Component 3	10 (100%) agreed that it is easy to use
		Component 4	10 (100%) confirmed that is it easy to use.
Trialability	Can the innovation be tried before making decision to adopt?	Component 1	10 (100%) confirmed that it can be tried before adopting.
		Component 2	10 (100%) said there is no strategy in place to reduce mental illness relapses and frequent readmission rates.
		Component 3	10 (100%) confirmed that it can be tried.

Table 7.2: Validation of developed strategy by the stakeholders (continued)

Criteria	Question	Strategy Components	Remarks
		Component 4	10 (100%) agreed that it can be tried.
Observability	will the results of the innovation visible and measurable?	Component 1	10 (100%) agreed that the results can be visible if the strategy is implemented practically.
		Component 2	10 (100%) agreed that It can still be observed through compliance rate
		Component 3	10 (100%) agreed that it can be noted by reduction in the rate of readmission of MHCUs which may reflect that the home environment is conducive.
		Component 4	10 (100%) agreed that it can be visible as MHCUs will remain in the community

- However, about 30% (n=3) suggested the inclusion of traditional healers and spiritual leaders as key stakeholders. The respondents agreed that the developed strategy components are compatible as MHCUs will be able to remain stable in the community on treatment with the support of family members and the community.

- ***Complexity checks if the innovation is easy to use***. All respondents agreed that the developed strategy components are easy to use as there is no need to add more staff in terms of MHCPs in the implementation of the strategy, the available MHCPs will adopt and implement the strategy as their daily routine. Four members of the forum (40%) also suggested that there is a need for the strategy to be implemented practically to achieve the desired results.

- ***Trialability checks if the innovation can be tried before deciding to adopt it***. All respondents confirmed that the developed strategy components can be tried before deciding to adopt. Two members of the forum (20%) suggested a list of topics to be taught to MHCUs like teaching them about their rights, how to initiate and maintain a healthy relationship, good communication skills and stress management.

- ***Observability checks if the results of the innovation are visible and measurable***. All respondents agreed that the developed strategy components will be visible and measurable as MHCUs will remain stable in the community without relapsing and readmitted in mental health establishments. Compliance with treatment can also be observed as there will be no defaulter and the home environment will be conducive for MHCUs to remain stable (Rogers, 2010).

7.4 Plan for Piloting the Developed Strategy

The developed strategy will be implemented by adopting the Diffusion of Innovation Theory (DIT) by Rogers (2010). The theory is regarded as a change model which guides technological innovation, and the innovation itself is modified and presented in a way that will meet the adopter's needs. The DIT also suggests methods and applications that influence the determinants and the need to accomplish the performance objectives for adoption, implementation and sustainability of new behaviour (Rogers, 2010). The community adopt new ideas, practice, products or innovations when the communication techniques are used properly to diffuse the information. DIT stressed that in most cases only a few people are open and adopt the new idea, and these early innovators spread the word about the new idea and eventually more people follow in implementing the new ideas. Over time the innovation

of a new idea or strategy will be diffused into the whole community until it reaches the saturation point (Rogers, 2010). During the meeting with the Vhembe District Mental Health Forum, stakeholders worked on the proposed Logic Model for Implementation of the Strategy which is displayed in Table 7.3.

For the strategy to be implemented fully and successfully, inputs such as funding, personnel, equipment, technology, volunteers, materials, transport and commitment from stakeholders will be needed. In addition, there is a need for stakeholders to plan and execute the activities which include developing and delivering training programs for providers and stakeholders, organizing advocacy campaigns, facilitating participation by stakeholders and organizing workshops and seminars, provisioning of technical assistance by experts and counselling of MHCUs to achieve the main goal of reducing the relapses and readmissions of users in mental health establishments. During the implementation process, there is a need to apply the DIT in communicating the strategy to stakeholders involved in the care of MHCUs to reduce the frequent readmissions.

Within the DIT, there are five stages of change where implementers and adopters can move within the five stages and the goal is to meet the needs of the community. The stages include knowledge or awareness stage, persuasion or interest stage, decision or evaluation stage, implementation or trial stage and confirmation or adoption stage as displayed by Table 7.4 (Rogers, 2010). The stages of change model describe knowledge as a very important step in changing the behaviour and knowledge can be regarded as power, but knowledge alone is not enough. The MHCUs know that they are mentally ill and need to take the treatment regularly to remain stable in the community. The MHCPs need to foster or persuade them constantly until they understand that they need to take the treatment regularly.

Table 7.3: Proposed Logic Model for Implementation of the Strategy

Inputs	Activities	Outputs	Outcomes	Impact
Funding	Degelop and deliver training programme (providers, stakeholders)	Training programmes developed and conducted	MHCUs motivated to take treatment	Reduced relapses and readmissions
Personnel	Organize Advocacy campaign	Participation of stakeholders encouraged	Community and family members providing support to MHCUs	
Equipment	Facilitate participation		MHCPs to have knowledge in the care of MHCUs	
Technology	Organize workshops and seminars			
Volunteers	Provide technical assistance by experts			
Materials	Counselling sessions for MHCUs			
Transport				
Stakeholder				
 **Resources**		 **Results**		
 **Planning**				
 **Implementation**				

Table 7.4: Stages of change

Stages of change	**Level of knowledge and attitude toward or experience with the new practice**	Behaviour **change techniques (BCTs) to be applied**
Knowledge or awareness stage	An individual is exposed to innovation but lacks complete information	Provide general information on behaviour -health links
Persuasion or interest stage	An individual becomes interested in the new idea and seeks additional information	Use argument to bolster self-efficacy
Decision or evaluation stage	Individual mentally applies innovation to his present and anticipated future situation, and then decides whether to try it	Provide instructions
Implementation or trial stage	An individual makes full use of innovation	Provide negotiation skills training
Confirmation or adoption stage	Individual decides to continue the full use of innovation	Prompt organization of social support
Source: Rogers (2010)		

To sustain the new behaviour, practice or innovation, support from the family members or community can be regarded as an important strategy for MHCUs to continue taking treatment to avoid relapse psychosis. When community members are supporting MHCUs in mental health treatment, users will easily adopt the practice as they will be receiving support from the community.

7.5 Summary

This chapter covered the development of the strategy to promote the effective management of MHCUs in mental health establishments in Limpopo Province. Needs assessment guided the development of the strategy and helped in developing the Logic Model of the Problem with the stakeholders, then worked on the Logic Model of Change. A four-component strategy was developed and validated by the forum for relative advantage, compatibility, complexity, trialability and observability. Chapter 8 presents the summary, strengths, limitations and recommendations of the study.

CHAPTER 8

SUMMARY, STRENGTHS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

8.1 Introduction

Chapter 7 outlined the process followed in strategy development, where a workshop with the Vhembe District Mental Health Forum was held, then the Logic Model of the Problem was identified, and the forum then worked on the proposed Logic Model of Change. The strategy to improve mental health care services in Limpopo Province was developed and the validation of the developed strategy was carried out by the stakeholders. No gaps were identified from the developed strategy. However, suggestions were made by the stakeholders on the developed strategy and they were included in drafting the final strategy and discussion thereof. The plan for piloting the developed strategy was also discussed. This chapter will therefore present the summary, strengths and limitations and recommendations of the study.

8.2 Purpose of the Study

The purpose of the study was to develop a strategy to promote effective management of MHCUs in mental health establishments in Limpopo Province, South Africa. The purpose of the study was achieved through the following objectives:

1. To explore the views and experiences of MHCPs and MHCUs related to the provision of care, treatment, rehabilitation (CTR), and rights of MHCUs in the mental health care establishments in Limpopo Province.

2. To explore the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province.

3. To develop a strategy to promote management of mental health services in Limpopo Province.

4. To develop a plan for piloting the developed strategy for managing mental health services in Limpopo Province.

Therefore, all four objectives of the study were achieved.

8.3 Summary of the Key Findings

In order to achieve the main purpose of the study, a convergent parallel mixed method design was employed to explore and describe the views and experiences of MHCPs encountering during mental health service delivery in Limpopo Province. This allowed the researcher to collect more information and different perspectives at their service delivery points. The MHCUs were also involved in data collection where they had their perspectives on how challenges can be resolved or managed by MHCPs. The MHCPs who participated in the study included psychiatric nurses, medical doctors, psychologists, psychiatrists, occupational therapist, social workers and physiotherapists who provide care, treatment and rehabilitation to MHCUs in mental health establishments.

Through the use of unstructured guide interviews for both MHCUs and MHCPs, the researcher conducted 34 in-depth interviews with MHCPs;in this case psychiatric nurses working in mental health units and 19 interviews with MHCUs who were stable and admitted in the unit waiting to be discharged or discharged, but waiting for their significant others to fetch them. Qualitative data were analyzed using Tesch's 8 steps

of inductive, descriptive and open-coding techniques. Six themes emerged as Structural related challenges, Inadequate management of MHCU when admitted, Improper application of safety measures in the wards, Poor MHCUs support, Insufficient knowledge regarding mental health care, and Strategies to improve the management of MHCUs. The researcher also used a questionnaire for service providers which a total of 305 MHCPs completed. Quantitative data were collected using a self-administered questionnaire and it was analyzed using Statistical Package for Social Sciences (SPSS) version 26.0 where tables and charts were used to present the data. Integration of results occurred where the researcher merged the data from the two strands (Qualitative and Quantitative) by following the procedure of side-by-side comparison where qualitative and quantitative data were combined and presented in a single table.

A one day's workshop was held with the Vhembe District Mental Health Forum (VDMHF) to present the study findings. The challenges affecting the implementation of mental health services were found to be a cluster of challenges related to patients, providers, family/community and institutional landscape. Patient-related challenges were poor mental health insight, substance abuse, treatment default / non-adherence to treatment regimen frequent readmission in mental health establishments and irregular taking of treatment. Community-related challenges were lack of knowledge in mental health issues, rejection of MHCUs by family members and community, lack of support of MHCUs. Provider-related challenges were not willing to work with MHCUs and negative attitudes towards MHCUs. Institutional challenges were premature discharge of MHCUs, mixing of MHCUs with medical patients, poor supply of treatment. After presentation of the results, the forum confirmed that the findings to be what they know and happening in the care of MHCUs in the district. The forum then identified the main challenge as the "revolving door", which is frequent relapses and

readmissions in mental health establishments by MHCUs. Policies and guidelines in the care and management of MHCUs were then explored. The researcher and the forum then worked on the Logic Model of the Problem and the proposed Logic Model of Change. The researcher and the forum then worked on the development of the strategy to improve the mental health services in Limpopo Province to reduce the rate of relapses and frequent readmissions in mental health establishments in Limpopo. Furthermore, the DIT was incorporated in the development of the strategy to improve mental health care services in Limpopo Province. The strategy was then sent to the members of the VDMHF for validation, using the criteria extracted from the DIT as they are the potential adopters and implementers. Finally, the researcher and the forum worked on the proposed plan to pilot the developed strategy.

8.4 Implications of the Study

The study provides the justifications in the care and management of MHCUs as it responds to the challenges that MHCPs experience in mental health management, that is, a high rate of relapses and frequent readmissions. The readmissions of MHCUs in mental health units put further strains on the already overburdened mental health establishments with limited resources to manage MHCUs. Additionally, it will be strengthening the management of MHCUs in the community where there is a need for support of people suffering from mental illness by either family members or the community. The study has revealed that MHCUs are not supported adequately in the community, hence, there is a high rate of mental illness relapses and frequent readmissions in mental health establishments. When MHCUs are supported by their family members, they will take their treatment as prescribed, avoid substance use which will, in turn, make them comply to treatment and remain stable in the community, it will reduce the high rate of relapses and readmission in mental health establishments.

Furthermore, the study also contributes to the body of knowledge as it is the first-ever to develop a strategy that promotes the effective management of MHCUs in mental health establishments. Likewise, it provides a conceptual model (Logic Model for Behaviour Change) on the care of MHCUs to reduce the high relapses rate and frequent admissions. The strategy developed to provide evidence-based behaviour change techniques and practices in the care and management of MHCUs as it proved to be effective in the care, treatment and rehabilitations of MHCUs, hence, reducing the relapses and frequent readmissions in the mental health establishments.

8.5 Strengths and Limitations of the Study

The use of the convergent parallel mixed methods design can be considered as a strength of the study as the researcher managed to collect data using both qualitative and quantitative methods at the same time. The advantage of the approach is that it was simple to use and implement and the results of the two strands showed convergence as results of one method confirmed the findings of the other method. It provided the strength and put aside the weakness of one method, either qualitative or quantitative. Also, it provided the inferences and allowed triangulation for the qualitative method (Creswell & Clark, 2018).

The researcher further used the theories in the development of the strategy to improve mental health services in Limpopo Province. The modified PRECEDE-PROCEED model was applied in conducting a needs assessment. Then the researcher presented the findings of the need assessment followed by developing the logic framework and stakeholders participated in the development of the strategy. The Diffusion of Innovation Theory (DIT) was also used in the development of the strategy. Again, the PRECEDE-PROCEED model was applied to address the plan to pilot the developed strategy.

However, several factors served as the limitations to the study. Firstly, the use of MHCUs was a limitation as some mental health establishments did not have stable MHCUs available for interviews and the study was only conducted in one Province which is regarded as rural and generalization and transferability of the results in a wider context might be difficult. The other eight provinces might not be encountering the challenges that are being experienced in Limpopo Province. One hospital responded to the researcher that they did not have a mental health unit, hence, the CEO rejected the application to collect data in the institution.

Furthermore, the study was confined to Limpopo Province and only MHCPs working with in mental health units were included. The other notable limitation was that few medical doctors participated in the study, and some refused to participate indicating that they do not have time to complete the questionnaire because they have a lot of work to do.

Besides, MHCPs from the community level were not included as the study was conducted in mental health establishment. Lastly, the family members of MHCUs and the community members were missed, and support from significant others and community serve as a strong pillar of support for MHCUs when they are discharged from the mental health establishments.

8.6 Recommendations

Recommendations include what the government, managers, MHCPs and policymakers could do to assist in the promotion of effective management of MHCUs in mental health establishments in Limpopo Province. The recommendations are presented as related to the government (Department of Health), policymakers, education and practice and further research.

8.6.1 Department of Health

- The study recommends that there is a dire need for the government to start taking mental health programs seriously and there should be funds allocated solely for mental health activities like the conduction of mental health campaigns to empower communities about mental health issues.

- The study recommends that the department must build mental health units in all hospitals for easy accessibility and use by MHCUs who need care, treatment and rehabilitation. These units must be built in a specified manner which will be impossible for MHCUs to abscond.

- The department must timeously order all the psychotropic drugs used by MHCUs to avoid shortage of treatment which results in mental illness relapse or relapse psychosis and readmissions in mental health units.

- The department should revise the allocation of staff and appoint more males in mental health units to provide staff in case there are aggressive MHCUs and need to be handled by males.

- The department should allocate more security officers in all mental health units as there is a need to manage MHCUs who are violent and those who abscond.

- The department should establish and revive the support groups for MHCUs and those for families of MHCUs so that they can share their experiences and MHCPs will be there to support them.

- The department should foster the establishment of mental health

advocacy from Provincial to Local area level who will serve as the spokesperson for mental health program.

- The department should establish halfway houses to accommodate MHCUs who have been rejected by family members. When MHCUs are stable, they will be released to the halfway house where they will be managed by MHCPs.

- The department should employ more staff in mental health establishments, especially psychiatrists and clinical psychologists.

- The department must support MHCPs working with MHCUs by providing continuous training and workshops on new information pertaining to mental health issues.

- The department must prioritize MHCPs working in mental health units and provide them with danger allowance.

- The department should employ the internal Doctors to handle the approval of Disability Grants (DGs) for MHCUs as the SASSA Doctor does not know the MHCUs because s/he is not in the mental health unit.

- The department should support the establishment of sheltered employment for MHCUs in all local areas to keep the users busy in the community as this will prevent relapses and frequent readmissions in mental health units.

8.6.2 Policymakers

- Policymakers should review the 72-hour observation for the first episode,

it is not enough to observe and properly diagnose the first episode users and those who are highly sedated.

- Policymakers should consider the addition of family members and support systems such as traditional leaders and faith-based organization in the MHCA would be of paramount importance.

- Policymakers should develop a policy that will specifically deal with family members who reject MHCUs, but using the DG of the user while admitted to a mental health establishment.

8.6.3 Education and Training

- The study recommends that mental health be incorporated into the curricular of social workers so that they can understand mental health topics from the first level.

- The inclusion of basic mental health in the training of all nursing categories like bridging courses and all postgraduate qualifications for easy understanding of mental health issues.

- Continuous training, workshops, conferences and in-service enhancements of MHCPs, home-based care workers (HBCWs) on mental health issues to increase mental health knowledge and so that they can provide good quality care to MHCUs.

- Training of community HBCWs on the issues of mental health so that they understand how to engage with them and check if they are complying with treatment when allocated to go and check on MHCUs at home.

- Training of nurses on basic mental health to equip general nurses without Psychiatric Nursing, so that they have mental health knowledge, especially those working in mental health units without psychiatric nursing.

8.6.4 Further Research

- Conduct pilot study of the developed strategy in mental health establishments to improve mental health service delivery.

- Process evaluation in the care of MHCUs using the developed strategy in mental health establishments.

- Assessment of impact for lack of mental health treatment in mental health establishments to expand the implementation nationwide.

- Develop a model to facilitate the management of MHCUs in primary health care facilities to manage and sustain the stability MHCUs in the community while avoiding readmission of users in mental health establishments.

- Assess the impact of the premature discharge of MHCUs in mental health establishments to family members so that coping mechanism can be explored and discussed.

- Evaluate knowledge of HBCWs in the care and management of MHCUs in the community to build mental health capacity for HBCWs.

- Investigate community knowledge about mental health issues and the management of MHCUs to empower the community regarding mental health issues.

8.7 Conclusions

The main aim of the study was to develop a strategy to promote effective management of MHCUs in mental health establishments in Limpopo Province. The objectives of the study were achieved through the use of the mixed method approach whereby qualitative and quantitative designs were employed to explore the views and experiences of MHCPs and MHCUs related to provision of care, treatment, rehabilitation, and rights of MHCUs in the mental health care establishments in Limpopo Province and to investigate the views and experiences of service providers caring for MHCUs in Limpopo Province. The study was guided by a theoretical framework and the study findings revealed several challenges that hinder the implementation of mental health service delivery. The challenges were found to be a cluster of challenges related to patients, providers, family/community and institutional environment.

The study also provided evidence that informed the development of the strategy. The developed strategy was validated by stakeholders who were involved in the development phase, and the results indicated that the developed strategy is congruent with the practice and it can be useful in promotion of effective management of MHCUs in Limpopo Province. It is hoped that the government and policymakers in Limpopo Province would find the developed strategy very useful in their quest to care and promote the effective management of MHCUs. However, further research in mental health is required to implement and evaluate the developed strategy and its feasibility in terms of its implication and acceptability.

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ANNEXURE A

UNIVERSITY HIGHER DEGREES COMMITTEE (UHDC) LETTER

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS B.S MANGANYE

SCHOOL OF HEALTH SCIENCES

FROM: PROF. J.E CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 10 SEPTEMBER 2019

DECISIONS TAKEN BY UHDC OF 10th SEPTEMBER 2019

Application for change of Doctoral promoters in Health Sciences: **B.S Manganye (11520559)**

Topic: "Development of a strategy to promote effective management of mental health care users in mental health establishment in Limpopo Province, South Africa."

Original Promoters:

Promoter	UNIVEN	Prof. H.A Akinsola
Co-promoter	UNIVEN	Dr. J.T Mabunda

New Promoters:

Promoter	UNIVEN	Dr. J.T Mabunda
Co-promoter	UNIVEN	Dr. L. Makhado

UHDC approved change of promoter

PROF. J.E CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

ANNEXURE B

UNIVERSITY OF VENDA RESEARCH ETHICS COMMITTEE (UVREC) CLEARANCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr BS Manganye

Student No:
11520559

PROJECT TITLE: **Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province South Africa.**

PROJECT NO: **SHS/18/PH/09/2205**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr JT Mabunda	University of Venda	Promoter
Dr L Makhado	University of Venda	Co - Promoter
Mr BS Manganye	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE
Date Considered: May 2018

Name of the HCTREC Chairperson of the Committee: Prof MS Maputle

Signature: .....

UNIVERSITY OF VENDA
OFFICE OF THE DIRECTOR
RESEARCH AND INNOVATION
2021 -03- 08
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE C1

REQUEST TO THE LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

P.O.Box 302
Xigalo
0981
01 February 2018

Provincial Manager
Limpopo Province
Department of Health
Polokwane

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification;

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT(015 962 8601)
Co- promoter: Prof Makhado L(015 962 8828)
Your positive response to my request will be highly appreciated

Yours Faithfully
Mr Manganye BS

ANNEXURE C2

PERMISSION FROM THE LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT THE STUDY

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Stander SS (015 293 6650) Ref: LP_ 20180S_013

Manganye BS
University of Venda
Private bag X5050
Thohoyandou

Greetings,

RE: Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province South Africa

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services, or incur any cost on the Department.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

20/06/2018
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

The heartland of Southern Africa – Development is about people!

ANNEXURE D1

APPLICATION LETTER TO VHEMBE DISTRICT

P.O.Box 302
Xigalo
0981
01 February 2018

District Executive Manager
Vhembe District
Department of Health
Thohoyandou, 0950

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification;

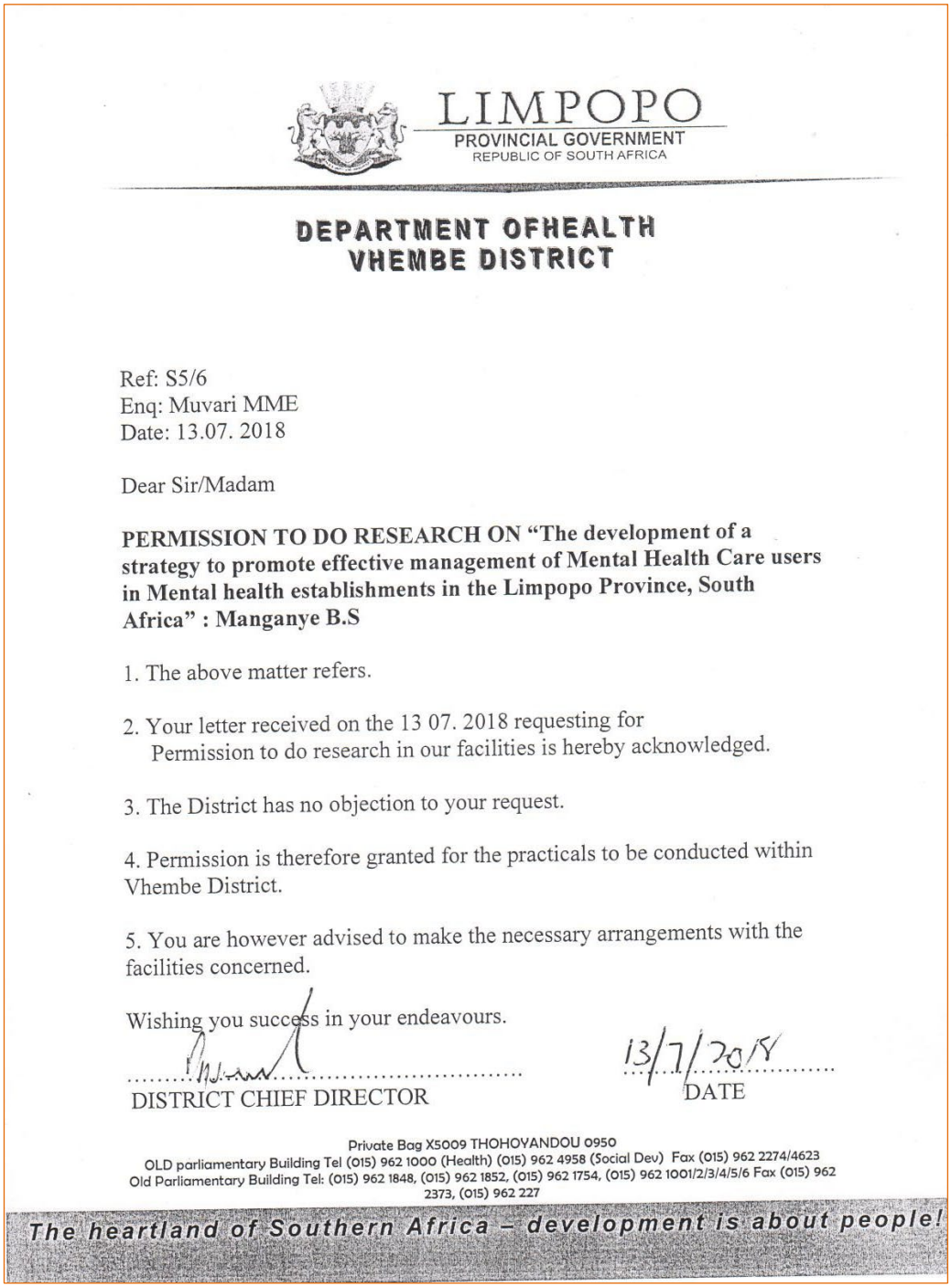
Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT (015 962 8601)
Co- promoter: Prof Makhado L (015 962 8828)

Your positive response to my request will be highly appreciated

Yours Faithfully
Mr Manganye BS

ANNEXURE D2

APPROVAL LETTER FROM VHEMBE DISTRICT



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 13.07. 2018

Dear Sir/Madam

PERMISSION TO DO RESEARCH ON "The development of a strategy to promote effective management of Mental Health Care users in Mental health establishments in the Limpopo Province, South Africa" : Manganye B.S

1. The above matter refers.

2. Your letter received on the 13 07. 2018 requesting for Permission to do research in our facilities is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the practicals to be conducted within Vhembe District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavours.

.....
DISTRICT CHIEF DIRECTOR

13/7/2018
.....
DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

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ANNEXURE E1

APPLICATION LETTER TO MOPANI DISTRICT

P.O.Box 302
Xigalo
0981
01 February 2018

District Executive Manager
Mopani District
Department of Health
Giyani, 0826

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

T
his letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification.

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT(015 962 8601)
Co- promoter: Prof Makhado L(015 962 8828)

Your positive response to my request will be highly appreciated
Yours Faithfully
Mr Manganye BS

ANNEXURE E2

APPROVAL LETTER FROM MOPANI DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MOPANI DISTRICT

Ref: S4/2/2
Enq: Mohatli Isiraele
Tel: 015 811 6543

To **Manganye B.S**
University of Venda
Private Bag x5050
Thohoyandou

Re: PERMISSION TO DO RESEARCH AT HEALTH FACILITIES WITHIN MOPANI DISTRICT: YOURSELF

1. The matter cited above bears reference
2. This serves to respond to the request submitted to do research on the topic '**Development of a strategy to promote effective management of mental health care users in mental establishments in Limpopo Province'.**
3. It is with pleasure to inform you about the decision to permit you to do research at Health Facilities within Mopani District.
4. You will be required to furnish hospital authorities with this letter for purposes of access and assistance.
5. You are further advised to observe ethical standards necessary to keep the integrity of the facilities.
6. The Mopani District wishes you well in your endeavour to generate knowledge.

Director: Corporate Services
Date: 2018/07/25

ANNEXURE F1

APPLICATION LETTER TO SEKHUKHUNE DISTRICT

P.O.Box 302
Xigalo
0981
01 February 2018

District Executive Manager
Sekhukhune District
Department of Health
Chuenespoort, 0745

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification.

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT (015 962 8601)
Co- promoter: Prof Makhado L (015 962 8828)

Your positive response to my request will be highly appreciated

Yours Faithfully
Mr Manganye BS

ANNEXURE F2

APPROVAL LETTER FROM SEKHUKHUNE DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mashiane PN
Tel: 015 633 2352 / 078 126 5414
E-mail: Philistus.Mashiane@dhsd.limpopo.gov.za

Date: 27 August 2018

To: Mr Manganye BS
University of Venda
Research and Innovation

From: Human Resource Utilization and Capacity Development.

Subject: Approval of permission for the collection of data: Yourself

1. The above matter bears reference.
2. Based on the approval granted by the Head of Department of Health, Limpopo Province regarding your request to conduct research in our institution, the District Executive Manager for Sekhukhune is permitting you to visit the institutions as indicated in your application letter to undertake your research.
3. Also take note that as per the approval granted, your research conduct is valid for a period of 3 years. You are also reminded that the collected data from our institutions should be kept confidential and after completion of your study, your findings should be shared with the District to serve as a resource and be loaded on the NHRD site (http://nhrd.hst.org.za).
4. **During assumption of data collection, you will present yourself, your scope of work and schedule to the Chief Executive Officer for the institutions you intend to visit.**
5. Hope the matter is found to be clear and understandable.

District Executive Manager
Mrs Maepa ML

27/08/2018
Date

Private Bag X04, Chuenespoort 0745 Tel: (015) 633 2300, Fax: (015) 6336487,Website:www.limpopo.gov.za

The heartland of southern Africa – development is about people!

ANNEXURE G1

APPLICATION LETTER TO CAPRICORN DISTRICT

P.O.Box 302
Xigalo
0981
01 February 2018

District Executive Manager
Capricorn District
Department of Health
Polokwane, 0699

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification.

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT (015 962 8601)
Co- promoter: Prof Makhado L (015 962 8828)

Your positive response to my request will be highly appreciated.

Yours Faithfully
Mr Manganye BS

ANNEXURE G2

APPROVAL LETTER FROM CAPRICORN DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH: CAPRICORN DISTRICT

REF : S.5/3/1/2

ENQ : Hlatshwayo MM

TEL : 015 290 9154/9096/9252

FROM : DISTRICT EXECUTIVE MANAGER

TO : Mr Manganye B.S
P o Box 302
Xigalo
0981
015 962 8161

SUBJECT : PERMISSION TO CONDUCT RESEARCH: DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLIMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA.

The above matter refers:-

1. Permission to conduct the above study is hereby granted.
2. Kindly be informed that :
   - In the course of your consultation there should be no action that disrupts the services.
   - After completion of the research, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - Kindly note that the Department can withdraw the approval at any time.
3. Your cooperation will be highly appreciated.

DISTRICT EXECUTIVE MANAGER

25-09-2018
DATE

1

ANNEXURE H1

APPLICATION LETTER TO WATERBERG DISTRICT

P.O.Box 302
Xigalo
0981
01 February 2018

District Executive Manager
Waterberg District
Department of Health
Nylstroom, 0510

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification.

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT (015 962 8601)
Co- promoter: Prof Makhado L (015 962 8828)

Your positive response to my request will be highly appreciated.

Yours Faithfully
Mr Manganye BS

ANNEXURE H2

APPROVAL LETTER FROM WATERBERG DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
WATERBERG DISTRICT

REF: 4/3/3
ENQ: NKGODI D.R (PA TO THE DISTRICT EXECUTIVE MANAGER)
DATE: 28/11/2018
TEL NO: 014. 718 0623 / 082 344 0227
E-MAIL: David.Nkgodi@dhsd.limpopo.gov.za

TO: MANGANYE B.S
UNIVERSITY OF VENDA
PRIVATE BAG X 5050
THOHOYANDOU

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

The above bear's reference:-

1. The office of the District Executive Manager, hereby confirms receipt of your request to conduct research on development of a strategy to promote effective management of Mental Health Care Users in Mental Health establishments in Limpopo Province, South Africa.
2. Permission is hereby granted as per approval by the HOD.
3. You are further requested to notify this office on when you are going to start with the research and make sure that there is no action that disturbs service delivery.

Your support and cooperation in terms of the above will be highly appreciated.

DISTRICT EXECUTIVE MANAGER
WATERBERG DISTRICT

28/11/2018
DATE

ANNEXURE I

PERMISSION LETTER TO HOSPITALS

P.O.Box 302
Xigalo
0981
01 February 2018

Chief Executive Officer (CEO)
Name of the Hospital:

RE: APPLICATION FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

This letter serves as a request for permission to conduct a research study in your institution. I am currently enrolled as a student at the University of Venda (UNIVEN) doing Doctor of philosophy (PHD) in Public Health. The research is conducted to fulfill the requirements of the degree mentioned above. The title of my research topic is: "**Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa**."

The purpose of the study is to develop strategies to promote effective management of mental health care users in mental health establishments in Limpopo Province. The participants for the study are the mental health care practitioners working in mental health units and stable mental health care users admitted in the mental health establishments. It is envisaged that the findings of the study may assist the management and policymakers in improving the mental health care services in the province. Data will be collected from the MHCPs and MHCUs who are stable during office hours in April to June 2018 in the mental health establishments in Limpopo.

The study has been approved by the UHDC and ethical clearance has been issued by the Univen research ethics committee (see attached). Below find my contact details including the one of my promoters should there be any issues pertaining the research study or in case you need more clarification.

Researcher: Mr Manganye BS (015 962 8424)
Promoter: Dr Mabunda JT (015 962 8601)
Co- promoter: Prof Makhado L (015 962 8828)

Your positive response to my request will be highly appreciated.

Yours Faithfully
Mr Manganye BS

ANNEXURE J1

APPROVAL LETTER FROM MALAMULELE HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MALAMULELE HOSPITAL

REF : S 4/5
ENQ : Siwela T.S
DATE : 20/07/2018

TO WHOM IT MAY CONCERN

SUBJECT: PERMISSION TO CONDUCT A RESEARCH: MANGANYI B.S

1. This is to certify that the above mentioned has been granted permission to conduct a research at Malamulele hospital.
2. The research topic is on **"Development of a strategy to promote effective management of Mental health care users in mental health establishment in Limpopo Province, South Africa"**
3. Attached hereto is the applicant's letter, research proposal, Training institution's Ethical clearance, participants' consent form, research questionnaire, Provincial and District offices approvals
4. Hopping for an effective cooperation between the participants of this research

Thank you

CHIEF EXECUTIVE OFFICER
MALAMULELE HOSPITAL

20/07/2018
DATE

CONFIDENTIAL

Malamulele Hospital Private Bag x9245 Malamulele 0982
Tel: (015) 851 0026/1020/1017/1019 Fax: (015) 851 0620

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ANNEXURE J2

APPROVAL LETTER FROM ELIM HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
ELIM HOSPITAL

Ref: S6/1
Enq: Raluthaga T
Date: 2018.07.23

Dear Mr. Manganye BS

SUBJECT: PERMISSION TO DO RESEARCH ON; THE DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA.

1. The above matter refers.
2. Your letter received on the 23 July 2018 requesting for permission to conduct research study is hereby acknowledged.
3. The institution has no objection to your request.
4. Permission is therefore granted for the research study to be conducted within Elim Hospital.
5. You are however advised to make the necessary arrangements with the HR office.
6. A completed report of the research has to be submitted to the District.
7. Wishing you success in your endeavours.

A10021
CHIEF EXECUTIVE OFFICER

23. 07. 18
DATE

P/Bag X312, Elim Hospital, 0960
Tel (015)556 3201/2/3/4/5, Fax (015)556 3160,
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RESTRICTED

ANNEXURE J3

APPROVAL LETTER FROM NKHENSANI HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
NKHENSANI HOSPITAL
Private Bag X 9581, GIYANI, 0826
Tel: 015 811 7300 Fax: (015) 812 2461

Ref: S5/1/6/2
Enq: Mathebula K.D
Date: 03 August 2018

TO: Manganye BS
University of Venda
Private Bag X5050
Thohoyandou

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY

1. It is with pleasure to inform you that your application to do research on the topic **'Development of a strategy to promote effective management of mental health care users in mental health establishment** has been granted at Nkhensani District Hospital.

2. The approval of your research study is subject to the following conditions:

2.1 In the course of your research study, Hospital services should not be disrupted.
2.2 Upon completion of your research you should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
2.3 After completion of the study, it is mandatory that findings should be submitted to the Department to serve as a resource.

3. You should liaise with the Office of the Chief Executive Officer (CEO) as and when you intend to start research study.

4. Your cooperation is always appreciated.

Jnolan 06/08/2018

CHIEF EXECUTIVE OFFICER **DATE**

Private Bag X 9581, GIYANI, 0826
Tel: 015 811 7300 Fax: (015) 812 2461 Website: http://www.limpopo.gov.za

1

ANNEXURE J4

APPROVAL LETTER FROM SILOAM HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SILOAM HOSPITAL
Confidential

Ref : S4/2/1/1/3
Enq : Mushaphi N.T
Date : 26 July 2018

SIL[illegible]PITAL
HU[illegible]RCE
2018 -07- 26
P/E
MAK[illegible]
LIMPOPO

To: Manganye B.S

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

1. The above matter refers.
2. The Hospital highly acknowledges the receipt of your letter dated 19 July 2018 regarding the above matter.
3. Kindly note that the institution is granting you permission to come and conduct your research.
4. You are kindly requested to adhere to the conditions as set out in your approval from the Provincial Office.
5. Hoping you will find the above in order

N Muthaw
Acting Chief Executive Officer

26/07/2018
Date

Private Bag X2432. Makhado, 0920
Tel (015) 973 0004/5/6, 015 973 1447/8, 015 973 1977, 015 973 1892/4/9 Fax (015) 973 0607.

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ANNEXURE J5

APPROVAL LETTER FROM LETABA HOSPITAL

CONFIDENTIAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
LETABA REGIONAL HOSPITAL

REF: S5/3/1/2
ENQ: Acting Deputy Director Quality
DATE: 06 September 2018

To: Manganye B.S
Student No: 11520559
University of Venda

SUBJECT: DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA

1. The above subject matter refers.
2. You are granted permission to conduct research at Letaba Regional Hospital as per approval granted by the Head of Department, Limpopo Provincial Health.
3. Hoping that you will find this to be in order.

CHIEF EXECUTIVE OFFICER

DATE

CONFIDENTIAL

ANNEXURE J6

APPROVAL LETTER FROM TSHILIDZINI HOSPITAL

TSHILIDZINI HOSPITAL ETHICS COMMITTEE

Memorandum of understanding

Tshilidzini Hospital Ethics Committee with MANGANYE BUMANI SOLOMON ..... at their meeting resolved to sign a Memorandum of Understanding after the two parties have agreed on the following information:

1. Reasons for making a research at Tshilidzini hospital.
   To improve the service delivery to MHCUs
   To Develop Strategies to promote effective Mx of MH Service
2. What will be the benefit of the entire hospital community out of your findings?
   The Mx may use the developed Strategies to improve the care for the Mx of MHCUs
3. Who to meet in conducting your research
   Mental health Care Practicners (MHCPs)
   Mental health Care users (MHCUs)
4. What do you do with your findings?
   Communicate with the department (National, Provincially and the Hosp.)
5. We will require the hard copy of your research
   Yes — hard copy will be provided
6. We do not anticipate any information to be divulged to all types of media without the knowledge of the Ethics Committee and Hospital Board.
7. Memorandum of understanding should be signed by both parties.

Signed by: .....

31/07/2018

Date: 31/07/2018

Researcher

DEPT OF HEALTH & SOCIAL DEVELOPMENT
TSHILIDZINI HOSPITAL
21-07-2018
PRIVATE BAG X 924 SHAYANDIMA 0945
VHEMBE DISTRICT

ANNEXURE J7

APPROVAL LETTER FROM HAYANI HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
HAYANI HOSPITAL

REF: 8/1/1
ENQUIRIES: Mulaudzi M.P/ Makakavhule T.
DATE: 01/08/2018

To: Mr Manganye B.S
PO Box 302
Xigalo
0981

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

1. The above matter refers:
2. We acknowledged receipt of your letter dated18 July 2018.
3. Permission is hereby granted to conduct the study on "development of strategy to promote effective management of Mental Health Care Users in Mental Health Establishment.in Limpopo Province, South Africa."
4. Kindly make sure that you contact Nursing Administration Office and arrange all the logistics before you start.
5. Hoping that you find this in order.

.....
ACTING CHIEF EXECUTIVE OFFICER

01/08/2018
.....
DATE

ANNEXURE J8

APPROVAL LETTER FROM WARMBATHS HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
WATERBERG DISTRICT
WARMBATHS DISTRICT HOSPITAL

Ref: S4/R
:Moloto M.D
E-mail: Mpho.Moloto@dhsd.limpopo.gov.za
☎: 014 736 7304
:16/01/2019

Mr. Manganye B.S
University of Venda
Private Bax 5050
Thohoyandou

1. The above matter refers
2. The Chief Executive Officer , hereby confirms receipt of your request to conduct research on "**Development Of a strategy to promote effective management of Mental Health Care users in Mental Health Establishments in Limpopo Province, South Africa**" .
3. Kindly be informed that permission is granted as per approval letters from the District Executive Manager (DEM) and the Head of Department (HOD).
4. Please be cognisent that it is mandatory that you submit your findings to the office of the HOD to serve as a source.

Your coorperation in this regard will be hihly appreciated.

ebelo
Lebelo K.E
Acting Chief Executive Officer

16/01/2019
Date

Warmbaths District Hospital Private Bag X1618 Bela-Bela, 0480
Tel (014) 736 7300 Fax (014) 736 5512

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BATHO PELE

ANNEXURE J9

APPROVAL LETTER FROM ST RITAS HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mashiane PN
Tel: 0156332352 / 078 126 5414
E-mail: Philistus.Mashiane@dhsd.limpopo.gov.za

Date: 27 August 2018

To: Director: Hospital Services
Chief Executive Officer: St Ritas Hospital

From: Human Resource Utilization and Capacity Development.

Approval for permission to collect data: Manganye BS (University of Venda)

1. The above matter bears reference.
2. The Head of Department of Health, Limpopo Province has approved a request to conduct research in our institution in respect of **Mr. Manganye**; therefore the District Manager for Sekhukhune District give permission to the applicant to visit your institution as he has specified in his individual application letter data collection.
3. Please take note that the approval for the research is valid for a period of 3 years. Also be informed that the collected data from our institutions will not be used for any other reasons unless for study purposes.
4. **During assumption of data collection, Mr Manganye Bumani Solomon will present himself to your offices, his scope of work and schedule on how he will be visiting your institution. The researcher's visits should not in any way disrupt the rendering of services during collection of data.**
5. Hope the matter is found to be clear and understandable.

27/08/2018

District Executive Manager
Mrs Maepa ML

Date

Private Bag X04, Chuenespoort 0745 Tel: (015) 633 2300, Fax: (015) 6336487,Website:www.limpopo.gov.za

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ANNEXURE J10

APPROVAL LETTER FROM PHILADEPHIA HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mashiane PN
Tel: 0156332352 / 078 126 5414
E-mail: Philistus.Mashiane@dhsd.limpopo.gov.za

Date: 27 August 2018

To: Director: Hospital Services
Chief Executive Officer: Philadelphia Hospital

From: Human Resource Utilization and Capacity Development.

Approval for permission to collect data: Manganye BS (University of Venda)

1. The above matter bears reference.
2. The Head of Department of Health, Limpopo Province has approved a request to conduct research in our institution in respect of **Mr. Manganye**; therefore the District Manager for Sekhukhune District give permission to the applicant to visit your institution as he has specified in his individual application letter data collection.
3. Please take note that the approval for the research is valid for a period of 3 years. Also be informed that the collected data from our institutions will not be used for any other reasons unless for study purposes.
4. **During assumption of data collection, Mr Manganye Bumani Solomon will present himself to your offices, his scope of work and schedule on how he will be visiting your institution. The researcher's visits should not in any way disrupt the rendering of services during collection of data.**
5. Hope the matter is found to be clear and understandable.

27/08/2018

District Executive Manager
Mrs Maepa ML

Date

Private Bag X04, Chuenespoort 0745 Tel: (015) 633 2300, Fax: (015) 6336487,Website:www.limpopo.gov.za

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ANNEXURE J11

APPROVAL LETTER FROM MANKWENG HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department Of Health
Mankweng Hospital
Recieved
2018 -11- 28
LIMPOPO PROVINCE

DEPARTMENT OF HEALTH

MANKWENG HOSPITAL

Ref: S5/3/1/2

Enq: Ramoba ML

From: HR Utilization and Capacity Development

Date: 21 November 2018
TO: MANGANYE BS

REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON:DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENT ,IN LIMPOPO PROVINCE AT MANKWENG HOSPITAL.

1. The above matter has reference.

This is to confirm that Manganye BS has been granted permission to conduct research on "Development of a strategy to promote effective management of mental health care users in mental health establishment ,in Limpopo Province at Mankweng Hospital."

2. Research will be conducted from 26 NOVEMBER 2018 to 31 OCTOBER 2021
3. Attached please find her application letter from the University of Venda, approval from Provincial Office, Research Ethics Committee and The National Health Research Database approval number,LP_201805_013.

Thanking you in advance.

Acting Chief Executive Officer

28/11/18
Date

ANNEXURE J12

APPROVAL LETTER FROM MATLALA HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
SEKHUKHUNE DISTRICT

Ref: 5/3/1
Enq: Mashiane PN
Tel: 0156332352 / 078 126 5414
E-mail: Philistus.Mashiane@dhsd.limpopo.gov.za

Date: 27 August 2018

To: Director: Hospital Services
Chief Executive Officer: Matlala Hospital

From: Human Resource Utilization and Capacity Development.

Approval for permission to collect data: Manganye BS (University of Venda)

1. The above matter bears reference.
2. The Head of Department of Health, Limpopo Province has approved a request to conduct research in our institution in respect of **Mr. Manganye**; therefore the District Manager for Sekhukhune District give permission to the applicant to visit your institution as he has specified in his individual application letter data collection.
3. Please take note that the approval for the research is valid for a period of 3 years. Also be informed that the collected data from our institutions will not be used for any other reasons unless for study purposes.
4. **During assumption of data collection, Mr Manganye Bumani Solomon will present himself to your offices, his scope of work and schedule on how he will be visiting your institution. The researcher's visits should not in any way disrupt the rendering of services during collection of data.**
5. Hope the matter is found to be clear and understandable.

27/08/2018

District Executive Manager
Mrs Maepa ML

Date

Private Bag X04, Chuenespoort 0745 Tel: (015) 633 2300, Fax: (015) 6336487,Website:www.limpopo.gov.za

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ANNEXURE J13

APPROVAL LETTER FROM EVUXAKENI HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
EVUXAKENI HOSPITAL

Ref No : S4/2/2
Enquiries : Chuma S
Tel No : 015 812 1138

20 August 2018

Mr Manganyi B.S
P.O. Box 302
Xigalo
0981

RE: PERMISSION TO DO RESEARCH AT HEALTH FACILITIES WITHIN MOPANI DISTRICT: YOURSELF

1. Your above-mentioned request has reference.
2. It is with pleasure to inform you that permission has been granted for you to conduct the research study at Evuxakeni Hospital on **"Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa"**.
3. Note paragraph 2 of the approval letter from the Provincial Office dated the 20 June 2018 for compliance/adherence.
4. Also note that further arrangements should be made with the relevant section/s of the hospital for assistance in consultation with the responsible manager/s.
5. Thanking you.

.....
HEAD OF INSTITUTION

20/08/2018
.....
DATE

ANNEXURE K

INTERVIEW GUIDE FOR MENTAL HEALTH PRACTITIONERS

TOPIC: DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA

1. **Central question**

   Can you share with me your views and experiences of mental health services provision in mental health establishments?

2. **Probing questions**

   - What are the contributory factors in the provision of such mental health services?
   - What is the strategy that can be used to promote effective management of mental health care users?

ANNEXURE L

INTERVIEW GUIDE FOR MENTAL HEALTH CARE USERS

TOPIC: DEVELOPMENT OF A STRATEGY TO PROMOTE EFFECTIVE MANAGEMENT OF MENTAL HEALTH CARE USERS IN MENTAL HEALTH ESTABLISHMENTS IN LIMPOPO PROVINCE, SOUTH AFRICA

Central question

- Can you share with me your views and experiences on the mental health services delivery in mental health establishments?

Probing questions

- Are you provided with good quality care here in the mental health unit?
- How are the attitudes of mental health practitioners towards mental health care users in the mental health establishment?
- What do you think need to be done to improve or promote effective management of mental health care users in mental health establishments?

Translated to Xitsonga

- Xivutiso xo sungula nkanelo
- Ndzi kombela mi veka mavonelo na ntokoto wa nwina hi vukorhokeri bya swa rihanyu ra swa miehleketo laha exibedle.

Swivutiso swo konanisa

- Xana mi nyikiwa vukorhokerhi bya xiyimo xale henhla laha e xibedlele?
- Matikhomelo ya vatirhi va swa rihanyu ra swa miehleketo eka vatirhisi va swa vukorhokeri bya vuvabyi bya miehleketo ya njhani xana?
- Xana I yini lexinga endliwaku ku antswisa vukorhokerhi bya swa rihanyu ra swa vuvabyi bya miehleketo?.

Translated to Setswana

1. **Potšisšo hlokwa**
   - ka abelana le nna tlhokomelo le maitemogelo a gago a thušo ye o e hweditšego mo go hlokomelwago ba malwetši a monagano?

2. **Potšišo fatišišo**
   - hwetša tshwaro e botse bohwetša kalafi bja monagano ?
   - Maitshwaro a ba maphelo a bjang kgahlanong le balwetši ba monagano mo di sentareng tša malwetši a monagano?
   - nagana ke eng e o e ka dirwang go ba go lokišwa go kgotsofatša tshwaro ya balwetši ba monagano mo disentareng tša malwetši a monagano?

Translated to Tshivenda

1. Mbudziso ya u thoma nyambedzano

Ndi humbela uri ni ambe ku vhonele na tshenzhemo yanu nga ha tshumelo ya tshumelo ya vhalwadze vha muhumbulo Vhuonbeloni

2. Mbudziso dza u isa phanda

- Hone afha vhuongeloni ni a newa tshumelo ya maimo a khwine sa vhalwadze vha muhumbulo?
- Ndi vhudifari de ha vhashumeli vha zwa vhulwadze vha muhumbulo kha vhashumisi vha tshumelo ya vhalwadze vha muhumbulo?
- Hone ni humbula Uri hu nga itwa mini u khwinifhadza vhulanguli ha u thogomela vhalwadze vha muhumbulo hafha vhuongeloni?

ANNEXURE M

QUESTIONNAIRE FOR PSYCHIATRIC NURSES, PSYCHIATRISTS, MEDICAL DOCTORS, CLINICAL PSYCHOLOGISTS, OCCUPATIONAL THERAPISTS AND SOCIAL WORKERS

This questionnaire is aimed at determining the views and experiences of service providers (MHCPs) caring for MHCUs in Limpopo Province

Please tick (**Mark with an X)** on the appropriate box or give explanation on the space provided.

Section 1: Biographic information

1. Respondent's code : _____
2. District

Capricorn	1
Mopani	2
Sekhukhune	3
Vhembe	4
Waterberg	5

3. Gender : _____ 1 Male 2 Female
4. Age : _____
5. Profession(occupation) : _____
6. Professional experience (years): _____
7.

Section 2: Views of mental health service providers (MHCPs) regarding the care being provided to MHCUs in their hospitals/facilities

Views on assessment of MHCUs

Statement	**Agree 4**	**Strongly agree 3**	**Do not know 0**	**Disagree 2**	**Strongly Disagree1**
8. MHCPs know how to conduct assessment of MHCUs before admission.					
9. MHCPs have knowledge and skills required for assessment of MHCUs					
10. I have doubt on the efficiency of assessment conducted by MHCPs					
11. Assessment of MHCUs is done in a convenient venue					

12. All MHCPs have been trained on the assessment of MHCUs					

Views on admission and treatment of MHCUs

Statement	Agree	Strongly agree	Do not know	Disagree	Strongly Disagree
13. MHCPs know the procedure to be followed during MHCUs admission.					
14. MHCPs know all the forms to be completed during admissions					
15. Treatment of MHCUs is paid for by the family members (REVERSE)	**1**	**2**	**0**	**3**	**4**
16. All MHCPs have been trained on the completion of all admission forms of MHCUs					

Views on rights of MHCUs

Statement	Agree	Strongly agree	Do not know	Disagree	Strongly Disagree
17. The rights of mental health care users are being observed in the institution					
18. MHCUs are taught about their rights in the units by MHCPs					
19. There is a chart displayed on the wall or notice board about the rights of MHCUs?					
20. MHCUs know their rights while admitted in the unit.					
21. Family members are also taught about the rights of their relatives in the unit					

Views on the provision of mental health services and relationship with MHCUs

Statement	Agree	Strongly agree	Do not know	Disagree	Strongly Disagree
22. MHCPs provide quality care to MHCUs					
23. Services provided to MHCUs are according to the MHCA 17 of 2002					
24. MHCPs always collaborate in providing mental health service to MHCUs					

25. MHCPs sometimes display negative attitude while providing care to MHCUs.					
26. Relationship between MHCUs and MHCPs is good in the unit					

Views on therapeutic milieu and availability of resources

Statement	Agree	Strongly agree	Do not know	Disagree	Strongly Disagree
27. The hospital environment provides therapeutic milieu to MHCUs					
28. There is mixing of MHCUs of different categories (SP, Observation, and chronic users) in the same unit					
29. There are enough beds for MHCUs to sleep when admitted					
30. Paint used in the mental health unit is bright and renovated frequently					
31. There is a separate unit designated solely for observation of MHCUs before transferred to the mental health unit.					

Section 3: Knowledge and awareness of MHCPs regarding the rights and privileges of MHCUs during admission and stay in a mental health establishment

32. In your opinion, the rights of mental health care users are being observed in the institution?

Yes	No

33. If NO to the above question, why is it so?

……

……

……

……

34. Do you think MHCUs are taught about their rights in the units by MHCPs?

Yes	No

35. If YES, Explain the rights that MHCUs while in the mental health establishment

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36. Which MHCA forms should MHCPs complete during admission of MHCUs?

1.....

2.....

3.....

4.....

37. Which are the drugs used to control psychosis of MHCUs in the unit

1.....

2.....

3.....

4.....

38. Do you have a forensic/72-hour observation unit in your institution?

Yes	No

39. If YES, How is the observation conducted

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40. And where is it conducted

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41. Explain the discharge procedure of MHCUs at your institution, and the referral procedures

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42. Explain the community based mental health services available in your District

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Section 4: Challenges faced by the MHCPs during their daily work activities in mental health establishments in Limpopo Province

43. Explain the resource challenges you experience at work (Human resource, Structural, Financial and Treatment)

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.....

44. Do you think there are clinical risks involved for staff working at the mental health/ observation unit?

Yes	No

45. If YES, what are the clinical risks involved?

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……
……

46. What do you suggest needs to be done to minimize the clinical risks?

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47. Is the clinical staff safe and protected in the units?

Yes	No

48. If NO, why?

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49. What do you suggest needs to be done?

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……
……

50. What are the work related stress that MHCPs experience?

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……
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51. Do you experience stigma and discrimination in working with MHCUs?

Yes	No

52. If YES, what are the types of stigma and discrimination experienced?

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……
……

……

……

53. Is the withdrawal of social grants from MHCUs affecting their well-being?

Yes	No

54. If YES, what should be done to re instate their social grant?

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ANNEXURE N

INFORMATION SHEET

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

INFORMATION LETTER

Title of the Research Study : Development of a strategy to promote effective management of mental health care users in mental health establishments in Limpopo Province, South Africa

Principal Investigator/s/ researcher: Mr Manganye BS (BCURNS, AHMP, DHSM, MPH)

Co-Investigator/s/supervisor/s: Dr Mabunda JT (BA.Cur(Hons), MPH, PHD)

Prof Makhado L(BCURNS, Mcur, PhD)

Brief Introduction and Purpose of the Study: The main aim of this study is to develop strategies to influence positive patient management changes in mental health establishments of Limpopo Province, South Africa. I am hereby inviting you to participate in the study.

Outline of the Procedures: The interview will last for about 45 minutes to one hour. If you agree to take part, I will ask you questions or give you a questioner to complete which will be in relation to impact of mixing the different categories of mental health care users and forensic observation in the same unit. As a researcher, my role is to listen to and understand your point of view, and not to pass any judgment during the interview. If however during the interview you fill uncomfortable with answering some of the questions, you are free to express your discomfort; you will not be penalized for such.

Risks or Discomforts to the Participant: There are no direct risk involved in the study. You are free to either withdraw from the study at any point, or refrain from answering questions which you feel are violating your rights; and no penalty will be imposed. However, I would really appreciate it if you share your thoughts and feelings in relation to the questions asked.

Recording the interview

I would like to ask permission to audio record the interview because it is not possible to write down all your answers quickly enough to capture all the important information. I might misrepresent your responses to some of the questions that you will be asked if recording is not done. It is important for you to know that the digital voice data and notes will remain confidential and your identity will not be disclosed. I am only interested in your honest responses to the questions.

Recordings and digital data of the interview will be listened to only by the researcher and the co-coder and will bear no names of the interviewees. The information will be analyzed and organised into a report

according to themes. The recordings and digital data files will be kept in a locked safe. In accordance with the national requirements the voice recordings and digital data will be destroyed two years after the publication of the research findings.

Benefits: Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates.

Reason/s why the Participant May Be Withdrawn from the Study: You are free to either withdraw from the study at any point, or refrain from answering questions which you feel are violating your rights; and no penalty will be imposed.

Remuneration: NONE

Costs of the Study: NONE

Confidentiality: The information that you give will be kept confidential. No names will be used when transcribing the interviews. I undertake that all information provided by you will be used only for the purpose of the study. Everything that you will say will be treated as private and confidential and no-one will know you answered the question apart from the researcher. The answers given by participants will be combined and analyzed according to common themes and categories and the combined information will be in the form of a report.

Research-related Injury: No injuries anticipated during the research study

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher (Mr. Manganye BS, 015 962 8424), Promoter: Dr Mabunda JT (015 962 8601) Co- promoter: Prof Makhado L (015 962 8828) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

ANNEXURE O

CONSENT FORM

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Mr Manganye Bumani Solomon, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: **SHS/18/PH/09/2205**,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant: ……..… Date: …….…… Time ……..……

Signature: ……

I, …… …… …… ……..

The researcher, Mr Manganye BS, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

…….. Date: …….. Signature: ……..……

Full Name of Witness (If applicable)

…….. Date: …….. Signature: ……..……

Full Name of Legal Guardian (If applicable)

…….. Date: …….. Signature: ……..……

ANNEXURE P

ATTENDANCE REGISTER FOR RESULTS PRESENTATIONS

University of Venda
Creating Future Leaders
School of Health Sciences
Department of Public Health

PHD RESULTS PRESENTATIONS: ATTENDANCE REGISTER

DATE : 28/10/2020

VENUE: VHEMBE DISTRICT BOARDROOM

NO	NAME AND SURNAME	COMPANY	CONTACT NO	EMAIL ADDRESS	SIGNATURE
1	Mr Mangenye BS	Univen	0724451960	lumani.mangenye@univen.ac.za	
2	Ms AE Manenzhe	Tshilidzini	0798912307	alumanenzhe@webmail.co.za	
3.	Musehane Thilifhel.	Donald Frazer	0159639263	tshashu@live.com	
4.	Netshilaonde NS	District office	0728523690	netshilaonde@gmail.com	
5.	Dr. Ramovha MR	DOH.H	0839481876	muvhango@gmail.co	
6.	Mufamadi M-C	District office	0820482572	Mpho.Mufamadi@dhsd.gov.za	
7.	NENGUDZA FR	DIO	0834984944	Rofhiwa.nengudza@gmail.com	
8	Mandle X	District off	0729868439	mandleavha@gmail.com	
9.	Mabunda JT	Univen	0838443698	jabu.mabunda@univen.ac.za	

10	MUVARI M E	VHEMBE DISTRI	083 457 2265	muvarim@gmail.com									
11	MATHEBULA A	Vhembe Distric	082 552 4837	mathebulaa@gmail.com									
12	Mulaudzi AT	Vhembe district	071 237 4330	Mulaudzi+@yahoo.com									
13	Chauke CM	Malamulele	079 102 4356	Chauke.cm@gmail.com									
14	Mungiedzi L	Vhembe Distric	084 082 4320	Mungiedzi@gmail.com									

ANNEXURE Q

PERMISSION TO PRESENT RESULTS IN VHEMBE DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARMENT
OF
HEALTH
VHEMBE DISTRICT

Enquiries: IPHC

Date : 26/10/2020

RE: RESEARCH STUDY FEED BACK SESSION PRESENTATION: BUMANI SOLOMON MANGANYE

1. The above matter refers

2. Following the letter received from your office indicating interest to present your study results (Study in mental health units)

3. The office of Chief Director hereby grant you permission to come and present your study findings on the **28 of October 2020** as follows:
   - Venue: Vhembe District Boardroom(Health)
   - Time: 10h00
   - Number of people to attend: 15 (fifteen including two from your side)

4. Hope you find this in order

CHIEF DIRECTOR-HEALTH

2020-10-26
DATE

ANNEXURE R

PARTICIPANT'S TRANSCRIPT (MHCP)

Researcher: *Afternoon mam.*

Participant: *Afternoon.*

Researcher: *How are you?*

Participant: *I'm fine and, how are you?*

Researcher: *I'm fine. Can you please come closer so that you can be heard heard here on my audio tape and speak loudly a little bit?*

Participant: *Okay.*

Researcher: *As I have said previously, my name is Manganye Bumani from the University of Venda, today I am here to interview you as agreed. Do you allow me to audio tape you?*

Participant: *Yes.*

Researcher: *Okay thank you.Okay I just want to, I just want you to feel free to talk to me.*

Participant: *Alright.*

Researcher: *I just want you share with me about your experience as a coordinator.*

Participant: *Alright.*

Researcher: *Advanced Psych Nurse.*

Participant: *Yaa*

Researcher: *Ahaa. Okay, I just want you to maybe share with me your views and experiences on the delivery of mental health services in your institution.*

Participant: *Okay. The first challenge that we have is the structure as itself .(Okay) because is not that well developed we admit mental health users in medical units, we do not have eeh, eeh mental health care unit like a psychiatric unit for mental health users so we admit them, mix them if they are more because we only have one room in male okay and one in female (mmm) so in that room in female we only have two beds only .(Okay) and in male we only have three beds .*

Researcher: *okay. If I heard you well, you said you do not have a psychiatric unit, and you have two beds in female, what happen when you admit more than two MHCUs?*

Participant: *if they are four then we mix them with medical patients, we just mix them .(Okay). and the second challenge that we have is that mental health users are not being reviewed six months by a*

psychiatrist. (mmm). It's been going on since, I think the whole of last year I was studying last year. (Okay). But they were not according to the sister who was in charge here. (mmm).

Researcher: *Can you clarify regarding the review of MHCUs six monthly, how are they being reviewed if no psychiatrist?*

Participant: *They were not reviewed 2017 from yaa towards 2017 I think or 2018. (mmm). and then they were not reviewed by psychiatrist, they were not done because apparently the psychiatrist were not being paid so until now .(mmm) .we have since last year the whole of last year they were not being reviewed (mmm).so mental health. so the treatment the medical practitioner they are not well trained some just do not like it at all so it's, it's a bit of a challenge (mmm) to, you know when they come they just need to prescribe and that's it (mmm) and others are not interest in working with mental health care users.*

Researcher: *Ok, so what is happening to their treatment if they are not reviewed?*

Participant: *We just continue with the treatment. (mmm). that was being prescribed I do not know for how long we are just continuing and yah that's the thing and then normally we just contact the psychiatrist telephonically we if have a patient in the unit. (mmm). And then another challenge that we have the security officer that we have if you check they were sitting outside they do not sit inside the unit.*

Researcher: *If I heard you well, you said security officers they sit outside, can you say more on that one of security?*

Participant: *If we need them that's where we call them to come inside the unit. (mmm) .they sit outside so anything happens with the patient inside if he is hanging himself no one is there to observe what is happening (mmm) and then basically we do not have enough psychiatric nurses in the unit is only two (mmm) psychiatric nurses in the male unit we only have one and in the female unit we do not have psychiatric nurses .(okay). yes.*

Researcher: *Okay, you also said that the structure is not that well developed what do you mean?*

Participant: *Okay like in that building if you go and check (mmm) the ceiling is not high, they use to abscond, they use the ceiling to just get inside the ceiling there (mmm) and they walk from that side (mmm) and that's when they get off (mmm) on the other side of room and that's when they get off (okay) and they go out of the hospital eeh and then sometimes the burglars there sometimes they are wide and they squeeze themselves there*

Researcher: *You said they squeeze themselves through burglar, can you say more about that?*

Participant: *Some they can go out through the burglars (mmm) and then they do not have, it does not have the windows from the male room (mmm) it does not have the curtains anyone can see from outside and it does not have,*

Researcher: *Why are the windows not having curtain?*

Participant: *Like we cannot hang curtains they tried to paint it but like when someone try to be like if someone is like the mental health user is trying to be aggressive and all that making sounds when people are walking they just come and watch (mmm) like from that side of the window (okay) so it's a bit of a challenge that one. And then the basins, it has basins they tried to make it a little bit suitable but it's not (mmm) (mmm) (mmm) to remove some because we use the rooms that were used by male medical we*

try to (mmm) just to say this room is for mental health users and we removed the mirrors, the basins (mmm) but is still not okay .

Researcher: *Let me take you back, so if I heard you well, you say here in the female there are three beds*

Participant: *Yes*

Researcher: *Let's take there by accident and they are more than three MHCUs how do you deal with such situation?*

Participant: *We just mix those that are more stable, we mix them with the male medical patients, okay we do not have a choice we just put them together*

Researcher: *What about those who are more psychotic?*

Participant: *Those that are most psychotic we just keep them in those closed burglars because they use the frames of the bed they turn it upside down and they get outside through ceiling*

Researcher: *Okay also you mentioned that they do abscond how often do you have such cases for them to abscond?.*

Participant: *I think this month we had on hhhhmmm December we had one (mmm) but it comes and go more especially the males side, the females is better but the males (mmm) in three month can be one or two (Okay).Yaa .*

Researcher: *Also, you also mentioned about the windows of the males is not painted and people they can come and watch? what do you mean?*

Participant: *Yes they can watch, you see is painted, I think from the bottom (mmm) but you can see (mmm) but by that time we were still busy trying to restrain the patient (mmm) we would say please move the security would be assisting us by the time we say please can you please move (mmm) they will have seen everything (mmm).*

Researcher: *They just come and watch you?*

Participant: *Yes, they exactly comes and watch us work, and there is no privacy (mmm) so it's a little bit of a challenge as well (mmm).*

Researcher*: Okay, okay you mentioned something very interesting mmm that doctors sometimes there are other doctors mmm who do not even like working in mental health mmm*

Participant: *They do not like they do not have that thing for psychiatric, they feel like because someone, some other doctors (mmm) also mentioned to me that they feel like there should be doctors specifically for psychiatric (mmm)*

Researcher*: What makes them not to be interested in psychiatric?*

Participant: *Because is too much for them to assess the medical patients (mmm) and as well as the mental health users, for mental health care user it takes time sometimes is a lot of work because they have to complete a form is a two hours assessment form (mmm) and is just too much for them with 23 patients it will be two doctors and they still have to they feel like is too much for them and there should have a separate ward.*

Researcher: *Okay they feel that there should be a separate Doctor who will service psychiatric ward?*

Participant: *Yes*

Researcher: *Who would be working as a psychiatric doctor?*

Participant: *Sometimes doctors feels, they feel like they are not that competent enough (ohh okay), for psychiatry, someone also mention to me that they are not that well trained in psychiatry unlike Thabamopo where they see psychiatric patients every now and then but here it's a bit of a challenge.*

Researcher: *Why are they not competent, are they not trained?*

Participant: *They say mmm well she said (laughed)she said that at eeh ehh what is it, in varsity (mmm) they only do it, I do not know if it is not enough (Okay) Doing that training because they do not do it that much compared to the medical side of it (Okay) and after completion as long as you haven't done it in a psychiatric hospital (mmm) like for a long time is a bit of a challenge (okay) so if they find it difficult they have to sit down call the Thabamopo, it takes forever to reach the psychiatrist (mmm) so they just feel like is not within their scope of practice.*

Researcher: *Okay you mentioned about the 72 assessment (mmm) where are you doing your 72 assessment?*

Participant: *Here in the unit*

Researcher: *Where? in this in room?*

Participant: *Yes. Actually, I can say is a mentally health unit*

Researcher: *That's where you are doing it? okay and then let's take it's a first-time episode how and where is this person assessed?*

Participant: *The same room*

Researcher: *The same room?*

Participant: *Yes*

Researcher: *Are you not, let's say you put him there are you not like putting a label on him or her because this is a mental health unit, and you admit in here, meaning he is, now he is mentally ill? when you are thinking that he is mentally ill, and find that he is not mentally ill it's something else you can exclude*.

Participant: *Mmm no! normally when we admit the patient we depend on the psychiatric nurses' assessment and the medical doctor who was there when we admitted the mental health user (mmm) once they say if they feel because normally they feel like is more of a medical that's why they say query meningitis or psychosis that's when they(mmm)*

Researcher: *So if they did write query meningitis?*

Participant: *We admit them like that with the forms but once the results are available immediately when the results are available and its found that this is due to meningitis mmm but with meningitis is very rare because they just relapse from there (mmm) and then they can but with other conditions (mmm)*

Researcher: *How would you know it is meningitis or mental illness?*

Participant: *We do not know, we just admit like substance induced or query until its ruled out but once the results comes out and the doctor assess and say this is not a mental health user (mmm) we discharge that patient 72 hours and then we move to medical .*

Researcher: *Okay so even the first time, the first episode stays in that unit that is a mental health unit?*

Participant: *As long as the sister and the doctor feels like mental illness, yes*

Researcher: *What is the act saying regarding 72 hours assessments?*

Participant: *As long as I know, I mean like if from the assessment there(mmm) I mean like isn't that sometimes you might think is a first episode depending only to find that is not a first episode (mmm) it depends on the family history (mmm) so that's why we normally admit as long as the psychiatrist and the Doctor says that this is more of a mental health user than a normal medical side of it (mmm)*

Researcher: *If I heard you well, you admit all episodes here, how do you exclude if it is not the first episode?*

Participant: *They take all the blood and then but normally the, the those users that can be treated here they check them there first and then they can be admitted after that but now if we say that first episode it will mean that it's kind of like collateral (mmm) sometimes is not really reliable*

Researcher: *Why do mean when you say collateral not reliable?*

Participant: *it's because they say its for the first time, like the patient that had recently been admitted, (mmm) according to the parents it was the first episode but when the patient woke up he said it was the second episode (mmm) the first one happened wherever (mmm) where he would see things and whatever that was the second episode.*

Researcher: *Okay so meaning that the family member were not having the… (Interrupted),*

Participant: *Yes exactly they were not there I mean the patient that I'm talking about it's a, how many I mean 28 years old (mmm) and he was studying somewhere (eheeee) they were at home (Okay) so they are not even sure during high school so they told them (mmm) that this is the first episode (mmm) but them they did not tell them that noo! he said is the first, second episode not the first time.*

Researcher: *Was he not on treatment for mental illness?*

Participant: *Hhh he said, he said he was admitted at some hospitals and given treatment discharged but then he didn't go for follow-up (ahh) that's when he it started again.*

Researcher: *Ahh no I understand mmm. What else can you share with me regarding the care of mental health in this unit that you are working in?*

Participant: *The other challenges that we have is that nurses sometimes they also feel like is too much for them like to nurse for psychiatric and also to nurse for medical (mmm) and mental health users*

Researcher: *How? Can you elaborate more?*

Participant: *They feel like why cannot there be a unit just like doctors sometimes they neglect MHCUs, not necessary coming to see them, so we have to talk to them, just like please come and check the patient (mmm) you cannot just leave a mental health user like that (mmm) so even the cleaners (mmm) you know*

like aggressive patients sometimes mental health care users can throw out things and sometimes urinate on the floor

Researcher: *What happens if the floor is wet and cleaners not cleaning?*

Participant: *You have to talk to the cleaners like can you please assist (mmm) and the security officer, so that we can clean the floor (mmm) because it will be stuffy so without you as a coordinator (mmm) trying to talk to them and all that (mmm) then the mental health user will be left unattended, so meaning that yes it's a bit of a challenge they have that mind of that they are not trained,*

Researcher: *They are not trained how? Can you clarify?*

Participant: *Because I remember the other one said I'm not that trained (mmm) to can care for the mental health user (mmm) but we explained the basic needs does not, need does not need you to be trained for psychiatric, basic needs are there is a scope of practice you are compelled to take care of mental health users .They are basic needs they need to be helped.*

Researcher*: Okay if I heard you well you also said, let's say in the current shift there is no one who is having a mental psychiatric nursing. Do they have to go and nurse the mental health users that side?*

Participant: *Yes, the basic needs are there, no I mean I am talking about the current situation (mmm) the current like now Yes there is no one with the psychiatric nursing…They go, they go if they have a challenge they will tell us that they cannot get in because, but sometimes you have to go and check was it done the vital signs, because you would ask them why the vital signs not done (mmm) because with the other people like all of them are like that mmm but the other people you have to be after them sometimes*

Researcher*: Okay, do you think mental health illness can be regarded as a specialty or not?*

Participant: *It is a specialty on its own and I think it needs because sometimes people do not understand it in a way like why there should be mental health, why cannot they go to Thabamopo like all of them. I think is because of that thing of, and I think is because people do not understand it.*

Researcher*: What makes them not understand mental health?*

Participant: *They think mental health is all about undressing you know (mmm mmm) so they do not deal with that at times so I think maybe (noise, sound of a fallen material)It need to be, people need to be trained about it like even if is from a lower level (mmm) as a specialty on its own just for them to understand this mental health user is like this because of this this and that(Sound)If we talk to them they will understand and try to help wherever they can (mmm).*

Researcher: *Okay, and then what else do you experience on the care of mental health care users?*

Participant: *I think also we do not have, ammm mental health programs you know like HIV,TB not in the hospital per ser (mmm) like in the District we do not have, you know those programs like workshops you know we do not have. You know (mmm) we do not have.*

Researcher: *How is so? Please clarify why there is none like in TB and HIV?*

Participant: *Mental health it's not treated the same way as other conditions (mmm), like is being put aside like is being (laughed) is not considered the same way as, as is not prioritized.*

Researcher: *In Can you please elaborate, what do you mean is not prioritized?*

Participant: *Mental health is neglected, yes in the district is not necessarily there because, currently we do not have the psychiatrist, we do not have a eeh review board in the district (okay), the last one completed last year October yaa October November.*

Researcher: *How are you handling the mental health care act forms if no review board?*

Participant: *Now we submitted the mental health forms to the district office (mmm), they are not being reviewed, we do not receive those things eeh .*

Researcher: *But what says the act regarding the review board?*

Participant: *Exactly they have to review those submissions that were done legally and people like if there were like complaints, we have to (mmm) and now there is nothing they need to review if the mental health users are being treated fairly into procedure but is not done (mmm) we are still writing the matter into . But it's not done it's like we are violating the rights of mental health users.*

Researcher: *Okay meaning that the care that you are providing, how can you rate it yourself as a mental health expert, because you are an advance psych nurse? How can you rate that care because you do not have the review board where you are submitting forms?*

Participant: *Is not like that good, I cannot say is good.*

Researcher: *Why do you say the care is not good? Please share more with me.*

Participant: *Because how can I admit the mental health users and I mean while the forms just do not end up with us, I mean all the forms need to be reviewed, if we did the right thing. If the treatment that we are providing is it the right treatment? Is it the right you know (mmm) but now is like we just meet and we just put the forms there eeh*

Researcher: *For how long?*

Participant: *I do not know for how long this will continue, after how long we gonna be having a review board, (mmm) if there something that will be done, I do not know we are not being updated .You know the last time they came the review board last year September, October was it September I do not know. When they told us that their contract is ending (mmm) so they do not know if it will be starting next year mmm but now we do not have.*

Researcher: *So all the patients that you are admitting you are admitting without the approval of the review board*

Participant*: Exactly*

Researcher: *And the act says what?*

Participant: *is illegal according to the act? Is not legal*

Researcher: *But you are doing it?*

Participant: *Yes, what can we do as long as we do our part, It is above our control there is nothing we can do and I cannot just say let's just complete the forms. It will be more, so it will just be worse (mmm) so we just do our part yes.*

Researcher: *Okay I understand you and then what other challenges that you are facing or experience?*

Participant: *Mmmm that one I spoke about provincial budget we do not have budget for Okay yaa yaa yaa the budget and we are not having workshops to update us on the recent developments in mental health.*

Researcher: *Why do you think you are not considered you are not given the budget as mental health?*

Participant: *I think it depends like with the people that are up there, you know sometimes some of the things are being done because people up there are advocating for them.*

Researcher: *Advocating how? Who must advocate? what do you mean?*

Participant: *Like you know (mmm) I think people there might provide a budget if the right people are there to, to advocate for mental health users, (mmm) it depends who is up there (mmm mmm) so with the right people there it can happen that we can have a budget (mmm) Is not like is not, being but I do not know with the right people there(mmm) there can be a budget for them and then yaa and apparently we do not have the half way homes for MHCUs, if they go home, they keep coming back. Some of them do not have families they are being taken by auntie's .she cannot cope anymore she is old (mmm) where do they go, we do not have half way homes. Like half way homes*

Researcher: *What do you mean when you say halfway homes?*

Participant: *For instance, we have legae-labathu (House of people) there.*

Researcher: *Legae labathu? What is that?*

Participant: *So this Legae Labathu.. After care, but apparently it was not approved by the province, so they were closing it, that was the last time I heard. (Oh okay). Yes, they wanted to close it so we do not have anywhere to send the mental health users. That's why they keep coming back to the ward every now and then.*

Researcher: *Okay So when you say they keep coming back how often do they keep coming back.*

Participant: *We have in a month we can have one person coming back twice. (Okay) coming back hmmmm .and when you check the situation is at home, the social part of it is not being taken care of (mmm) and that's another thing this Nyaope thing (mmm) and canabis.*

Researcher: *So what is happening to Nyaope and cannabis?*

Participant: *In this area Nyaope is more, they smoke it a lot*

Researcher: *Is more, how?*

Participant: *They inject it and there are more cases.*

Researcher: *And then you also mentioned that eeh you do not have workshops for mental health care, how do you get updates on the new development, the treatment that have been faced out?*

Participant: *We had, I cannot say it was, it was a meeting in, but then eix we do not (mmm) we do not that's the thing. When I asked the district manager last time, why cannot we get workshop like HIV/AIDS she said no there is no budget.*

Researcher: *No budget? How? Please elaborate*

Participant: *Yes so sometimes she said like she used to, last time after I talk to her there was (Knock Knock door opening, tjooh sorry door closing) (Oh okay) because she used ehh because now apparently now she is doing mental health, I think is chronic medical condition so she try squeeze us just for a small meeting but is still not mental health (mmm)*

Researcher: *Okay so let's take now you talked about this Legae labathu and the after care, Let's take it was there do you think it was going to make an improvement in the..,*

Participant: *It if was working yes working it was going to be, yaa you know it was gonna*,

Researcher: *Why do you think so?*

Participant: *Because when mental health care users get discharged they are not being looked after like properly (mmm) is all about that, we neglect them, get the grant and that's it .*

Researcher: Who needs the grant?

Participant: *The family members (mmm) yes because sometimes the mental health users won't be staying with them but. You might find out that the mental health care user is staying with the grandmother or the husband and the husband is no longer like, into her, she is no longer interested and she wants to go (mmm) you know how it's .*

Researcher: *When you say the family member, they neglect them, they get grant who get grant?*

Participant: *The family members.*

Researcher: *They get grant of the,*

Participant: *Yes, isn't that they claim to look after the mental health care user, so when you hand the mental health user back home to them, they will be holding the SASSA card saying I'm buying this and that for the mental health user, but you only found out that no that's not the case.*

Researcher: *So meaning that family members they do use the grant for their own needs not for the patient*

Participant: *Exactly, exactly not for what is intended to be used for exactly Okay . Because the instead they are using (mmm) matshonisa (loan sharks), the loan sharks (mmm) give the details you might find that we admit the mental health user and when you ask for the grant, no one was there when the mental health user admitted he is being seen by the Social Workers, the OT and the psychologist no one now when the Social Worker try to find out more about this patient (mmm)*

Researcher: *Who use the loan shark?*

Participant: *You might find that the patient does not even have the ID the ID is with the loan sharks (mmm) somewhere (mmm) . So now how are we going to care for this patient after if the SASSA card is with loan sharks and you might find out that he is owing more than his pay, he might not even finish paying that amount anytime soon, (mmm)*

Researcher: *What do you mean when you say owing more than his pay?*

Participant: *So this some of the family members try to make loans using the details of the mental health user (Ahh) Okay so if there was like,there were homes it would have been much better because we would know that the treatment is being given correctly and the mental health care user is being taken care of*

like the basic needs and all that (mmm) and the follow up visits we will be able to go there and check them and so ever.

Researcher: *Mmm okay. So the family members are not taking care of their patients or they*

Participant: *Some they do yes, some they do not .Because I remember we had one patient,one mental health user where we stuck with here and the family said we are fed enough and remember we send a mental health care to Thabamopo and Thabamopo said the patient is fine now we need to return the mental health user back .And then when, when, when I had the name I remembered that this mental health user has social problems, lets contact the family to find out*

Researcher: *Social problems like what? What happened when you contacted the family?*

Participant: *So when we contacted the family the family said no we do not want her .So that's when I was like where are we going to take the mental health user, where can we take her, if the family cant not even like the mental health user, I mean her,where then Social Workers were involved and them that side also at least I managed to go home trying to talk to them and so ever (mmm)*

Researcher: *Why are the family members didn't want the MHCU?*

Participant: *Apparently the mental health user has done some serious case that's why they are refusing to take her back (mmm) and until they were advised and I remember another challenge that we have mental health users commit serious crimes in the community, they are not being reported and in Thabamopo they want a report of those cases (mmm) like if she tried to kill or if she burned whatever there should be a case opened at the police station (mmm) so when they have hers of his record they should be able to say nooo! This is a serious mmm like she cannot go back home (mmm) they won't be safe at home (mmm) but that one there were serious cases that were not even reported.*

Researcher: *Serious cases like what that were not reported?*

Participant: *Like the last time she, she locked the door for the 7 years old for about a week .The child was not going to school starved, was not eating and she also, I think that when she burned the house. She took out the furnisher outside and then burned the house (mmm) and another one she attacked some of the nurse here(mmm) it was before I came here I think it was 7 years or so from one of the local member of the community because she remembered her she was holding a knife fortunately enough there was another man(Office phone rings) It was like a series of crime*

Researcher: *Why do you think this crime are not reported by even a nurse?*

Participant: *But that one was not reported but apparently we went to court and she said nooo on Saturdays we take the knives and go to pill (mmm) like she lied about the whole thing and they believed her, sorry I mean they believed her (mmm).*

Researcher: *They believed her how? Please clarify on that one*

Participant: *They believed her and the case was dismissed (wooow) that's what her sister told me and then it was years back and then now and even before she was admitted at the hospital she went to some stores in town and say can you give me a fridge, closed the door for them and pointed them with a knife.*

Researcher: *To give her a what? A fridge .*

Participant: *A fridge (mmm) apparently, she bought a fridge there before and it stopped working and after a few months she went there and say come and take your fridge and give me a new fridge now. And the store was closed, and she said if anyone comes in I'm gonna stab (mmm) and that's when they gave her a fridge and then she even that one they didn't report it (mmm)*

Researcher: *Why didn't they report it because it's a serious case?*

Participant: *The police just came and say just give her a fridge because she bought a fridge and is not working that when they gave her a fridge, So It's it's seriously it's a lot but she is back home now she seems to be coping (Oky) oh she is back from Thabamopo. Yaa*

Researcher: *Okay. Can you please share with me more about challenges?*

Participant*: Other challenges?, I think it's eix I cannot remember*.

Researcher: *Oh its fine when you remember you will go back to it. Eeh .Okay eeh what do you think need to be done?A strategy that you think it can be done in managing well the mental health care users, strategy in cubing all this challenges that you tried to mention? .*

Participant: *We need to have top people that can help us to implement some things. Even if we can have proper structures and so whatever we need to have someone there at the top in the province like involved like you know (mmm)*

Researcher: *What do you mean when you say we need someone at the top to advocate?*

Participant: *Advocating for the mental health users trying to advocate for workshops and whatsoever programs to that something done there. Even in the district make sure that some eeh psychiatric mental health care practitioners doing some outreach (Ehhh). And also train more psychiatric nurses as well (mmm) and then*

Researcher: *What do you mean when you say outreach?*

Participant *: With outreach there should be identified doctors who are interested in psychiatry (mmm) and with the clinics that we have. they should at least join us and then in that way we can improve the mental health services in the hospital*.

Researcher: *What else do you think we can do to improve?*

Participant: *Mhhhh oh security obviously security? The security yes we need to have .At least we need to have one in the unit we cannot have one outside its useless anyway because by the time mental health users try to do something it will be too late*

Researcher: *Okay.Ammmm the one that you talk about that you do not have workshops. What do you think we can do so that we can improve in the care?*

Participant: *(Noise) Once in two month or you know at least something there should be done (mmm) Eix it depends(Laughed)they are a lot of topics like as long is something to do with mental health (mmm), to start with yaa. Example 72 hours assessment okay .*

Researcher: *Can you share more about the families who neglect or dump their family members*

Participant: *Us here? The strategies in fact everyone, remember this mental health users they go back to the community they do not stay here with you. Those who are interested in opening the aftercare homes.*

I think they need to support them and maybe to promote the opening like the, those who are interested in opening after care homes (mmm) they need to support them

Researcher: *How can they support them?*

Participant: *Like and ensure that is properly like is legalized (mmm) so that we can make sure they are being treated fairly. .I mean we cannot really force anyone who does not want a mental health user (mmm) because she has been there and she had enough, but you cannot force them to take them back Mhmmm but then*

Researcher: *What can be done if you say you cannot force them?*

Participant: *We just to make them understand the condition and how to manage it and help them in a way that they can cope in a community is just that we just need to have after care homes at the district*

Researcher: *Okay and this one of cannabis and nyaope how what do you think we can do so that we lower the use of this cannabis so that you do not re admit this patients back to the units?.*

Participant: *Well there is I do not know if its legalized or what Recently we have nyaope, there is, I do not know if is an after care I just heard it last week (mmm) so she is going to present it the lady (mmm) tomorrow I do not know how is gonna is the first time I heard about it (mmm)*

Researcher: *How can we assist them?*

Participant: *But I think after care and maybe creation of jobs which is because usually they are young people who smoke Nyaope usually they are not doing anything and the recreation thing that they can do*

Researcher: *Mhmm.*

Participant :*Yaa and another challenge that Nyaope is sold by officials like police,*

Researcher: *Sold by what?*

Participant: *By people who are officials like the police officers okay so it's difficult to, to control it (mmm) so this police officers, but I cannot say I am sure that's what we hear from them. I do not have proof I cannot say they are buying from them yaa*

Researcher: *But that's what you heard*

Participant: *Yes. So meaning that we are still having a hinder because if they are the police who are doing that that can hinder, it is a challenge on its own (yaa),*

Researcher: *Yes*

Participant: *There was a rumour that some of the staff, not necessarily nurses but some of the hospitals remembers they inject it neh? (mmm) this cannabis they buy it from some of the staff members .I do not know if it's a nurse or whatever but as long as you work in the hospital you buy the needles from them (mmm)*

Researcher: *Where do they get the syringes?*

Participant: *Sometimes they use to steal, you know those used ones that we put in the dust bin (mmm) they used to take them out, and I think it was last year that the bins for injections was stolen, I mean (mmm) we keep them safe and after that is then that we realized that this thing are being sold at location.*

Researcher: *Okay what do you think we can do to like curb that one in a location they are being sold eeh used needles in order to get this injectable needles .What do you think you as a coordinator must we do so that this people must stop the whatsoever that they are doing?.*

Participant: *Because we tried to educate them I mean like the danger of this things (mmm), Do you know that eeeeh what do they call that…Bluetooth.. I think I have heard about it even though you educate its addiction they go back and do it again (mmm) so with rehab is expensive also (mmm) so it depends if your family has money they can take you to rehab (mmm) so after rehab they need something then to maintain them in the community (mmm).Okay,*

Researcher: *So about the family who like reject their family members what do you think we can do so that the really understand that this are their relatives.*

Participant: *I think we just need to do more education even in the clinic unit (mmm) just to awareness of mental health and them yaa I think awareness (mmm)*

Researcher: *Do you think education if we really educate, educate it will work?*

Participant: *(launged)I'm not sure I'm not sure but we have to try yaa if we see that is not working we can just okay .Yes Ehmmm and there is this serious, cases the last case that we spoke about with series of crimes like not reported. What do you think we can do so that this people they know that even though you are mentally ill you can be reported and get arrested? I think with that family tried, when I tried to find more,*

Researcher: *The family have tried how?*

Participant: *I asked them why do not you try to call the police, they said no because normally is the police who do not want to assist and the police said no she is mentally ill, there is nothing we can do (mmm) take her to the hospital and when she comes here she is a mental health user we do not admit here*

Researcher: *Why did they say they do not admit mental health users?*

Participant: *The police said has she has done something serious, that when we said no whether she has done worse or not the police says we cannot arrest a mental health user (mmm) that's why that's why we expect them that mental health user or not if they have done something wrong they have to go to the police station (mmm) that why we told them that next time whenever she does a crime whether is big or small take her to the police station .That when they were willing to take her.*

Researcher: *In other words what I am hearing from you our police officials do not know?*

Participant: *They just think that our mental health user even though they have killed somebody they just need the hospital. Yes that's what I do not get there because normally we have the meeting even in the meeting we invite them to come over (mmm) they do come over but even with the issue of mental health user within the community we need to be (mmm) be assisted by the police, they we still have a challenge as such sometimes (mmm)*

Researcher: *Challenges like what? Please elaborate*

Participant: *They refuse they say we do not have enough police vans or whatever vehicles (mmm) it's a challenge with police station (mmm) but then the district manager tried to talk to, I have forgotten the name of the police from one in charge of the police station, station commander? yes (yaa) she called them for a meeting she had a meeting with them .Everyone (mmm) once in a while we have cases like that police*

officers they say that they cannot arrest and she tells the family that so that's what we hear from the family saying noo we cannot open a case whether is a mental health user .

Researcher: *So what do you think is the causes of that?*

Participant: *It might be ignorance, it might be lack of knowledge*

Researcher: *Lack of knowledge how? Please elaborate*

Participant: *The police do not know that according to the act they are supposed to do 1,2,3 is I do not know they were trained last year but we are trying to train them because it was a district problem (mmm) some district are even worse (mmm) so it was a district problem she tried to and we also whenever we have a challenge we just go straight to the station commander with an Act and explain everything whenever she do not understand that's when she will ask and then she I do not know what to do whether (Voices of people)*

Researcher: *So what do you think need to be done?*

Participant: *Mhmmm so we need to do something because this police officers we are in the same board, maybe it's a new one or something it need to be an ongoing training or something (yaa),*

Researcher: *Police officers*

Participant: *Yes, yes so that they understand yes the acts yes it shouldn't be done once in a while like ongoing nhhhh Yes,*

Researcher: *What else do you think we can do? You said the loan cards they take the loan cards for our patients. What do you think we can do to make sure that this card is meant for the mental health user is not even meant for the family member?*

Participant: *Exactly I think it should be reported like that one at the police station, is important like that one that every case should be treated the way it is. You can even go home (mmm) and if not what do we do, do we go to the loan sharks or we go to the police station and report or what (mmm)*

Researcher: *Okay and for the family members who are taking the cards and using it for themselves what do you think we can do.*

Participant: *The only problem we only realize that when we are with them but we do not (mmm) know that the money she is getting is little so we do not. should be taken back to the mental health user some of them are incapable to use them (Mmm).*

Researcher*: What should be done if family members are abusing the grants. Who can administer the cards for the mental health user?*

Participant: *The other members maybe the one who is willing to take care of them. If not that's why I am saying homes will be best, yes.*

Researcher: *Okay, okay and then what other things that you think we can do that you think of?*

Participant: *Oww I do not know because mental health is a broad problem currently is getting worse actually*

Researcher: *Getting worse how?*

Participant: *I think, I thought maybe things were getting better from like last year, from last year it was just getting worse I mean how can a mental health user in the whole district not be seen by a psychiatrist in the whole district (mmm) taking treatment without being reviewed, so they take treatment even they are having side effects.*

Researcher: *What happens if they are having side effects? Serious side effects?*

Participant: *That's when they contact the Doctor, because even when they conduct follow up. They come to OPD and we advise the doctors when they come to OPD that if they are unsure what to be given a mental health care user and then they are unsure what to do (mmm) we consult the mental health care practitioner in Mokopane just for second opinion.*

Researcher: *What else (participant laughed) The strategy that you think we can do to improve the care services (voices of people).*

Participant: *And also, non-governmental organization they can help.*

Researcher: *How do you think NGO can help?*

Participant: *Like through monitoring within the community. Like the other one that was working very well it was for another condition, it was for HIV We used to call her Ceccilia I do not know if you know her.*

Researcher: *NGOs like, for example do you have examples of those NGOs.*

Participant: *The other one that we had was for HIV we used to have like the other one that we had was working very well. She used to I mean those mental health .HIV but apparently the organization closed*

Researcher: *How were they assisting?*

Participant: *But it was working very well because when people are discharged from the hospital she used to come and check the treatment and take them and those who were unable to in fact who do not have family members to come and take them (mmm) used to come take them back to their family, I mean the family home and also monitor the treatment in their daily basis and ensure they comply .We have a home based care but then we do not see it effectiveness, not that effective they say they are scared of mental health care users*

Researcher: *What do you think we can do to these home base career so that they are not scared they understand that mental health user is just a condition?*

Participant: *We just need to, I think they should understand that they cannot go there alone they need to be with a mental health practitioner to go there(mmm) and if it's in a clinic nurses need to go with the nurse with them and explain to them (mmm)*

Researcher: *So, you think the NGOs can assist in the relapse rate?*

Participant: *Yes,The admission rate okay, and why cannot the government does not have why cannot they build those containers for wellness and the whatsoever. If we cannot have a ward why cannot we have a clinic like for wellness like the containers for mental health (mmm) and we can have a clinic and it can be run by at least one doctor who is interested in psychiatry (mmm) then I think it will improve while waiting for the psychiatrist because you never know when one will meet the psychiatrist, so at least we know once a week there is a clinic eeh,*

Researcher: *You said the psychiatric clinic? How will this clinic operate? Please clarify*

Participant: *I mean psychiatric clinic run by doctor and all the MDT members and they assess mental health care who were given discharge and where ever referrals from the clinic (mmm) and then can just do and whenever we get stuck we call the psychiatrist for because now there is a because now there is a follow up I mean referral from the clinic they just refer to OPD and then the Doctor just assess according to her own understanding (mmm) and those who were who come for follow-up you cannot really know if she did come for follow-up or not*

Researcher: *Why cannot they know if the patient is coming for follow up?*

Participant: *Because she comes at OPD you are not even sure did she come for you know where as if we had a clinic on this day for mental health care clinic we can be definitely sure that mental health user on this day, did come back for follow-up but now we do not have a clinic, we tried to have a clinic but now they feel like they are not competent enough to run a clinic*

Researcher: *Okay so the doctor wants a psychiatrist to run a clinic they cannot run it by themselves. They cannot run it themselves.?*

Participant: *They cannot run it without, we wanted a clinic you know like a clinic, a psychiatric clinic day (mmm) whereby the other condition like (yaa) so the other unit said since you do not have a clinic you cannot be running a clinic like the when mental health users make follow-ups they will come at OPD (mmm) as our patient like you know anyone can see like any doctor can see them not a clinic per se on a certain day.*

Researcher: *Okay so are you involved in the OPD when now they are coming for follow-ups, you are not involved you do not see them? You only see them here?*

Participant: *I do not see them yes I do not see them, unless I gave a mental health care user a date to come back he must come and pass by so that I can see them oooh, other than one you cannot see them mhmm okay*.

Researcher: *Any other things?*

Participant: *No, Nothing more*

Researcher: *Okay, thank you very much for your time we do have talked at length about the challenges and the strategies and on how to promote the effectiveness of management so thank you if I go through the audio that we were taking I find that there is something that I need clarity from you, I will come back so that you can clarify me that what did you mean when you say this, so that I can get more clarity*

Participant*: Mhmm*

Researcher: *Thank you very much for your time*.

Participant: *Thank you*

ANNEXURE S

VALIDATION TOOL

Dear members of the DMHF

You are invited to validate the developed strategy by answering the questions below. Your inputs are valued.

NB: Please send the completed evaluation to Bumani.manganye@univen.ac.za or bumanis84@gmail.com

Validation of developed strategy by the stakeholders

Criteria	Question	Strategy Components	Remarks
Relative advantage	Is the strategy better than the present?	Component 1	
		Component 2	
		Component 3	
		Component 4	
Compatibility	Does the strategy fit with the intended audience?	Component 1	
		Component 2	
		Component 3	
		Component 4	
Complexity	Is the innovation easy to use?	Component 1	
		Component 2	
		Component 3	
		Component 4	
Trialability	Can the innovation be tried before making decision to adopt?	Component 1	
		Component 2	
		Component 3	
		Component 4	
Observability	Will the results of the innovation visible and measurable?	Component 1	
		Component 2	
		Component 3	
		Component 4	

ANNEXURE T

STRATEGY COMMENTS EXAMPLE

STRATEGY TO IMPROVE MENTAL HEALTH CARE SERVICES IN LIMPOPO PROVINCE

Four components that constitute the strategy were identified and described with the stakeholders.

Name of the strategy**: Strategy to improve mental health care services in Limpopo Province**

Aim of the strategy: **To reduce relapse ~~psychosis~~ (how about mental illness) and frequent readmission by MHCUs in Limpopo Province**

Objectives:

- To influence individual and interpersonal level of antecedents of MHCUs decision making and risk taking.
- To influence health providers, family and community members regarding supporting MHCUs.

7.4.2.1. Component 1: Increase knowledge, ~~encourage healthy attitude and develop skills~~ (develop skills can be coupled with *7.4.2.3* then the other be written under the fourth component and be number 5)

A strategy outlines specific strategic actions to be done e.g. assess learning areas in need of empowerment and teach the user, family and community to increase their knowledge. Give directional statements/actions to be done.

This component will help MHCUs make healthy decisions about mental illness. This focus can also influence other levels ~~for instance~~ changing community social norms and perceptions, strengthening institutions that care for MHCUs and encouraging adults to communicate effectively with MHCUs. Community and family members and specifically MHCUs need clear and accurate information regarding mental illness and the importance of taking treatment. Health education activities can affect many of the factors that influence MHCUs and other stakeholders' decision making.

Myths, beliefs and misconception regarding the causes of mental illness can be dispelled through (organize) mass media campaigns (give mental health education regarding causes of mental illness to dispel myths, beliefs and misconception) (Identify key figures) whereby traditional leaders will spearhead the mental health campaigns in the community. Community members will be allowed to voice their beliefs about mental health or mental illness and health professionals will be able to clarify and give extensive health education during the

village meetings or indaba. Skills can be achieved through training and workshops for mental health. N.B. write your strategies I numbers or bullet form.

7.4.2.2. Component 2: Improve Social Environment

Support of MHCUs by either the immediate family members, MHCPs and community members forms the basis of improved quality mental health services. This component will enable MHCUs to feel accepted when having challenges where they can consult freely without any fear of being judged in mental health establishment. Community members can also contribute in supporting both the families of MHCUs and users by accepting and including them in all decisions made in the community. Traditional leaders can also play a role by making the environment where there are MHCUs to be stigma and discrimination free so that they can feel accepted.

~~MHCUs will be encouraged to select a buddy at home~~ (e.g. encourage/ask MHCU to select a buddy at home), get support from community health care workers and local spaza shops owners to remind the MHCUs to take treatment regularly. (Establish support groups)This component will also help in establishing mental health advocacy leaders in mental health establishments and community mental health. The (establish mental health advocacy group) will assist in fighting for the rights of MHCUs and lobbying of funds to be used by the mental health directorate during mass media campaigns and further fight for inequalities in health programs as all health programs are important. (Establish relationship with the municipality and develop a home for those who need supervision)

7.4.2.3. Component 3: Improve social kills of MHCUs

In most cases, MHCUs are regarded violent and aggressive towards family and community members. The reason for the community to label MHCUs as being aggressive might be alluded to the way MHCUs behaved during the psychotic phase as others does display aggressive behaviour towards people. MHCPs can provide training to MHCUs regarding the control of their anger and negotiate not to be called by ugly names like being crazy or mad. The training can include how to be assertive, fighting for their rights as MHCUs without violating other people's rights. Furthermore, MHCUs may also be taught to try and avoid people who drinks alcohol or smoke dagga as this behaviour can make~~s~~ them forget to take treatment and results in relapse psychosis and get readmitted in mental health establishments.

7.4.2.4. Component 4: Improve self-efficacy to obtain and take treatment by MHCUs.

This component will boost the self-confidence for MHCUs that they can still lead a normal life with mental illness in the community being stable by going to the clinic or hospital to collect treatment and follow Doctor's prescription. It can also be achieved by giving similar example of some MHCUs who are on treatment but leading a normal life, occupying high positions in their workplace. MHCUs can be given instructions on how to take treatment on specific time schedules, storage of treatment can serve as a vital element whereby the users will be instructed to store the psychotropic drugs away from direct sunlight and closing the lid tightly.

Monitoring of MHCUs can be done by family members as they will be able to check if the behaviour of users has changed and when they observe any signs of relapse psychosis they must report to the nearest facility. Family members are the ones who can easily identify if the behaviour of MHCU has changed as they stay with the user on daily basis. When MHCUs are maintaining the stable condition

in the community, feedback must be provided by the MHCPs that the user is doing great by taking treatment, this will increase motivation to continue taking treatment as positive feedback was received.

(Refer) to community home base care workers ~~can also~~ (to)assist ~~MHCPs~~ by monitoring the treatment compliance to MHCUs as they visit homes of MHCUs daily and they can serve as an extended hand for the government. The strategy used in TB for Directly Observed Treatment (DOT) can be applied for MHCUs who are not complying to treatment in their homes, spaza shops or primary health care facilities to strengthen compliance.

N B. Please the check the yellow !!!!!!!!

ANNEXURE U

LANGUAGE EDITING AND TYPESETTING CERTIFICATE

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28 April 2021

To Whom It May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the **PhD** dissertation by **Bumani Solomon Manganye**, titled: "**Development of a Strategy to Promote Effective Management of Mental Health Care Users in Mental Health Establishments in Limpopo Province, South Africa**" The manuscript was also professionally typeset by me.

Sincerely Yours

Cert. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD (Medicine)