



University of Venda

**A MODEL TO PROMOTE FAMILY INVOLVEMENT IN CARING FOR MENTAL
HEALTH CARE USERS IN LONG-TERM MENTAL HEALTH INSTITUTIONS OF
LIMPOPO PROVINCE, SOUTH AFRICA**

By

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DECLARATION

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I declare that **“A MODEL TO PROMOTE FAMILY INVOLVEMENT IN CARING FOR MENTAL HEALTHCARE USERS IN LONG-TERM MENTAL HEALTH INSTITUTIONS OF LIMPOPO PROVINCE, SOUTH AFRICA”** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Signature _____ Date _____

DEDICATION

This thesis is dedicated:

To my late mothers N'wa-Makhongele Khataza Dorah Mabunda, N'wa-Misengi Mamayila, my late sister Rifumuni Salphinah, my late grandmother N'wa-Ngove Mdavazi Njakan-njaka, my father Zulu Daniel Mabunda, my brothers and sisters, grandsons and granddaughters of the Mabunda family for their continued understanding and support throughout my academic venture. You will always be in my mind.

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ABSTRACT

Family involvement in caring for mentally ill patients in long-term mental healthcare institutions is defined as a strategy in which family members and long-term healthcare professionals become partners to provide the best possible care for a person with mental illness. The study seeks to develop a model to promote family involvement in long-term mental health care institutions in Limpopo Province, South Africa. Mixed methods was used. Unstructured interviews were conducted with 21 family members and 6 focused group discussions with MHCUs in qualitative phase. Self-administered questionnaires were used to collect data from 360 nurses in the quantitative phase. Data was analysed independently of which convergent analytic approach was used to merge the two data sets.

The study reports that the MHCUs' attitudes towards families contribute to poor involvement by family members in the care/visit of the MHCUs while admitted in long-term mental health care. The rejection of the MHCUs also came up strongly during data analysis. Nurses perceived that insufficient family involvement hinders the provision of mental health care services. Eight steps in the Walker and Avant Method were adapted to clarify and distinguish the definition of the main concepts. A model to promote family involvement was conceptualised using the six areas as described by Dickoff, James and Wiedenbach (1968).

A model was validated against its rationale and purpose of the study. Justification on the contribution of the family involvement in mental health care revealed that "*family involvement in caring for MHCUs*" is an engagement and encourages family members to participate in the diagnosis, treatment and recovery process. Study recommended that a developed model should be implemented in health establishments providing mental health services. Policies should be reviewed to include activities which the families should be notified of immediately the mentally ill patient is declared to receive mental health care, treatment and rehabilitation. Developed model should be piloted and evaluated to identify areas that will further improve the quality of mental health services.

Key words: mental illness and family, family involvement, caring for mental health care users in long-term, family involvement in mental health, family engagement in mental health, family involvement model.

ACRONYMS

ANA:	American Nurses Association
AHNA:	American Holistic Nurses Association
AOT:	Assisted outpatient treatment
CBR:	Community-based rehabilitation
CTO:	Community treatment orders
FPE:	Family psychoeducation
ID:	Identity document
LOA:	Leave Of Absence
MDT:	Multi-Disciplinary Team
MEC:	Member of Executive Council
MHP:	Mental Healthcare programmes
MHCUs:	Mental Health Care Users
MHCI:	Mental Health Care Institution
PLWHA:	People Living With HIV/AIDS
SPSS:	Statistical Product and Service Solution
WHA:	World Health Assembly
WHO:	World Health Organisation
WPC:	Whole-Person Caring

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CHAPTER 1

STUDY OVERVIEW

1.1 INTRODUCTION

Family involvement in mental health care is the best practice because it leads to the recovery of the patients and good interpersonal relationship between the patients and the family members. Although every individual desires good mental health, the endowment of services to the person with mental health problems is a societal compulsion. Mental disorders are commonly viewed as a family responsibility rather than a communal problem (Yip, 2003; Lauber & Rossler, 2007; Yang, 2007; cited in Marimbe-Dube, 2013).

Family affiliates may be entitled to offer care giving roles that depend on which member of the family is mentally ill. In addition, there are particular challenges within families where parents are mentally ill and may not be able to support their families (Yip, 2003 cited in Marimbe-Dube, 2013). The Mental Health Care Act, No.17 of 2002 describes patients living with insanity as mental health care users (MHCUs) and specifies the circumstances of providing care, treatment and rehabilitation for them (South Africa, 2002).

In terms of the Mental Health Care Act, No.17 of 2002, an individual, human formality and discretion of all MHCUs must be respected during the care provided by nurses and relatives who are taking part in the care of those patients. Therefore, rehabilitation for a person who is mentally ill also includes the involvement of family members in caring for the patient together with the health care providers (South Africa, 2002).

This was supported by Uys, Chipps, Kohi, Makoka and Libetwa (2013) when stipulated that family intrusion is the most vital milieu for the treatment and reintegration of patients living with insanity. Finkelman (2000 cited in Banyini, 2012) asserted that deterioration and hospitalisation may decrease due to family support intervention as the MHCUs and their families interact sufficiently. The researcher observed that families find it difficult to accept mental illness. Family members also seem to be frustrated, exhausted and frightened even when the patients are stabilised in mental health hospitals.

Furthermore, the family affiliates of the mentally ill do not visit their loved ones in mental health institutions. It is in this light that the researcher decided to conduct this study in order to answer certain questions. The researcher has also been observing certain odd behaviour among family members of the mentally ill patients. In instances where family members visit those in the hospital, they show frustration, exhaustion and are not at ease with the patients.

1.2 BACKGROUND

Family involvement is vital for fruitful community-based mental health care. Over the past years, mental healthcare was increasingly being steered by service users, with re-possession as fundamental in treatment. Therefore, involving family members to interact with service users and discuss exactly how mental illness has emotional impact all areas of the individual's life may aid to build trust. Hence the more the MHCUs interact with their families, the quality of mental health care services improves (Gale & Marshall-Lucette, 2012).

However, the treatment gap for mental disorders is large globally. It has been shown that between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment. However, in high income countries people with severe mental disorders range between 35% and 50%. In addition, World Health Assembly (WHA) indicated that mental disorders can be prevented and promoted in the health sectors. Therefore, evidence on the effectiveness of intervention to promote mental health includes the involvement of family members, civil society organisations, persons with a mental illness and care givers in voicing their opinions and decision-making procedures (WHA, 2012).

However, there is growing evidence from around the world that families in western countries are scantily supported to provide the care required by their family members with mental illness and struggle to provide this support. This is because of community attitudes and beliefs which frequently have an effect on the type of assistance provided to families of individuals with mental illness (Marsh, 1999; Yang, 2007 cited in Marimbe-Dube, 2013). In the United States of America estimates have shown that between one and two thirds of persons with long-term psychiatric disabilities, care is provided by family members. Studies also show that 40% of patients with schizophrenia live with their relatives, while in China, more than 90% of the people with this condition live with their families (WHA, 2012).

Similarly a study was conducted across Europe by Schuize and Rossler (2005) which revealed that caregiver burden in schizophrenia was high across England, Denmark, the Netherlands, Italy and Spain. A report called Worried, Tired and Alone, which set out to analyse issues affecting caregivers in Western Australia, revealed that the majority of caregivers experienced personal, emotional and physical strain in their lives as well as loss of

personal freedom as a result of caring for a mentally ill relative (Marimbe-Dube, 2013). Although much of the research on family caregiver burden has been conducted in settings of high income countries, similar findings were evident in Southern Africa. A qualitative study conducted in Botswana by Marimbe-Dube (2013) revealed that family members have become the primary source of psychological support to the MHCUs.

However, family members perceived the situation as burdensome because of inadequate resources. Family members and health professionals were frequently required to negotiate the care of the patients (Marimbe-Dube, 2013). Community care requires teamwork and partnership. Despite the assistance offered by health professionals, families often become discouraged, stuck, overburdened, and fatigued by the care of their relatives. In this way, the process of forming the partnership and teamwork is of significance (Hartfield & Lefley, 1987 cited in Marimbe-Dube, 2013).

Botswana established their first psychiatry institution in 1938. After realising that their only psychiatry institution became overcrowded, as the number of patients exceeded the bed capacity, there was a shift from hospital care back to community care, and families again became responsible for the care of their relatives (Marimbe-Dube, 2013). Chamber, Ryan and Connor (2001) conducted similar study in the same country. Authors report that families became pivotal to the care of their ill relatives as a result of this shift from institutional care to community care (Chamber et al., 2001). According to WHA, mental disorders make a substantial contribution to the burden of disease. WHA also raised concern that millions of people are affected by mental illness (WHA, 2012).

However, studies in other countries show that family carers experience high degree of family burden, and knowledge had an indirect impact through negative coping strategies (Lim & Ahn, 2003; Alejandra et al., 2006 cited in Kidula, 2010). Therefore, this study developed a model to promote family involvement in caring for long-term MHCUs in Limpopo Province.

1.3 RATIONALE OF THE STUDY

For this study, family involvement in caring MHCUs is significant. The researcher seeks to reveal how family members of mentally ill patients experience burden as well as their physical and psychological wellbeing in being involved in caring for MHCUs. This study will also describe the perceptions of MHCUs regarding the involvement of their family members. The identified psychosocial problems in families that are affected by mental illness and the coping mechanisms when caring for MHCUs, will be described.

However, there are activities to promote mental health awareness within the mental health profession. Long-term mental health institutions have programmes in which psychiatric nurses are delegated to promote mental health. Mental health awareness campaigns are conducted at schools and community functions about the predisposing factors of mental illness and related topics to educate community members and youth. Different topics about mental illness are also presented on the local community radios.

Furthermore, there are T-shirts which health professionals wear on Fridays which have mental health messages at the back depending on the theme of the particular function. Moreover, the Department of Health also conducts annual family day within the long-term mental health institution where

families/ relatives of the MHCUs are invited to promote interaction. The Constitution of South Africa also states that everyone has a right to have access to healthcare services; including those who are unable to support themselves and their dependents. These led to developed de-institutionalization from long-term mental health hospitals through the development of family and community support services (South Africa, 2002).

This study also revealed the perceptions of nurses on the involvement of family members in caring for MHCUs. This will strengthen and support family members in caring for MHCUs and improve and promote family mental health. In addition, this study will establish and describe the importance of family members' involvement in the life situation, MHCUs' need for support, as well as nurses' perception and support of the family members in caring for MHCUs from the perspective of relational ethics.

1.4 PROBLEM STATEMENT

The researcher works in a mental health care institution as a professional nurse. Observations are made on a daily basis in terms of family involvement in caring for MHCUs in long-term mental health institutions. It is apparent that most of the patients in long-term institutions remain for some days and month without any visitor. Despite the efforts made by nurses working with MHCUs in hosting family day in the institution, some patients still remain with no one coming to visit them in the hospital.

The trends with MHCUs is that instances of patients not being visited by family members/relatives from the time of admission are increasing within the institution. About 12.6 percent of the MHCUs do not have family contact to trace. About 17.37 percent of the MHCUs who have family contacts, when

traced, there is no responsible family member who can visit the MHCU. When the hospital Multi-Disciplinary team (MDT) members conduct home visits together with the MHCUs to promote interaction, the family members reject the MHCUs and lock gates. In addition, about 1.08 percent of the MHCUs, when granted leave of absence (LOA) as trial for discharge, most of them abscond from home back to the mental health institution. Furthermore, 2.97 percent also failed LOA due to relapse. Finally, 11.36 percent of the MHCUs do not have identity documents and when they die they are buried by the government after failing to trace the families/relatives.

Mental health institutions have strategies to promote an interaction between the MHCUs and family members, such as annual family-day functions where family members are invited. In addition, the Department of Health also has annual Mental Health Awareness campaigns where health nurses are delegated to the different communities to create awareness. In addition, local radios are used to create awareness among community members which is not yielding good results as MHCUs are still rejected by their families.

1.5 THE PURPOSE OF THE STUDY

The purpose of the study was to develop a model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

1.6 RESEARCH QUESTIONS

Based on the problem statement, the following research questions arise:

- What are the perceptions of family members regarding their involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province?
- What factors contribute to insufficient family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province?
- What are the views of the MHCUs regarding family involvement while in long-term mental health institutions in Limpopo Province?
- What are the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province?

1.7 OBJECTIVES

1.7.1 Qualitative objectives

Objectives of the study were:

- To explore and describe the perceptions of family members regarding their involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- To determine factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- To explore and describe the views of MHCUs regarding the involvement of family members while in long-term mental health institutions in Limpopo Province.

1.7.2 Quantitative objective

Objective of the study were:

- To explore and describe the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

1.8 SIGNIFICANCE OF THE STUDY

The study is envisaged to contribute towards the promotion of the involvement of the family members in the caring of MHCUs. MHCUs will benefit as family members can realise the importance of visiting the patients at the mental health institutions, thus promoting patient recovery. Family members of mentally ill patients will benefit in the sense that factors and obstacles experienced by the family will be addressed. Nurses may benefit as they will be knowledgeable about intervention on identified problems that strictly need family members, rather than conducting home visits. The hospitals may benefit from the study as quality mental health care may improve.

In addition, the research findings will indicate areas for further research in relation to family involvement and reveal the ways in which family involvement in mental health can be put into practice. The provincial and national health departments may benefit as the overall system's performance may improve. Policies may be reviewed; MHCUs may be discharged and return to their normal state of mental health and occupy their position if they were employed before.

1.9 FOUNDATION OF THE STUDY

This section outlined the conceptual framework used to contextualise the research results, assumptions and methodology underlying the study.

9.1 Conceptual framework

Chinn and Kramer (1995; 2014) defined conceptual framework as a logical grouping of related concepts or theories, usually created to draw together several different aspects that are relevant to a complex situation such as a practice setting or educational programme. According to James (2011) a conceptual framework is used in research to rough draft probable courses of action or to present a preferred tactic to notion or thought, in order to come to understand the nature of the theory and its role in professional research (James, 2011 cited in Horn & Brem, 2013). In this study, the researcher adopted Thornton's Model of Whole-Person Caring (WPC). The WPC framework is consequent from theorists in the fields of nursing, physics, and systems analysis (Thornton, 2013).

In addition, Thornton's Model is further described as a framework designed to guide health care professionals towards health and wellness within the health care organisations. Hence it was originally developed to assist health professionals in creating healing within nursing environments for both patients and health professionals (Thornton, 2013). Therefore, it was found that the whole-person caring theory presents convincing arguments concerning the vital importance of integrated body-mind-spirit healing in a whole-systems approach to the researchers (Van der Merwe, 2013).

In this model, the energy field is considered to be the first field of the manifest universe. However, the metaphor of a diamond represents the whole-person concept, the foundation of the diamond is nursing spiritual nature (Figure 1.1).

Therefore, self-realization is the essence of nurses and arises from the spiritual field and the field of Love (Thornton, 2013).

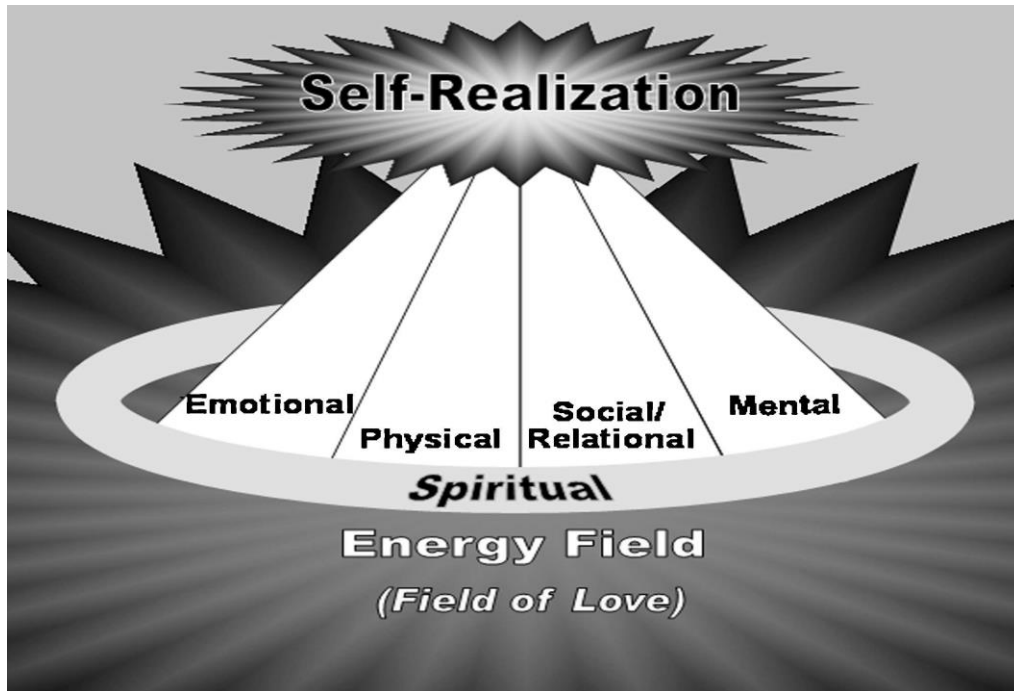


FIGURE 1.1 Concept of the whole-person (Thornton, 2013)

1.9.2 Assumptions

- A person is an energy field that is built up, infinite, and spiritual in quintessence, and in constant mutual process with the environment. In addition, each person demonstrates unique physical, mental, emotional, and social/relational patterns that are interrelated, inseparable, and continually evolving (Thornton, 2013). In this study, the researcher assumes that in caring for MHCUs, their unique physical, mental, emotional, and social/relational patterns requires family members to be involved.
- The environment is an energy field beyond and comprehensive of the person. Although a person and the environment are in a state of constant mutual process, there is no distinction from an energetic perspective (Thornton, 2013). In this study, the researcher assumes

that in caring for MHCUs, family members should pay visits to the mental health care institutions in order to interact with them.

- Health is the subjective experience of well-being (Thornton, 2013). In this study, the researcher assumes that in the caring of MHCUs, family members should be involved to promote mental health recovery.
- Whole-person caring is the delivery of care and services to endorse well-being. However, the WPC is based on the concepts of blessedness of being; therapeutic partnering; self-care and self-healing; optimal whole-person nourishment; transformational health care leadership; and caring as a sacred practice (Thornton, 2013). In this study, the researcher assumes that caring for MHCUs, physical health, mental health and social care needs, and supporting MHCUs to recover and return to their own homes, is a significant aspect that involves family members.
- Spiritual is a dimension unifying field that integrates the physical, mental, emotional, and social/relational aspects of being. The spiritual dimension is the essence of self and also transcends the self. It is nursing's closest, most direct experience of the universal life force (Thornton, 2013). In this study, the researcher assumes that in caring for MHCUs, nurses should be more open when providing mental health care and awake to the spiritual essence of being and access every area until life is resuscitated.

Therefore, Thornton's Model is appropriate to this study because MHCUs are primarily spiritual beings. However, the focus of this model is on nourishing a person's body, mind, heart and soul as a whole. It also promote healthy lifestyle practices (Thornton, 2013). Miles and Mezzich (2011) argued that though science, ethics and care are the enduring traditions of the health profession, the patient-centered medicine is of significance in attending to the whole person and the biological, psychological, social and spiritual aspects of health which unifies these strands.

This was supported by American Holistic Nurses Association (AHNA), and American Nurses Association (ANA) (2013 in Thornton, 2013) who stated that caring for the whole person, is foundational to integrative medicine, hence defined the holistic nursing as “all nursing practice that has healing the whole person as its goal”. Yet, the essential to integrative and holistic care is understanding the interrelatedness of the mental, emotional, spiritual, physical and relational aspects of a person as well as recognizing the inseparability of these aspects from cultural and environmental influences (Thornton, 2013). In addition this model emphasises healing/harmony, exploring meaning and source of symptoms. Therefore, involving family members in caring for MHCUs is significant.

1.10 DEFINITION OF CONCEPTS

- **Model**

A representation of reality, such as social workers using the system model to represent the interaction in the family system and to discover where the pathology lies in the family interaction (Barker, 2003).

In this study a “model” means a description of a situation in order to promote family involvement in caring for MHCUs in long-term mental health institutions.

- **Promote**

To influence somebody to do something by making it easier for them and making them to believe it is a good thing to do (Wehmeier, 2005). In this study “promote” means to encourage family members to interact with MHCUs and ensure that they believe it is good to do so.

- **Family**

The family is defined as a group of interacting persons related by blood or marriage especially a husband, wife and their children (Wehmeier, 2005; Bak, Fransen, Jansen & Drukker, 2014). In this study “family members” means parents, guardians and next of kin, including any relatives closer to the MHCUs.

- **Involvement**

The act of taking part in something you care about (Wehmeier, 2005; Bak et al, 2014). In this study “involvement” means visiting and making decisions in caring for MHCUs who are admitted in long-term mental health hospitals.

- **Caring**

Caring is a sense and it displays empathy and concern of others that requires actions (Lachman 2012 cited in Roland, 2014). In this study, “caring” means providing mental healthcare services to a person diagnosed with mental illness in a long-term mental health hospital.

- **Mental Health Care users**

A person receiving care, treatment and rehabilitation services or using health services at a health establishment aimed at enhancing the mental health status of a user (South Africa, 2002). In this study “MHCUs” means person with mental illness, admitted in a mental health hospital to receive care, treatment and rehabilitation.

- **Long-term Mental Health institutions**

Facilities, buildings or residence where persons receive continuous care, treatment, rehabilitative assistance, diagnostic or therapeutic interventions or other health services and includes services such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals (South Africa, 2002). In this study long-term Mental Health Care institutions means

Mental Health Care hospitals providing continuous care, treatment, rehabilitation (Evuxakeni, Hayani & Tabamoo) in Limpopo Province.

1.11 RESEARCH DESIGN

The researcher used a mixed method research design, due to the nature of data which combines the qualitative and quantitative characteristics as supported by Creswell and Clark (2011). In this study an exploratory and descriptive mixed methods research was used to supplement each other. Exploratory studies are intended to increase knowledge in a specific field of study, in cases where little previous research has been piloted (Babbie & Mouton 2003 cited in Du Toit & Mouton, 2013).

Descriptive studies have as their main objective the representation of that which is being studied; be it persons, status quo or groups (Burns & Grove 2001 cited in Tobor, 2014). In addition a convergent design was used to acquire different but balancing data on the same topic to best comprehend the research problem (Morse, 1991 in Creswell et al., 2009).

The current study is divided into three phases:

Phase one, addresses objectives one, two and three. In stage one, a qualitative study was conducted to determine the factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province; and to explore and describe the views of MHCUs regarding the involvement of family members while in long-term mental health institutions in Limpopo Province.

During stage two, a quantitative study was conducted to explore and describe the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

Phase two addresses the purpose of the study: to develop a model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province under the following headings:

- Concept analysis
- Model development
- Description of the model

Phase three addresses model validation.

1.11.1 Population

Phase one: stage one

The target population comprised all family members of MHCUs admitted at the selected mental health hospitals of Limpopo Province and MHCUs admitted for long-term mental health care.

Phase one: stage two

Target population were all nurses working at Evuxakeni, Hayani and Thabampoopo Mental Health Hospitals.

Phase two

Concept analysis and model development

Phase three

For validation the target population comprises of all professional nurses working at the selected Mental Health Hospitals.

1.11.2 Sampling

In this study, non-probability stratified purposive sampling was used to select participants from corresponding target populations, namely family members and MHCUs as well as probability stratified random sampling to select nurses for phases respectively.

1.11.3 Data collection and instruments

For phase one: stage one, data was collected by means of unstructured in-depth interviews with the family members and focus group discussions (FGDs) with the MHCUs. In phase one stage two and phase three data was collected by means of self-administered questionnaires from nurses.

1.11.4 Trustworthiness of the data obtained in phase one

Trustworthiness in this study was ensured by applying Lincoln and Cuba's criteria for judging the quality in qualitative research. The four constructs namely, credibility, transferability, dependability and conformability were applied and described in detail in chapter three. Credibility was ensured through prolonged and varied field experience, collected data until data saturation is attained, member checking, interview technique and referential adequacy (Polit et al., 2009; Gunawan, 2015).

Dependability was ensured by doing an inquiry audit when an enquiry of the data and appropriate supporting documents were done by an external reviewer as well as using the voice recorder and the transcripts which was available to the external auditor for verification if it is necessary. Confirmability was ensured by conducting the interview until data saturation was attained and an audit trail was develop which was a systemic collection

of documentation. Transferability was ensured by describing the research setting richly and thoroughly, and also describing what transpired during the interviews in detail (Polit et al., 2009; Gunawan, 2015).

1.11.5 Validity and reliability for phase two

Validity was ensured by conducting a literature review and providing operational definitions of key concepts. The researcher ensured validity by applying basic ways to assess the validity of an instrument that include face, criterion, content and construct validity. To ensure face validity, the researcher submitted a measuring instrument to experts who judged the instrument based on their knowledge and experience in mental health. For criterion validity, the researcher structured questions on the instrument that were, for the greatest part, modified, and reassembled that link with the objectives of the study.

In order to ensure content validity the, developed questionnaire was given to some experts in mental health to scrutinize the content in relation to the study objectives. Furthermore, construct of the instrument was based on logical relationship among variables and theory underlying it. The researcher has ensured that the information in the questionnaire is reliable and valid, based on current research. The researcher has ensured the reliability by developing the questionnaire from existing ones in consultation with the supervisors.

1.11.6 Data analysis

For phase one stage one, the researcher used Tech's Technique to analyse the data. During data reduction, the richness of the data was maintained. The themes and patterns from the data were identified (Burns & Grove, 2011). In

phase one stage two and phase three, data was analysed by a statistician by means of Statistical Product and Service Solution version 22 (SPSS). Finally, the researcher interpreted how the combined results answer the qualitative and quantitative, and mixed methods questions (Creswell et al., 2009).

1.11.6 Ethical considerations

In this study, ethical procedures encompasses ethical clearance, approval to conduct the study, quality of the researcher and the research project. Confidentiality, anonymity and informed consent. In addition, are deliberated in detail in chapter three.

1.12 OUTLINE OF THE DISSERTATION

The study comprises of eight chapters, set out as follows:

Chapter 1: Orientation to the Study

It is an introductory chapter. It discusses the background, rationale, significance of the study, problem statement, purpose of the study, research questions, objectives, conceptual framework, definition of concepts, the outline of the dissertation, a brief description of research design, trustworthiness as well as ethical consideration.

Chapter 2: Literature Review

This chapter discusses the literature review related to the topic of family involvement in caring for MHCUs in long-term mental health institutions of Limpopo Province, South Africa.

Chapter 3: Research Methodology

An overview of the methodology used in phase one, two and three are presented. This chapter designates the research design, population, sampling, data collection and data analysis of this study. Ethical considerations and measures to provide trustworthiness are also deliberated.

Chapter 4: Data Analysis, Interpretation and Discussion

The findings of the study were analysed, interpreted and controlled through the literature.

Chapter 5: Concept analysis

This chapter discussed the concept analysis of phase three utilised in this study.

Chapter 6: Model development

This chapter discussed the model development and description of phase two utilised in this study.

Chapter 7: Model validation, justification of the original contribution to the body of knowledge

This chapter discussed the model evaluation of phase three utilised in this study. This chapter also focuses on the justification and contribution to the body of knowledge.

Chapter 8: Limitations, Recommendations and Conclusion

This chapter provides the conclusion, including strengths and limitations of the research findings. There are also recommendations with reference to the presented research, guidelines to operationalize the model and future research.

1.13 CONCLUSION

In this chapter the following aspects have been discussed. The introduction and background; rationale and significance of the study; problem statement, purpose of the study, research questions, objectives, conceptual framework, definition of concepts; the outline of the dissertation; and a brief description of research design, trustworthiness and ethical consideration as well as outline of the dissertation. Chapter two will discuss the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Previous chapter introduction and background; rationale and significance of the study; problem statement, purpose of the study, research questions, objectives, conceptual framework, definition of concepts; the outline of the dissertation; and a brief description of research design, trustworthiness and ethical consideration as well as outline of the dissertation. This chapter discusses review of literature on research relevant to family involvement in caring for MHCUs in long-term mental health institutions. Various authors defined literature review as a process of finding, reading, understanding and forming conclusions about published research methodology and theory by authoritative scholars on a particular topic. A literature review ascertains and compares prior studies, and helps to evade duplication and preventable repetition (De Vos et al., 2011; Babbie & Mouton, 2003; Burns, Grove & Gray 2011).

The researcher reviewed literature that identifies the research problem and studies with similar topics and content to avoid duplication. However, due to the progressively more growing amount literature in the field of health. According to Souza, Silva and Carvalho (2010); Whitemore and Knafel (2005) researchers need to construct all types of literature review that include systematic review, meta-analysis integrative qualitative reviews. Systematic reviews defined as research reviews that combine the evidence of multiple studies regarding a specific clinical problem to inform clinical practice.

However, the systematic method is special for evidence-based practice initiatives that requires a well specified clinical question, explicit methods, and a comprehensive search for relevant primary studies. Meta-analysis refers to a research review method that associates the evidence of multiple major studies by engaging statistical approaches, thus improving the independence and validity of outcomes. Integrative review method is the only approach that allows for the combination of diverse methodologies, and has the potential to play a greater role in evidence-based practice for nursing. With respect to the integrative review method, strategies to enhance data collection and extraction have been developed (Whittemore & Knafl, 2005; Souza et al. 2010).

In this study, integrative literature review methodology was used to provide synthesis of knowledge and applicability of results of significant studies into practice. In addition, integrative literature review was used to integrate extensive variety of purposes such as defining concepts, to review theories and evidence, as well as to analysing practical issues of family involvement in caring for MHCUs in long-term Mental Healthcare institutions (Whittemore & Knafl, 2005).

Books, journals, the internet, reports as well as extracts ranging from 2005 to 2015 pertaining to family involvement in caring for MHCUs in long-term Mental Healthcare institutions was reviewed. However, the terms “relatives” and “family members” were thus used with regard to the relatives involved. In addition, the term caregiver was widely used. However, it applies to both health personnel and non-professionals. Caring for another person means to be somehow involved (Weimand, 2010). In this study, the literature review will be guided by objectives and Thornton’s Model of WPC theoretical framework.

The literature review has been discussed under the following headings:

- History of mental illness
- Factors contributing to insufficient family involvement in mental health care
- Nurses' role in mental health care
- Promoting involvement of the family members in long-term mental health care
- Perceptions of family members regarding mentally ill patients
- Views of MHCUs regarding the involvement of their family members in mental healthcare

2.2 HISTORY OF MENTAL ILLNESS

A study by Foershner (2010) highlighted the history of mental illness, which revealed that various attempts to treat mental illness, such as the discovery of trephined skulls in regions dated back as early as 5000 BC, were household to prehistoric world cultures. The author indicated that it was extensively believed that mental illness was a consequence of supernatural phenomenon such as spiritual or demonic custody, bewitchment, the immoral eye or an angry divinity, and so responded with equally mystical and sometimes brutal, treatment (Foershner, 2010).

The study found that trephining first occurred in Neolithic time, of which a hole or trephine was chipped into the skull using a crude stone instrument procedure to treat mental illness. It was believed that through this trephining

of the skull, the evil spirit thought to be dwelling in an individual's head and triggering their psychopathology to be released and the individual, would be cured (Foershner, 2010).

Funk (2016) indicated that mental illness is a complex issue, and the successful treatment of different psychiatric disorders often incorporates multiple types of therapy. Mental healthcare programmes (MHP) involve health care professionals, students in various health service discipline, community members, families and parents in the decision-making procedure. This was also supported by the reports on the National Alliance for the Mentally Ill's legislative initiatives aimed at establishing a model system of mental health care based on recovery-oriented programs: involvement of consumers and family members on state mental health planning (Monroe-DeVita, Morse & Bond, 2012).

A study by Berthelsen, Lindhardt and Frederiksen (2014) found that the support of family members and relatives on mental health is crucial. However, the study also reflected that knowledge is needed to reinforce their involvement in advance treatment programmes. These revealed that there is a gap in the involvement of family members in mental healthcare. Probabilities are that WPC theory revealed that MHCUs are an energy field that is built-up, infinite, and spiritual in quintessence, and in constant mutual process with the environment. In addition, MHCUs demonstrate unique physical, mental, emotional, and social/relational patterns that are interrelated, inseparable, and continually evolving families (Thornton, 2013).

This mixed method study promoted the involvement of family members in caring for MHCUs, thus improving the quality of nursing care at the selected mental health care hospitals in Limpopo Province. A convergent parallel mixed methods research design was used, both qualitative and quantitative data were collected simultaneously and analysed separately and merged.

2.3 FACTORS CONTRIBUTING TO INSUFFICIENT INVOLVEMENT OF THE FAMILY MEMBERS IN MENTAL HEALTHCARE

A qualitative study by Eassom, Giacco, Dirik and Priebe (2014) to synthesise the substantiation on implementing involvement of the family members in the mental health services, revealed different forms, reliant on the level of need and convenience of services. It also found that nurses offer family members psychosocial education, consultation, family interventions and therapies. However, it also found that family members are significant in treatment planning. They also recognise patient relapse and response to early warning signs and further assistance in accessing MHCUs for appropriate intervention (Eassom et al., 2014).

The study also revealed that family involvement leads to better outcomes from psychosocial therapies and medication. Yet, a quantitative and qualitative studies to explore and describe the experiences of MHCUs reported that families feel marginalised in the care planning process of their family members who are mentally ill. The study found that family members also feel that confidentiality is used by nurses as a way to withhold information (Eassom et al., 2014).

However, it was shown that family therapy as a treatment approach is startlingly under-implemented the mental health practices. Therefore, the study contributed to poor contact between nurses and family members, as family also feel unaccepted and unwilling to be involved in the treatment and care of their mentally ill relatives; these families only respond to telephone calls during crisis periods (Eassom et al., 2014). In South Africa, particularly where the study focused, the factors contributing to insufficient involvement of the family members in caring MHCUs have been determined and described.

2.3.1 Attitude of family members

A study conducted in China to clarify the concept of expressed emotion and its application to family members with mentally-ill patients found that expressed emotion has been a useful construct for understanding the quality of involving the family members in mental healthcare. The study revealed that family members were more negative towards mental illness than MHCUs' friends, hence this affects the quality of mental health care (Sun, Fan, Nie, Zhang, Huang, He & Rosenheck, 2014). Furthermore, study suggested that family members should be accountable and take full responsibility to support their love ones with mental illness (Sun et al., 2014). In this study, the attitude of the family regarding caring for MHCUs were determined.

2.3.2 Stigma

A study by Evavold (2003 cited in Rall, 2017) revealed that family members with mentally ill individuals found that accessing mental health care was relatively easy. However, mentally ill patients were taken voluntarily or involuntarily to mental hospitals. It was further found that in many cases, the patients were hospitalised for long period, for the rest of their lives. In addition,

family members had limited time to interact with the patients. Families were told the patient might never return home (Evavold, 2003 cited in Rall, 2017). Therefore, visiting the patient was also discouraged for several reasons. It was believed that families often caused the patient to relapse and become agitated. Furthermore, families were expected to be care givers of their loved ones and fulfil caretaking responsibilities as family members.

However, it was shown that the implication of psychotropic medications and deinstitutionalization have had a great impact on mental healthcare. It was estimated that 65 percent of the discharged mentally ill patients, were a result of interacting with their families (Rall, 2017). In this study perceptions of nurses regarding the involvement of family members and perceptions of family members on interaction with their MHCUs in long-term mental healthcare hospitals were described.

However, patients in acute situations were referred to the families directly, after assessment and diagnosed of certain conditions, or secondarily after a hospitalization, for specific days or particular weeks. Nurses, social workers as MDT members are accountable for mental health care all through home visits. Sustenance is similar to that undertaken within the full-time hospitalization unit to be found in the hospital. In addition, study identified that there was insufficiently relationship between the MHCUs and their families (Tanskanen, Morant, Hinton, Lloyd-Evans, Crosby, Killaspy, Raine, Pilling, & Johnson, 2011).

2.3.3 Organisation management

A study by Eassom et al. (2014) found that obstructive attitudes of hospital directors and nurses were restraining the implementation of family involvement. It was further found that management culture neglects family members by active opposition, not committed to overcome challenges experience by family members. However, the value emerged from having regular MDT meetings to address the significance of developing strategies to prioritise family involvement in a clinical practice. The study found that routine assessment of all family members will give MDT a chance to ask questions to the families that will provide reliable data when conducting patient reviews (Eassom et al., 2014).

Furthermore, the study found that nurses lack adequate supervision and training. These barriers hinder involvement of the family members. Nurses reported that they lack skills and confidence to involve the family members. However, some problems of service delivery such as managing family dynamics also emerged; for example it was found that staff skills and experience may also be influenced by supervision (Eassom et al., 2014).

Moreover, the nurses also reported that the value of belief in the nursing approach and having an identity in their role is also influenced by on-going supervision support to help nurses to involve family members (Eassom et al., 2014). In this study, a model to promote family involvement in caring MHCUs in long-term mental health hospital was developed. Probabilities are that in caring for MHCUs, their unique physical, mental, emotional, and social/relational patterns requires family members to be involved (Thornton, 2013).

2.3.4 Collaboration of MDT within the organisation

A study by Eassom et al. (2014) found that MDT attitudes, commitment and cooperation affect team members trained in family intervention. It was also found that collaboration was often lacking and requires the whole team to be committed to involve families. However, in cases, where some patients do not have family members, it was reported that other professionals resist making referrals, family involvement is forgotten and the families themselves become resistant when involved. Therefore, acting as a facilitator was seen to be promotion of family involvement (Eassom et al., 2014).

In this study, factors contributing to insufficient involvement of the family members in caring MHCUs was determined. However, previous studies suggested that support and training of nurses to carry out family involvement is important for the improvement of the quality of mental health care. The study also found that in order to implement family involvement effectively, all MDT members should be trained and regularly supervised (Eassom et al., 2014). In this study, the contributing factors to insufficient involvement of the family members in caring for MHCUs were determined and described.

A study by Eassom et al. (2014) also found that from the staff perspective, the organisational culture, organisational attitudes and paradigms, practical needs associated with family members, management culture, training needs, team attitudes, commitment and multidisciplinary cooperation, are the major problems. In addition, it was found that the organisational culture and experience of implementing family involvement were characterised by isolation of family members in the mental health system (Eassom et al., 2014).

The study also found that mental health professionals did not value or prioritise the involvement of family members. However, multidisciplinary cooperation and working systems are not in place. Thus practical burdens associated with family involvement were sometimes inseparable. The study concluded that in order to mirror the existing challenges, family involvement should take place to change the culture of family intervention (Eassom et al., 2014).

Regarding organisational attitudes and paradigms, the study found that family involvement was not valued; rather family seemed to be neglected. Furthermore, nurses find it difficult to collaborate with the family members; thus giving up the role of the didactic problem solver. It was also found that the practical needs associated with family work requires time, resources and funding, and is difficult to integrate these with other departments in areas with high demands and crises intervention (Eassom et al., 2014). In addition, lack of systems and structure for carrying out and recording family members who interact with their patient with mental illness, was a major challenge for the implementation and solving of patient's problems (Eassom et al., 2014).

However, some of the information that are found in other countries is exactly what is happening in Limpopo Province where the study focused. Whole-person caring is the delivery of care and services to endorse well-being. In addition, the WPC is based on the concepts of blessedness of being; therapeutic partnering; self-care and self-healing; optimal whole-person nourishment; transformational health care leadership; and caring as a sacred practice (Thornton, 2013). In this study, factors contributing to insufficient involvement of the family members in caring for MHCUs were determined and described.

2.4 NURSES' ROLE IN MENTAL HEALTHCARE

Fung, Chan and Chien (2014) conducted a study to identify interventions by psychiatric nurses in advanced practice. The study found that psychiatric nurses play significant multifaceted roles and provide mental health care services in various contexts. The study further revealed that the nurses are able to manage clients with different mental disorders. In addition, the study showed that nurses involve family members for pre-discharged MHCUs in order to identify predisposing factors that need urgent intervention (Fung et al., 2014).

2.4.1 Family support

A study by Blythe and White (2012) revealed that the role of the mental health nurse with regards to physical health care, intervention, and attaining the necessary knowledge also involves the families of mentally ill patients. It was found that the physical health-care of MHCUs is not supported. In addition, it was found that when the user is granted LOA, there is no personal hygiene supervision at home. MHCUs came back from LOA with dirty clothing, saying the user refuses to bath. However, the long-term mental healthcare setting allows patients to be rehabilitated and be independent under supervision to meet their physical health needs (Blythe & White, 2012).

2.4.2 Stress

A study by Zobi (2010) revealed that nurses work in an environment of understaffing and attrition, which leads to reduced job satisfaction. However, the shortage of nurses in South African hospitals leads to nurses working in stressful situations to overcome the work load of existing staff members. It was found that this raises the level of stress, fatigue and emotional exhaustion, and also affects the quality and safety of patient care (Yumna,

2010:18). Fung et al. (2014) conducted a study to identify mediations by psychiatric nurses in advanced practice. The study revealed that the nurses play a significant role in handling clients with depression and psychological stress, and demonstrate their value when developing corporations with non-mental health service providers.

The same study discovered that the nurses play an insignificant role in performing temporary care for pre-discharged mental health service users (Fung et al., 2014). Weimand, Sällström, Hall-Lord and Hedelin (2013) conducted a study to describe nurses' perceptions about supporting family members of patients with mental illness. The study revealed an ultimate premise to the nurses' possibilities of supporting families. The study also identified three descriptive categories that show areas of significance to this proposition: the context framing the nursing care, aspects of the actors, and relational concerns. The study found that nurses have challenges in supporting family members (Weimand et al., 2013).

Regarding the context edging the nursing care, the study indicated that the common view on mental illness within mental healthcare, the routines, and legislation affected the nurses' perceptions. In addition, study also indicated that families and relatives of MHCUs were excluded in mental health care. However, there was an opportunity for nurses to support family members such as observing patients' rights (Weimand et al., 2013).

It was found that some of the MHCUs are manipulative and adopt patients' rights as an excuse to treatment, while ignoring the responsibilities of patients in treatment and care. However, nurses sometimes managed to share some information and support mental patients emotionally, paying attention and

listening to them (Weimand et al., 2013). Confidentiality was found to be a major concern, which sometimes made it difficult or impossible to inform family members. Moreover, it was found that nurses sometimes have a challenge in breaking confidentiality in order to support family members (Weimand et al., 2018).

Furthermore, the study found that cultural beliefs were viewed as challenging because the nurses lacked the knowledge needed to understand their points of view. It was found that nurses had a challenge on being responsible for cultural activities since they sometimes do not even understand what the family members are saying. However, nurses in general and individuals' views of family members were influenced by their personal and professional experiences. The authors indicated that maturity and courage could also encourage them to share information and listen to family members, even those who were considered to be difficult to deal with (Weimand et al., 2013).

Yet, it was found that most of the psychiatric nurses experience problems in caring for MHCUs with HIV/AIDS. This may be an outcome of MHCUs lack of the support they need from family members (Chorwe-Sungani, Shangase & Chilinda, 2014). This was supported by Berthelsen, Lindhardt and Frederiksen (2014) who reported that family support on mental health may assist nurses to identify challenges that may delay patient recovery. In this study, the nurses described their perceptions regarding the involvement of the family members in caring for MHCUs in long-term mental health hospitals. The WPC theoretical framework revealed that the spiritual dimension as the essence of self and also transcends the self. It is nursing's closest, most direct experience of the universal life force (Thornton, 2013).

2.5 PROMOTING THE INVOLVEMENT OF THE FAMILY MEMBERS IN LONG-TERM MENTAL HEALTHCARE

Family involvement models have been developed in the provision of professional care and treatment within psychiatric and mental health services in various parts of Sweden (Cullberg, Levander & Holmqvist; 2002, Malm, Ivarsson & Allebeck, 2003; Pippo & Aaltonen 2004 in Castaño, 2014). However, it was found that a national follow-up from a different perspective may be of great value to obtain an overall picture of mental health from the patients, healthcare professionals and organisations (Ewertzon et al., 2010).

This may limit or enable the family members' participation in the professional care. Therefore, it should be noted that this study will also promote the involvement of the family members in caring for MHCUs in long-term mental health care hospitals. The office of the Nursing and Midwifery Services Director conducted a study on the role of the psychiatric nurse in the implementation of A Vision for Change in Ireland (Cusack & Killoury, 2012).

The report proposed a widespread model of mental health care service and recommended that an integrated multidisciplinary approach should address the biological, psychological and social factors that contribute to mental health difficulties. The study also highlighted that psychiatric nurses are the largest profession working in mental health services 24 hours as core mental health professionals who deliver comprehensive mental health care. Furthermore, all the other health professionals depend on nurses, including the family members and community as a whole (Cusack & Killoury, 2012).

A study by Tanskanen et al (2011) revealed that all European countries have advanced strategies to strengthen the outmoded hospital-based model of mental healthcare and have also developed mental health facilities in the public for people with severe mental disorders. The study found that facilities and programmes to endorse social insertion were unified within the community. However, care, treatment and rehabilitation were also endorsed through a wide series of activities, including family therapy (Tanskanen et al., 2011). In this study, a model to promote family involvement in caring for MHCUs in long-term mental health hospitals was developed.

2.5.1 Mental Health Care Act

The Mental Health Care Act no 17 of 2002 entitles MHCUs to legal representation and to be informed of their rights. (South Africa, 2002). However, the right to health is central to the physical and mental well-being of all individuals and is an obligatory condition for the exercise of other human rights, including the detection of an adequate standard of living. Mental Health can be conceptualized as a state of well-being in which individuals realize their own aptitudes, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community (WHO, 2005).

The main purpose of the Act is to standardise, fit in, co-ordinate access to mental healthcare, treatment and rehabilitation services on a non-discriminatory basis. This Act also focuses on the development of community, district and regional mental health services; de-institutionalization from long-term mental health hospitals through the development of family and community support services (South Africa, 2002). In addition, legislation also regulates the family members to be involved in the development of mental health policy and legislation, as well as planning mental healthcare services.

Chapter III of the Mental Health Care Act, 17 of 2002, on the rights of people with mental illness, specifies that mentally ill people have the following rights in addition to any rights under other statutes:

Respect, human dignity and privacy

The person, human dignity and privacy of every MHCU is an obligation to be respected and the facilities directed to them must be comparable to their mental health condition, and may intrude only as little as possible to give effect to the suitable care, treatment and rehabilitation (South Africa, 2002).

Consent to care, treatment and rehabilitation services and admission to health care establishments

A MHCU must consent to the care, treatment and rehabilitation services or to admittance, except due to mental illness. Any postponement in providing care, treatment and rehabilitation services or admission may result in the bereavement or be damaging to the health of the user and others. Care, treatment and rehabilitation services may not be used as chastisement or for the expediency of other people (South Africa, 2002).

Unfair discrimination

A MHCU may not be deceitfully discriminated against on the grounds of his or her mental health status, and must receive care, treatment and rehabilitation services according to those services applicable to any other health care user (South Africa, 2002).

Exploitation and abuse

Every health care provider or health establishment should ensure that MHCUs are protected from exploitation, abuse or any degrading care, treatment and rehabilitation are not used as punishment; and also ensure that MHCUs are not subjected to forced labour.

Therefore, any person witnessing MHCUs being abused should report in a prescribed manner (South Africa, 2002).

Determinations concerning mental health status

Determinations concerning mental health status of MHCUs should only be made or referred for the purpose relevant to the mental health status or for the purpose of providing weight of Criminal Procedure Act, not on socio-political, economic status, racial or sacred background or kinship (South Africa, 2002).

Disclosure of information

A person or health institution may not divulge any information which a MHCU is permitted to keep confidential in relation to any other statute (South Africa, 2002).

Limitation on intimate adult relationship

The conditions subjected to providing care, treatment and rehabilitation services in health establishments revealed that the head of a health institution may limit intimate relationships of adult MHCU only if due to mental illness, the ability of MHCUs to consent is diminished (South Africa, 2002).

Right to representation

MHCUs are entitled to a representative, including when submitting an application, lodging an appeal or appearing before a magistrate, judge or Review Board subjected to laws governing rights of appearance in a court of law (South Africa, 2002).

Discharge report

MHCUs admitted for the purpose of receiving care, treatment and rehabilitation have a right to be discharged in a prescribed form by the health establishment (South Africa, 2002).

Knowledge of rights

MHCUs have a right to be informed of their rights, unless admitted due to mental illness. In this study, MHCUs, family members and nurses will describe factors that contribute to poor involvement of family members in long-term mental health care. Molinaro, Solomon, Mannion, Cantwell and Evans (2012) have developed standards to promote family involvement in Philadelphia; although the mental health programmes vary widely. Family support is significant in mental health. However, it was found that there are barriers to implementing the family involvement standards within the hospitals. Therefore, strategies to promote changes in nursing practices through family involvement were developed through pilot projects (Molinaro et al., 2012).

In this study, nurses described their perception regarding families' role in caring for MHCUs. The family members described their perception regarding being involved in caring of MHCUs. Thus MHCUs also described their perception regarding the involvement of patients' family members in mental health institutions. These enabled the researcher to develop a model to promote family involvement in mental health care. The WPC theory revealed that a person and environment are in a state of constant mutual process, there is no distinction from an energetic perspective (Thornton, 2013). Study assumptions are that in caring for MHCUs, family members should pay visits to the mental health care institutions in order to interact with them.

2.6 PERCEPTIONS OF FAMILY MEMBERS IN THE CARE OF MENTALLY-ILL PATIENTS.

A study conducted by Ewertzon et al. (2010) revealed that the involvement of family members in long-term mental healthcare is an important aspect in the recovery of patients with mental illness and subsequently reduces the burden on the family members with mentally ill relatives. It was found that the majority of members believe that they have insufficient opportunities to participate in long-term mental health treatment at any level. The majority of family members seem to be satisfied with the level of mental healthcare in hospitals (Ewertzon et al., 2010).

Yet, family members' experiences with the mental healthcare professionals' approach may influence their feelings of being involved or not. This is similar to the qualitative study by Goodwin and Happell (2007 cited in Angel & Frederiksen, 2015) who argued that good communication skills and respect are important aspects of the families' experience on being involved in mental health care. Therefore, respect and attitude of nurses are regarded as central aspects in the involvement of the family members. In this study, the family members described their perceptions regarding their involvement in caring for MHCUs in long-term mental health hospitals.

2.6.1 Role of Family members in Mental Health Care

According to Pradeep (2008 cited in Kochher & Bhakhry, 2015) a family unit is an essential variable in the onset, progression, treatment and outcome of mental illness. According to Pradeep various researchers have been explored to understand the role of family members in the management of mental disorders. The study found that family members contributed to the

development of mental disorders over the past decade. When an individual is affected by mental illness, the whole family is also affected. It was found that family members should be involved in mental health care to support and supervise treatment compliance (Pradeep, 2008 cited in Kochher & Bhakhry, 2015). Thus, this study developed a model to promote the involvement of the family members in caring for MHCUs in long-term mental health care hospitals.

2.6.2 Stress

Family members with mentally ill patients experience subjective distress, when caring for a family member with mental illness. Both (family member and mentally ill patients) reward and challenge the responsibility of the family. However, it was believed that the patient may be able to take control over the illness through treatment compliance. The study found that prognosis of the illness should involve the family members (Pradeep, 2008 cited in Kochher & Bhakhry, 2015).

The researcher indicated that the family is a reliable source to provide patients' information about the illness. It was found that this also facilitates the treatment plan. The role of the family is helping to supervise treatment at home, family involvement in rehabilitation programmes and promoting patient recovery and also minimise dependency (Pradeep, 2008 cited in Kochher & Bhakhry, 2015). This was also supported by Makua (2006 cited in Aphané, 2015) who conducted a study to explore and describe the role of families in supporting their mentally ill patients. The Study identified five themes that stress the family members who are involved in mental healthcare.

Study found that physical, psychosocial, financial and developmental support and frustration are experienced by the family members (Makua, 2006:27 cited in Aphane, 2015:4). In this study, family members described their perceptions regarding being involved in caring for MHCUs in long-term mental health hospitals.

2.6.3 Physical support

According to Makua (2006 cited in Aphane, 2015) family members are bound to provide physical support to their mentally ill patients, even when they are not physically well. However, their own health condition challenges the provision of physical support both, physical and mental. Makua's findings correlate those of Nemecek, who found that family members offer physical support to their mentally ill patients, while at the same time trying to go about their daily living activities (Nemecek, 2004 cited in Detweiler, Sharma, Detweiler, Murphy, Lane, Carman, Chudhary, Halling & Kim, 2012).

The study found that mentally ill patients definitely spend their money and presume the families to provide them with basic needs. It was found that mentally ill patients decline to collect medication at the clinic and thus need supervision to comply with treatment. However, the physical support includes challenges such as: excessive appetite, physical aggression, abusing patients' rights by refusing treatment. It found that mentally ill patients also refuse to maintain personal hygiene (Aphane, 2015). In this study, family members described their perceptions regarding being involved in caring for MHCUs in long-term mental health hospitals.

A study by Berg-Weger (2000 cited in Mayberry & Heflinger, 2013) revealed that family members are at increased risk of mental and physical health deterioration. The findings correlate with those to the study in USA, which revealed that family members of patients with mental illness have poor physical health as well as limited activity more often than family members without mentally ill patients. However, these studies have also presented that people with severe mental illness are more inclined to become victims of ferocious crime. The study found that violence is a stressor that affects family members, both emotionally and physically (Baldassanol, 2004 cited in Grover, Chakrabarti, Ghormode & Dutt, 2015).

Moreover, among violent patients admitted into psychiatric institutions, research shows that 50 percent are related to family members with mentally ill patients (Teplin, McClelland & Linda, 2005 cited in Sherry, 2016). Therefore, the researcher assumes that family members are at risk of physical harm. In this study, family members described their perceptions regarding being involved in caring for MHCUs in long-term mental health hospitals.

2.6.4 Psychosocial support

According to Makua psychosocial support is a source of stress that affects the family member's social lives. However, it was found that families offer sustenance to their mentally ill patients without the knowledge and skills to provide proper support or coping mechanisms (Makua, 2006 in Aphane, 2015). This finding correlates with that of the study by Kritzinger and Magaqa, who found that families of patients with mental illness suffer social isolation. However, it was found that family members are restricted from attending personal events such as church services, funerals and other important traditional gatherings due to the support of their mentally ill patients.

Furthermore, Makua's study revealed that nonexistence of libido; mood disruption and substance abuse also challenge psychosocial support (Kritzinger & Magaqa 2000 cited in Sturgeon, 2014). Marimbe-Dube (2013) indicated that families with mentally ill patients are also overwhelmed by lack of social support from nurses, resulting in the family members feeling unsupported and being restricted from their daily living activities.

However, it was found that frustration in supervising treatment compliance, coping with altered interpersonal behaviour and fatigue from continuous supervision of their mental ill patients, added to family members' burden. In addition, family members were found to have great anxiety due to fear that their mentally ill patients might attempt suicide (Marimbe-Dube, 2013). In this study, family members described their perceptions regarding being involved in caring for MHCUs in long-term mental health hospitals.

2.6.5 Financial support

However, the financial sustenance that the family members afford, included giving their mentally ill patients money to buy tobacco. The study revealed that family members are also responsible for the grant of their mentally ill patients and their ability to control money effectively (Makua, 2006 cited in Aphane, 2015). According to Makua family members experience difficulties in upholding employment and supporting their mentally ill patients. Therefore, it was concluded that family members rely on government grant, which is insufficient to cater for basic needs including education of siblings (Makua, 2006 cited in Aphane, 2015).

Makua also highlighted that mentally ill patients struggle to maintain the rest of the family. However, the study found that these patients sometimes destroy people's property due to relapses and that leads the owners to claim back the money to repair the property from the family member. Therefore, their grant is spent on repairing property. It was found that some refuse the disability grant and depend on the family members for financial support. The study discovered that the challenges of financial support also include selling their belongings and being financially exhausted (Makua, 2006 cited in Aphane, 2015).

These findings correlate with those of Biegel and Schulz (1999 cited in Marimbe-Dube, 2013) who found that mentally ill patients damage properties, which results in loss of productivity for the family members. A study by Osaka, Altman, Ekblad, Katz, Nguyen, Rosenfeld, Williamson & Tapera (2010 cited in Marimbe, Kajawu, Muchirahondo, Cowan, & Lund, 2016) found that family members of mentally ill patients have a heavier burden that was associated with the educational level and age of their patient. The researchers found that this was due to the cost of looking after the patient and the cost of mental health services, out of their pockets, without assistance from their mentally ill patient (Osaka et al., 2010 cited in Marimbe, 2016). In this study, family members described their perceptions of being involved in caring for MHCUs in long-term mental health hospitals.

2.6.6 Developmental support

The misconception of associating mental illness with witchcraft was found to affect families. However, it was also believed that when a client does not respond to psychiatric treatment, family members become frustrated. It was found that family members also lack health education on mental illness, treatment and its adverse effects. In addition, inactivity and tolerance of the

mentally ill patients frustrate the family members. It was found that mentally ill patients are not involved in daily living activities; they eat and sleep without being involved in domestic activities (Makua, 2006 cited in Aphane, 2015).

Therefore, the researcher is aware that the involvement of family members is significant in the care, treatment and rehabilitation of the patients. The researcher is also aware that rehabilitation prepares the patients and minimises dependency at home. In this study, family members also described challenges with regard to health education of mental illness and involving mentally ill patients in daily living activities.

2.6.7 Attitude of nurses

Ewertzon et al (2010) found that family members believed that nurses are not interested in the information family members wished to convey. Yet, a lack of transparency, openness and cooperation signifies experiences of being negative in nature. Similarly, it was found that family members are not invited to the planning of care. This contradicts the earlier qualitative study by Jakobsen and Severinsson (2006 cited in Bee, Brooks Fraser & Lovell 2015) which revealed that family members have experienced an inability to obtain reliable information of their mentally ill patient. In this study, the purpose of involving family members in mental health care is significant in the planning of such care. Therefore, the appropriate planning of care should also include the family members.

2.6.8 Nursing support to family members

Weimand (2012) conducted a study on the experiences and nursing support to the families of patients with severe mental illness. It was found that family member's everyday life is affected. This has a negative impact on social relationships, causes inability to be employed and financial problems. The study also revealed that the family members' experiences of sharing lives with a severely mentally ill next-of-kin are a major challenge. This was experienced as a challenging process in terms of balancing a complexity of considerations and dilemmas. Regarding their meetings with health personnel, it was found that family members had to balance their own behaviour carefully, since any unwanted approach could easily turn against them (Weimand, 2012).

However, it was found that historical negative attitudes of nurses towards involving the family members in treatment and care had not shifted. Eassom et al. (2014) revealed that nurses' attitudes against family members affect the quality of mental health care. Furthermore, facilitation of family involvement, also shifts nurses' attitudes towards the value of the family as a reliable source to solve problems (Eassom et al., 2014). According to Tanskanen et al. (2011), the provision of long-term mental health care is a major challenge within the mental health systems. Although these ailments have a low prevalence, the study found that the impression they have on individuals, families and societies is crucial (Tanskanen et al., 2011).

However, the involvement of the family members in most countries affects the expansion of community services as a multifaceted process. The study found that barriers exist at policy level. However, these may arise when there is privation of satisfactory mental health policies and statutes, or when budgets are insufficient. It was found that where there is discrimination in

contradiction of persons with mental disorders, there is inadequate health indemnification (Tanskanen et al., 2011). However, discussions above are the same with what South Africa is experiencing. In addition, the WPC theory revealed that a person demonstrates unique physical, mental, emotional, and social/relational patterns that are interrelated, inseparable, and continually evolving (Thornton, 2013). In this study, family members also described their perceptions with regard to the health education of mental illness and involving mentally ill patients in daily living activities.

2.7 VIEWS OF MHCUs REGARDING THE INVOLVEMENT OF THEIR FAMILY MEMBERS IN MENTAL HEALTHCARE

A study by Eriksen, Sundfor, Karlsson, Raholm and Arman (2012:3 cited in Cheetham, 2014), revealed that being recognized as a human being is essential even for people living with mental illness. The researchers found those mentally ill patients perceive being recognized by nurses and their relationship is a significant aspect in their recovery.

2.7.1 Nurse-patient relationship

Eriksen et al. (2012 cited in Cheetham, 2014) revealed that the relation between nurses and MHCUs is mutual and primarily the equivalent to any other affiliation in the sense that both are human beings who also recognize others as human beings. The researchers found that there is an ethical challenge to the nursing staff and that involvement encourages family members to be involved in mental healthcare.

2.7.2 Stigma

Discrimination of mental illness has also been found to be a result of blame and shame by the extended family in the form of social avoidance. However, three studies conducted in the USA reported that about a fifth to a third of family members reported strained and distant relationships with extended family members with mental illness (Marimbe-Dube, 2013). However another study in the same country found that 10 percent of the MHCUs reported occasional avoidance by family members (Phelan et al., 1998 cited in Corrigan, Druss & Perlick, 2014).

This differs from Thornicroft (2006 cited in Thompson, 2016) who found that mentally-ill patients have limited social networks and are more strongly linked to their family members and are dependent on them for their daily living activities. Therefore, the researcher assumes that limited social networks may be a result of stigma or the mental disorder itself. Furthermore, it was found that associated loneliness and social isolation may be a predisposing factor for poor patients' recovery (Thornicroft, 2006 cited in Thompson, 2016). In the present study, MHCUs described their views with regard to involvement of families of patients in mental healthcare treatment and rehabilitation.

However, the experience of being mentally ill is a fight for dignity in the face of discernment and rejection. The study found that being dependent is experienced as a problem in itself that needs a family member to be involved. However, strategies to cope with the dependence and limitations set by the mental illness also involve the family member. Furthermore, the study showed that MHCUs are concerned with their relationships to other people, their own role in relations to others and on how they believe others remark about them (Eriksen et al., 2012 cited in Cheetham, 2014).

Therefore, it is significant to consider the extent to which it will be possible and helpful in promoting the involvement of the family members in long-term mental health care. A study conducted in New Zealand, found that mentally ill patients admitted to a hospital under the legislation feel a loss of autonomy and perceive hospitalization as coercive (Zobi, 2011).

Even though it is internationally recognized that the majority of MHCUs should be treated voluntarily, under circumstances where the patients might cause significant distress and be a potential danger to themselves or others, they might be forced against their will (Moosa, & Jeenah, 2008: cited in Schoeler, Monk, Sami, Klamerus, Foglia, Brown, Camuri, Altamura, Murray & Bhattacharyya, 2016). In accordance with this MHCA, it was indicated that MHCUs may be treated involuntarily at a health establishment on an inpatient basis under very specific regulations which serve to protect the users' rights as much as possible (Moosa & Jeenah, 2016).

A study conducted in Zambia revealed that stigma and discrimination were caused by a misunderstanding of the etiology of mental illness and the perception that psychiatric patients may be dangerous (Kapungwe, Cooper, Mwanza, Mwape, Sikwese. Kakuma, Lund & Flisher, 2010 cited in Magallares, Perez-Garin, & Molero, 2016). This was supported by Kleintjes, Lund and Swartz, who conducted a study to investigate the perception of South African MHCUs policy directions and service development requirements to support patients' recovery (Kleintjes et al., 2012).

The study found priorities such as addressing stigma, discrimination and disempowerment of the family member's links between mental health and poverty. The study suggested that challenges should be addressed through

mental health awareness campaigns, legislative and patients' rights in public (Kleintjes et al., 2012). In this study, MHCUs will describe their perceptions with regard to involvement of their family members in mental health care, treatment and rehabilitation.

A study by Scheffer (2003 cited in Shu & Chen, 2011) describes stigma as experiences of patients with mental illness and their family members. It was found that stigma is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and or avoidance in patients with mental illness. However, stigma leads MHCUs to suicide, desocialisation and unemployment for patients with mental disorders. Scheffer identified labels as one of the factors contributing to stigmatisation. Furthermore, the study found that family members with mentally ill patients may be stigmatized as a result of mental illness related behaviour such as anxiety, tension and intellectual disability (Scheffer, 2003 cited in Shu & Chen, 2011).

2.7.3 Social support

A study by Berthelsen (2014) found that family support for mental health patients is important. However, knowledge is needed for the family members to strengthen their involvement in fast-track treatment programmes. The study established that family members of mentally-ill patients resolved their problems through three interchangeable behavioural modes: protecting mode that provides love and respectful support regularly; substituting mode, which encourages practical and cognitive support; and an adapting mode, where family members try to involve themselves within the mental healthcare requirements (Berthelsen et al., 2014).

Tanaka and Davidson (2015) conducted a study to understand MHCUs' narratives about nurses within a relational perspective. It was found that recovery is a personal journey. Therefore, the opportunity for success of the journey may be influenced by being recognized and good interaction with health professionals (Tanaka & Davidson 2015).

The findings correlate with those by Davidson, Rakfeldt and Strauss to describe recovery from mental illness as the restoration of meaningful and productive life (Davidson et al, 2010 cited in Fernando, 2014). However, some of the information that are found in other countries are exactly what is happening in Limpopo Province where the study focused. In this study, MHCUs described their perceptions with regard to the involvement of family members in the patients' mental healthcare treatment and rehabilitation.

2.8 CONCLUSION

This chapter discusses literature review that encompasses the following headings: History of mental illness; factors contributing to insufficient family involvement in mental health care; nurses' role in mental health care; promoting involvement of the family members in long-term mental health care; perceptions of family members regarding mentally ill patients as well as the views of MHCUs regarding the involvement of their family members in mental healthcare. Chapter three will discuss the research design.

CHAPTER 3

RESEARCH DESIGN

3.1 INTRODUCTION

The previous chapter discussed literature review undertaken for this study with the following headings: history of mental illness; factors contributing to insufficient family involvement in mental health care; nurses' role in mental health care; promoting involvement of the family members in long-term mental health care; perceptions of family members regarding mentally ill patients; and views of MHCUs regarding the involvement of their family members in mental healthcare. This chapter presents an overview of the research design that guided the scientific activities of the study. In this chapter, the mixed method research design phase one and two was utilised with regard to population and sampling; data collection and analysis; trustworthiness and ethical considerations have been discussed. Therefore, the research design will be guided by objectives and WPC theoretical framework.

A research design is a systematic plan to study a scientific problem (Gorard, 2013). Furthermore, Bless, Higson-Smith and Sithole (2013) defined research design as the plan or blueprint according to which data are collected to investigate the research question in the most economical manner. In this study a mixed method research design was used due to the nature of data which combines the qualitative and quantitative characteristics as supported by Creswell and Clark (2011). Regarding the mixed methods, Creswell and Clark (2011) argued that the qualitative approach may be given priority over the quantitative aspect, if quantitative data is much more detailed than the qualitative data.

According to Creswell and Clark (2011) if the qualitative sample is much less important than the quantitative sample, it helps the researcher to get a more comprehensive discussion through interviews than a laborious quantitative investigation of the topic.

3.2 MIXED METHOD RESEARCH DESIGN

Various authors have defined mixed methods research design as a methodology for conducting research that encompasses collecting, analysing, and assimilating or collaborating quantitative and qualitative research (and data) in a single study or a longitudinal programme of inquiry. However, several definitions of mixed methods research have merged over the years, that integrate various elements of methods, research process, philosophy; and research design (Teddlie & Tashakkori, 2003; Teddlie & Tashakkori, 2010; Johnson & Onwuegbuzie, 2004 cited in Denscombe, 2014; Creswell, Fetters & Clark, 2009; De Vos et al., 2011).

In this study a mixed methods research was used to find different but corresponding data on the same topic to best understand the research problem (Creswell, Klassen & Plano Clark, 2011). The qualitative data provided a detailed understanding of the problem while quantitative data provided a more general understanding of the problem. The qualitative understanding was required from MHCUs and their family members. It was used to explore their perspectives in greater depth, whereas quantitative understanding arose from nurses (Creswell et al., 2009). In this study a mixed methods research was used as it encouraged the researcher to collaborate across some relationships between qualitative and quantitative researchers.

Creswell et al. (2009) summarised four major types of mixed methods designs. These are as follows: exploratory, explanatory, convergent or triangulation, and embedded designs. In addition, two instances of designs that bring multiple design fundamentals together are transformative and multiphase design (Creswell et al., 2011). In this study a convergent design was used.

3.2.1 Convergent design

A convergent design is a mixed method design in which the researcher uses simultaneous timing to implement the quantitative and qualitative strands during the same phase of the research process, prioritises methods equally, and keeps the strands independent during analysis and mixes the results during overall interpretation of the data (Creswell et al., 2009; Creswell et al., 2011). According to De Vos et al. (2011), a convergent mixed method design is a one-phase design in which the researcher uses both qualitative and quantitative methods during the same time frame and with equal weight to best understand the phenomenon of interest (Creswell et al., 2009).

Convergent design take place when the researcher collects and analyses both qualitative and quantitative data during the same phase of the research process and merges the two sets of results into inclusive interpretation (Creswell et al., 2009). According to Ivankova et al. (2007 cited in De Vos et al., 2011), the triangulation/convergence is the most well-known and popular of the four mixed methods designs. It commonly involves the simultaneous, but discrete collection and analysis of quantitative and qualitative data in order to relate and contrast the different findings to see the degree to which they do or do not agree with each other (De Vos et al., 2011).

This enabled the researcher to yield additional comprehensive and well validated conclusion. The purpose of convergent design is to acquire diverse but corresponding data on the same topic to best understand the research problem. This design is used when the researcher needs to triangulate the methods by directly comparing and contrasting statistically quantitative results with qualitative findings for corroboration and validation purposes (Morse, 1991 in Creswell et al., 2009).

A convergent design also illustrates quantitative results with qualitative findings to develop a more complete understanding of phenomena and comparing multiple levels within the system (Creswell et al., 2009). The advantage of using a triangulation design is that, it makes instinctive sense. It is an efficient design in which both types of data are collected during one phase of the research at roughly the same time. Each type of data can be collected and analysed separately and independently, using techniques traditionally associated with qualitative and quantitative research. The challenge of triangulation design is that much effort and expertise are required to collect and analyse the two but separate sets of data prevalence (Creswell et al., 2009).

In this study triangulation mixed method design was used to compare quantitative results with qualitative findings to cultivate a more complete understanding of phenomena and compare multiple levels within the system. In addition the intent of using this design was to bring together the different strengths and non-overlapping weaknesses of quantitative methods with those of qualitative methods (Patton, 1990 cited in Creswell et al., 2009).

The researcher felt that there was equal value for collecting and analysing both qualitative and quantitative data to understand the problem. Furthermore, the researcher managed all-embracing data collection and analysis activities (Creswell et al., 2009). In this study, the researcher followed the procedures for convergent design that outlines the four major steps. Firstly, the researcher collected both quantitative and qualitative data about family involvement in caring for MHCUs in long-term mental health hospitals of Limpopo Province concurrently but separately (Creswell et al., 2009).

Then the researcher analysed the two sets separately and independently from each other, using typical quantitative and qualitative analytic procedures. Once the two sets of initial results were in hand, the researcher reached the point of interface and worked to merge the results. Finally, the researcher interpreted research results as to what degree and in what ways the two sets of results converge, diverge from each other, relate to each other and combine, to create a better understanding in response to the study's overall purpose.

The researcher thought to triangulate the methods by directly, comparing and contrasting quantitative statistical results with qualitative findings for corroboration and validation purposes. The researcher also wanted to compare quantitative results with qualitative findings to develop a more complete understanding of phenomena and compare multiple levels within the system (Creswell et al., 2009). In addition exploratory descriptive design was used in this study to compare quantitative results with qualitative findings to develop a model to promote family involvement in caring for MHCUs in Limpopo Province.

Exploratory design

Various authors defined exploratory design as a study conducted to investigate the phenomenon, its manifestation and related factors. Exploratory design is conducted to explore the dimensions of a phenomenon in order to gain insight in to situation (Polit et al., 2009; De Vos et al., 2011; Brink et al, 2013). In this study, the researcher explored the perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province. All factors related to family involvement in caring for MHCUs in long-term mental health institutions were explored.

Descriptive design

Descriptive design refers to the accurate description of characteristics of the population. Descriptive design involves identifying the nature of phenomenon in order to understand its relationships (Polit et al., 2009; Brink et al, 2013). In this study, the researcher described the perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province. All factors related to family involvement in caring for MHCUs in long-term mental health institutions were described.

3.3 RESEARCH SETTING

Research setting is the location in which a research study is conducted (Miller & Salkind, 2002 in Burn & Grove, 2011). The context of this study was the clinical settings at Evuxakeni, Hayani and Thabamooopo mental health hospitals of Limpopo province. Evuxakeni hospital is the only mental health care hospital in Mopani District situated in Giyani East location, section A. Evuxakeni hospital is 5, 5 km from R81 road in the Greater Giyani municipality in Mopani District. Hayani hospital is the only mental health care hospital in

Vhembe District situated opposite Makwarela in Sibasa. Hayani hospital is 6, 5 km from R524 road in the Greater Thulamela municipality in Vhembe District. Thabamooipo hospital is 47 km from R81 in R37 road in Lebowakgomo. All mental health hospitals in Limpopo, (Evuxakeni) Mopani District, (Hayani) Vhembe District and (Thabamooipo) Capricorn District also admit acute psychiatric MHCUs.

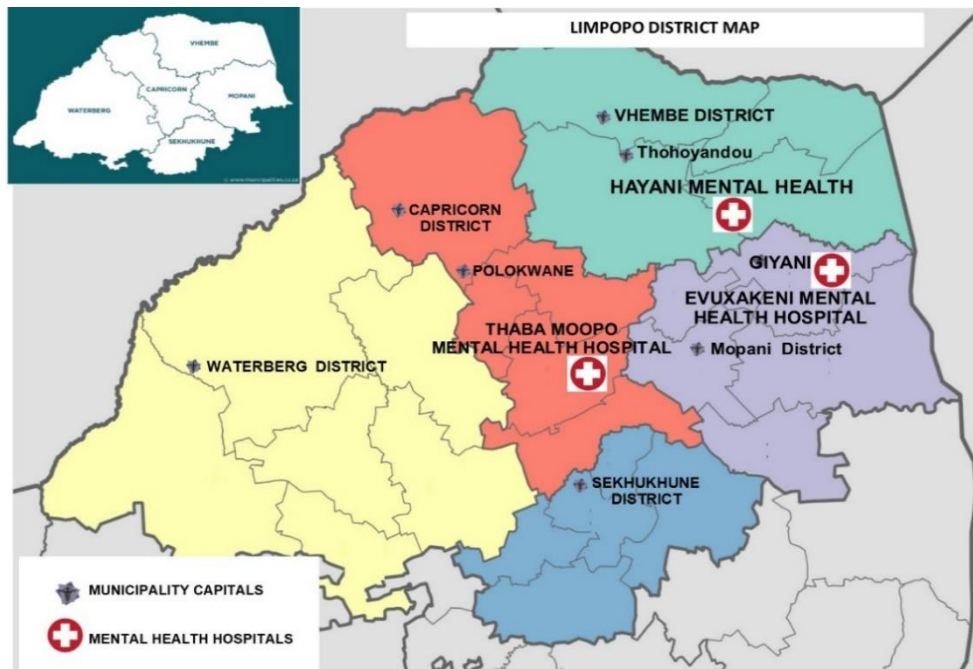


Figure 1.2 Limpopo Province districts map

3.4 RESEARCH PHASES SUMMARY

Table 3.1 Research phases summary

Objective	Research design	Population	Sampling approach	Data collection	Data Analysis
1. PHASE ONE					
1.1 Stage one					
1.1.1 To determine factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province	Qualitative	Family members	Non-probability stratified purposive sampling	Interview	Tech's steps by Creswell et al (2009)
1.1.2 To explore and describe the perception of family members regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province	Qualitative	Family members	Non-probability stratified purposive sampling	Interview	Tech's steps by Creswell et al (2009)
1.1.3 To explore and describe the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province	Qualitative	MHCUs	Non-probability stratified purposive sampling	Focus group discussions	Tech's steps by Creswell et al (2009)
1.2 Stage two					
1.2.1 To explore and describe the perception of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province	Quantitative	Nurses	Probability stratified random sampling	Questionnaire	SPSS version 22
2. PHASE TWO					
2.1 Concept analysis and model development	Eight steps in the Chinn and Kramer (1999) Walker and Avant (2014)				
3. PHASE THREE					
2.1 Model validation	Quantitative	Professional nurses	probability stratified random sampling	Questionnaire	SPSS version 22

3.5 RESEARCH PHASES

3.5.1 PHASE ONE: STAGE ONE QUALITATIVE APPROACH

Burns and Groove (2011) indicated that in qualitative research design, people's natural setting is studied in order to discover the social world of culture by observing and interacting with them. Therefore, the researcher is able to identify the characteristics and impact of human experiences as described by the participant and construed by the researcher. This is supported by various researchers who indicated that the focus of qualitative research is on perceptions and experiences in a natural setting where human behaviour and events occur (Hanson, 2006 cited in Mackey & Gass, 2015; Polit & Beck, 2009).

The qualitative study conducted in phase one: stage one to cover the first three objectives: To determine factors contributing to insufficient effort in caring for MHCUs at the selected district of Limpopo Province; To explore and describe the perception of family members regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province; and to explore and describe the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province. However, the WPC theory is based on the concepts of blessedness of being; therapeutic partnering; self-care and self-healing; optimal whole-person nourishment; transformational health care leadership; and caring as a sacred practice (Thornton, 2013).

The study assumptions are that caring for MHCUs' physical health, mental health and social care needs, and supporting MHCUs to recover and return to their own homes, is a significant aspect that involves family members.

Qualitative approach was used in this study because the researcher wanted to describe and analyse human experience in detail (Mackey & Gass, 2015).

3.5.2. POPULATION AND SAMPLING

3.5.2.1 Population

In this study the population for objective one and two were all family members. The researcher defines the family members as the persons in the universe who possess specific characteristics (De Vos et al., 2011). In addition, the population for objective three were MHCUs.

3.5.2.2 Accessible population

In this study the accessible population was all family members of MHCUs. Furthermore, the accessible population was the MHCUs admitted at Evuxakeni, Hayani and Thabamooopo mental health hospitals of Limpopo Province.

3.5.2.3 Target population

The target population was all family members of MHCUs admitted at the selected mental health hospitals of Limpopo Province. Moreover, the target population interviewed MHCUs admitted for long-term mental health care who were mentally stable and able to express themselves. The researcher had made arrangements with the unit managers to avoid interrupting daily routine.

3.5.2.4 Sampling

3.5.2.4.1 Sampling of hospitals

Purposive sampling was used to select the long-term mental health hospitals from (Evuxakeni) Mopani, (Hayani) Vhembe and (Thabamooopo) Capricorn Districts of Limpopo Province as all institutions have similar characteristics (provide mental health care services) of being selected.

3.5.2.4.2 Sampling of family members and MHCUs

Non-probability stratified purposive sampling approach was used because the researcher wanted to select elements through non-random methods. Purposive sampling is a non-probability sampling method used when data are collected from selected participants because they exhibit certain features that are of interest for a particular study (Silverman, 2000 in De Vos et al., 2011). The researcher selected family members who insufficiently visit their MHCUs admitted in long-term mental health hospitals.

In addition, the researcher obtained family members contact details from MHCUs files as their contact details were recorded on MHCUs on admission. However, some of the contact details were obtained from the visitors' book and also from MHCUs with the assistance of nursing staff. In addition, non-probability purposive sampling approach was used to select MHCUs admitted for long-term mental health at Evuxakeni, Hayani and Thabamooopo mental health institutions.

3.5.2.5 The inclusion criteria

Inclusion criteria refers to criteria that specify target population (Polit, Beck & Hungler, 2009). Inclusion criteria were mental health institutions providing long-term mental health care services. Furthermore, the inclusion criteria were all male and female family members with the MHCUs admitted for long-term mental health care, who are not visiting the MHCUs gradually. The researcher made arrangements telephonically with the MHCUs' families to confirm the dates to conduct interview and the convenient times which the families would be available at home. The researcher also obtained the direction to the families' homes during arrangements. Moreover, the inclusion criteria were all male and female MHCUs admitted for long-term mental health at Evuxakeni, Hayani and Thabamopo mental health institutions at, with poor family contact who were stable during the data collection process.

3.5.2.6 The exclusion criteria

According to Polit et al. (2009), exclusion criteria refers to those characteristics that people must not possess. In this study exclusion criteria were family members who often visit the MHCUs. In addition, exclusion criteria were MHCUs admitted at the selected mental health care hospitals, with good family contact, those who are not stable and those with intellectual disability, unable to follow instructions.

3.5.2.7 Sample size

Patton (2002 in De Vos et al., 2011) says that there are no rules for sample size in qualitative inquiry. However, sample size is being relatively limited, based on saturation, not statistically determined and involving low cost and less time. In this study, the qualitative sample was influenced by the relative homogeneity and heterogeneity of the population, and the desired degree of

reliability for the purpose of investigation (Hysamen, 1993 cited in De Vos et al., 2011). Therefore, 21 family members and six focus group discussions (FGDs) were the sample size at the point of saturation.

3.5.3 DATA COLLECTION

Data collection is the process of gathering information needed to address a research problem (Polit & Beck, 2008 cited in Cope, 2014). In this study, an in-depth interview was used to collect data from the family members to gather detailed information. The researcher used an unstructured in-depth interview at family members' homes for qualitative approach. Home visits were arranged for family members around Mopani, Vhembe and Capricorn Districts of Limpopo Province.

Prior arrangements were made, particularly family members who live too far from Mopani, Vhembe and Capricorn districts. The researcher made special arrangements such as introducing the researcher and, how the researcher got participants' details, what the researcher aims to find out, when the researcher was about to visit the family, how long the interview was to be conducted, as well as the researcher's contact details. In addition, one open-ended question was asked (De Vos et al., 2011).

- *“Explain briefly your perceptions regarding involvement in caring for MHCUs who are admitted in long-term mental health institutions?”*

The researcher recognised thin areas and probed follow-up questions to determine the factors contributing to insufficient involvement in caring for MHCUs in long-term mental health institutions. Hence paraphrasing was

used to unveil additional information and guide the discussion and to ensure that the objectives one and two were covered during the interview (De Vos et al., 2011), see Annexure C.

However, FGDs methods were used to collect data from MHCUs. Akinsola (2005 cited in Nuq & Aubert, 2013) defined FGDs as the group of people who are highly homogenous in all aspects such as age, sex and social characteristics. The researcher believes that FGDs facilitated active participation because MHCUs were accustomed to climate meetings. Furthermore, FGDs were useful as a way to prepare for in-depth interview (Akinsola, 2005 cited in Nuq & Aubert, 2013).

The researcher developed and pre-tested the topic to guide the discussion. The researcher ensured that the question were translated into three languages, namely Xitsonga, Tshivenda and Northern Sotho, in the University of Venda language department to accommodate all participants, see Annexure C. Furthermore, the researcher established a rapport by introducing herself and facilitators to motivate the MHCUs to speak and respond to each other. One open-ended question was used to guide the discussion to ensure that all the objectives were covered during the interview (De Vos et al., 2011).

- *“Discuss briefly your views regarding the involvement of your family members in your mental health care, treatment and rehabilitation.”*

A voice recorder was used to record and take field notes during the interviews. The field notes were used in order to account for what the researcher heard, saw, experienced and thought about in the course of the interview (De Vos et al., 2011).

The researcher ensured that there were no distractions during the interview. Furthermore, the researcher also practiced questions beforehand to ensure they were sound, natural and comprehensive.

3.5.4 DATA ANALYSIS

Data analysis is the systemic organisation and synthesis of research data (Polit et al., 2008 cited in Cope, 2014). In this study the researcher used Tech's Technique to analyse data (Creswell et al., 2009; Creswell (2014). The following are eight steps of Tesch's inductive, descriptive open coding technique Creswell (2014) was used by following the steps below:

Step 1 – Reading through the data

The researcher got a sense of the whole by reading all the verbatim transcriptions carefully. This gave ideas about the data segments and how they look like/mean. The meaning emerged during reading were written down and all ideas as they come to mind. The researcher carefully and repeatedly read the transcripts of all the participants and understood them. An uninterrupted period of time to digest and thought about the data in totality was created. The researcher engaged in data analysis and wrote notes and impressions as they come to mind (Creswell et al., 2009; Creswell, 2014).

Step 2 – Reduction of the collected data

The researcher scaled down the data collected to codes based on the existence or frequency of concepts used in the verbatim transcriptions. The researcher then listed all topics that emerged during the scaling down. The researcher grouped similar topics together, and those that did not have association were clustered separately. Notes were written on margins and

the researcher started recording thoughts about the data on the margins of the paper were the verbatim transcripts appears (Creswell et al., 2009; Creswell, 2014).

Step 3 – Asking questions about the meaning of the collected data

The researcher read through the transcriptions again and analyse them. This time the researcher asked herself questions about the transcriptions of the interview, based on the codes (mental picture codes when reading through) which existed from the frequency of the concepts (Creswell et al., 2009; Creswell, 2014). The questions were “Which words describe it?” “What is this about?” and “What is the underlying meaning?”

Step 4 – Abbreviation of topics to codes

The researcher started to abbreviate the topics that has emerged as codes. These codes needed to be written next to the appropriate segments of the transcription. Differentiation of the codes by including all meaningful instances of a specific code’s data were done. All these codes were written on the margins of the paper against the data they represent with a different pen colour as to the one in Step 3.

Step 5 – Development of themes and sub-themes

The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that relate to one another to create meaning of the themes and sub-themes (Creswell et al., 2009; Creswell, 2014).

Step 6 – Compare the codes, topics and themes for duplication

The researcher in this step rework from the beginning to check the work for duplication and to refined codes, topics and themes where necessary. Using the list of all codes she checked for duplication. The researcher grouped similar codes and recoded others were necessary so that they fit in the description (Creswell et al., 2009; Creswell, 2014).

Step 7 – Initial grouping of all themes and sub-themes

The data belonging to each theme were assembled in one column and preliminary analysis was performed, which was followed by the meeting between the researcher and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

Step 8 – Recoding if necessary

Classification of themes was also done to simplify data retrieval. In addition, reflective remarks were made, where thoughts was recorded in double brackets at the end of the recording. During data reduction, the richness of the data was maintained (Creswell et al., 2009; Creswell, 2014).

Therefore, in this study, data was analysed separately as soon as data collection started and not at the end of data collection. Verbatim transcripts were made by the researcher by listening to the audio recordings before data analysis was conducted. The researcher analysed data in three steps; namely, description, analysis and interpretation. The researcher familiarised herself with the data by reading and rereading the notes and transcripts. Audio recordings were listened to and transcribed as soon as possible (Burns & Grove, 2011). In addition, immersion of data and interaction with data by

the researcher occurred. The researcher put brackets for the personal feelings about the phenomena identified and garnered separately. Reduction of data was done by selecting, focusing, simplifying and abstracting. Furthermore, for the current study, selection of codes and coding was done by independent coder with the purpose of identifying themes. Classification of themes was also done to simplify data retrieval. In addition, reflective remarks were made, where thoughts was recorded in double brackets at the end of the recording. Remarks were put in the right hand margin and data was displayed where the main ideas of the research were conveyed (Burns & Grove, 2011).

Crucial features were identified and the interrelationships described. Themes and configurations from the data was also identified. Narrative analysis was used to obtain the central focus of the data (Burns & Grove, 2011). The researcher's own analysis of what was happening and what was done at this stage, focuses on effectiveness of findings about clinical practice or theorizing. Relationships emerge from sets, actions, participants, events and guesses. These were used to formulate cautious intentions. Validity was tested by distributing uncertain theories with participants and guesses were articulated and tested on the same sample since they were text-specific. Finally, conclusions were drawn (Burns & Grove, 2011).

3.5.5 TRUSTWORTHINESS

Trustworthiness is a method of instituting validity and reliability of qualitative research, and it is achieved when it precisely represents the experience of the study participants. It measures the truth value of a study. It embraces four criteria; namely, credibility, dependability, confirmability and transferability (Polit et al., 2009; Speziale & Carpenter, 2007 cited in Khalaf, Abu-Moghli, LoRocco & Al-Maharma, 2017). Trustworthiness in this study was ensured

through Lincoln and Guba's criteria for judging the quality of qualitative research:

- Credibility
- Dependability
- Confirmability
- Transferability

For this study, the researcher tried and safeguarded trustworthiness (quality of study) by applying mostly the Lincoln and Guba (1999 cited in Kavalieratos, Mitchell, Carey, Dev, Biddle, Reeve, Abernethy, & Weinberger 2014; Gunawan, 2015) criteria as indicated in table 3.2 below.

Table 3.2 Trustworthiness

Trustworthiness	
Credibility	<p>Prolonged engagement for six month was achieved since the researcher sometimes meets participants (family members) when they visit the hospital.</p> <p>The researcher collected data until data saturation was attained.</p> <p>The researcher made a reflective summary after each interview to try and engage with data collected.</p>
Dependability	<p>Dependability was ensured by using the voice recorder and the transcripts which were available to the external auditor for verification if necessary.</p>
Confirmability	<p>Conducting the interview until data saturation was attained.</p> <p>The co-coder also ensured confirmability to ensure that themes and sub-themes that emerged from the collected data.</p> <p>The transcripts were done independently before discussing the themes and subthemes and reaching an agreement.</p>
Transferability	<p>Transferability was ensured by describing the research setting richly and thoroughly, and also describing what transpired during the interviews in detail.</p>

3.5.5.1 Credibility

Credibility refers to taking the final report to the participant (Lincol & Guba, 2009 cited in Kavalieratos et al., 2014; Gunawan, 2015). It involves two aspects: firstly, carrying out the investigation/study in a way that enhances its credibility, and secondly, taking steps to exhibit believability (Polit et al., 2009). In this study, credibility was achieved as follows:

- Since the researcher works at Evuxakeni Hospital as a professional nurse, she is familiar with the hospital structures and some of the family members and MHCUs admitted in the hospital.
- Prolonged engagement for six month was achieved since the researcher sometimes meets participants (family members) when they visit the hospital. These helped the researcher to understand the fundamental concerns that might affect the quality of the data since it assist to develop trust with study participants.
- The researcher collected data until data saturation was attained. The investment of sufficient time was also ensured through building of trust and rapport between the researcher and the participants.
- The researcher ensured the honesty of participants by:
 - informing the participants that the participation was voluntary and that they could withdraw at any time
 - involving only family members and MHCUs admitted in the hospital who volunteered and who was willing to take part in the study
 - establishing rapport and explaining to the participants that there are no right or wrong answers
 - explaining the researcher's independent status to the family members that she is working on her own and undertaking her studies
 - ensuring interactive questioning by encouraging the participants to ask clarification queries when they do not understand the questions
 - probing and asking complementary questions to the central question after the responses of the participants, with the aim of seeking clarity and a more detailed explanation and to exclude any inconsistencies in the answers which would denote falseness
- The researcher had a reflective summary after each interview to try and engage with data collected. This engagement was a signal that data analysis had started already.

- The researcher as a data collection and analysis instrument qualified in conducting the study since she holds a master's degree and was experienced in research because, as a professional nurse, she also assists certain student nurses with their research projects.
- Referential adequacy was ensured by using a voice recorder.

3.5.5.2 Dependability

Dependability refers to data steadiness over time and under different conditions (Polit et al., 2009). In order to estimate reliability, researchers construct various hypothetical notions (for example, true score theory). However, the present researcher is aware that this is not applicable to qualitative approach; therefore the concept of dependability will be applied (Lincol & Guba, 2009 cited in Kavalieratos et al., 2014; Gunawan, 2015). In this study, dependability was ensured by doing an inquiry audit when an enquiry of the data and appropriate supporting documents were done by an external reviewer. Dependability was ensured by using the voice recorder and the transcripts which were available to the external auditor for verification if necessary.

- A comprehensive description of the study phenomenon and of the context from which data was collected and given by the researcher for the purpose of ensuring dependability.
- An independent coder was also involved in the coding of the data collected to ensure dependability of the study.

3.5.5.3 Confirmability

Confirmability refers to the detachment or a neutral stance of the data, such that two or more people would agree about the relevance or meaning of the data (Polit et al., 2009). Lincon and Guba (2009 cited in Kavalieratos et al.,

2014) indicated that the confirmability audit trail is an adequate trail that needs to be recorded to enable the auditor to determine whether the conclusions, interpretations, and recommendations can be traced to their sources and whether these matters are supported by the inquiry. The researcher ensured confirmability of the study by:

- Conducting the interview until data saturation was attained.

An audit trail was developed which was a systemic collection of documentation. The documentation comprised of the field notes which the researcher took during the interviews, the voice recordings of the measures during the interviews and the word for word transcripts that were done by heeding to the voice recordings. An audit trail allowed an independent auditor to draw conclusions about the collected and analysed data.

- Findings were also supported by comparing them with already existing literature.
- The involvement of the co-coder also ensured confirmability in this study because there was a consensus between the researcher and the co-coder about themes and sub-themes that were emerged from the collected data.
- The researcher and the coder coded the transcripts independently before discussing the themes and subthemes and reaching an agreement. Classification of themes was also done to simplify data retrieval.
- Themes and configurations from the data was also identified. Narrative analysis was used to obtain the central focus of the data (Burns & Grove, 2011). The researcher's own analysis of what was happening and what was done at this stage, focuses on effectiveness of findings about clinical practice or theorizing.

3.5.5.4 Transferability

Transferability refers to the level that the outcomes from the data can be conveyed to other settings or groups and is related to the concept of generalizability (Polit et al., 2009). In this study, transferability was ensured by describing the research setting richly and thoroughly, and also describing what transpired during the interviews in detail. The non-verbal clues observed during the interviews were also described thoroughly. The comprehensive description of the researcher in this study assisted the next person to decide whether or not to transfer the results to another context.

3.6 STAGE TWO: QUANTITATIVE APPROACH

Creswell and Clark (2011) defined quantitative as an inquest into a social or human problem, constructed on testing a theory composed of variables, restrained with numbers and analysed with statistical techniques in order to conclude whether the analytical generalization of the theory holds true. Several authors have distinguished quantitative from qualitative research design. However, the quantitative category includes national systems, pre-experimental or hypothesis development, surveys or descriptive, quasi-experimental or associative studies and true experimental or cause-effect/explanatory relationships (De Vos et al., 2011; Neuman, 2014; Welman, Kruger & Mitchell, 2010 cited in Makhuzeni, Barkhuizen & Maubane, 2015).

The quantitative approach addresses the third objectives: To explore and describe the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

3.6.1. POPULATION AND SAMPLING

3.6.1.1 Population

Bless et al. (2013) defined population as a comprehensive set of events, people or things to which research findings are to be practical. In this study the population were all the nurses working in long-term mental health institutions at Evuxakeni, Hayani and Thabamooopo Mental Health Hospitals of Limpopo Province.

3.6.1.1.1 Accessible population

According to De Vos et al. (2011) accessible population is the collective of cases that adapt to the labelled criteria and that are accessible to the researcher as a puddle of subjects for a study. In this study the accessible population were all the nurses working at Evuxakeni, Hayani and Thabamooopo Mental Health Hospitals of Limpopo Province during the research study.

3.6.7.1.2 Target population

In this study target population were all the nurses working at selected mental health hospitals who experience challenges regarding the involvement of the family members in long term mental health care.

3.6.1.2 Sampling

3.6.1.2.1 Sampling of hospitals

Akinsola (2005 cited in Nuq & Aubert, 2013), defined sampling as the process of selecting representative units of a population study in a research

investigation. In this study, purposive sampling was used to select mental health hospitals as each hospital has similar characteristics (provide long-term mental health care services) of being selected. The reason for choosing these three long-term mental health institutions is the fact that Limpopo has only three long-term mental health institutions. All three were considered in order to make a realistic representation.

3.6.1.2.2 Sampling of nurses

In this study, probability stratified random sampling was used. Stratified random sampling, refers to a sampling process in which population is divided into subgroups or strata according to a variable or variables of importance of the study, so that each element of the population belongs to only one stratum (Bless et al, 2013; De Vos et al., 2011). In this study, probability stratified random sampling was used in order to divide nurses into deferent groups so that each element of population belongs to only one stratum.

However, probability stratified random sampling was used since the information about nurses was well-known prior to sampling in order to make the sampling method more efficient (Grinnell & Unrau, 2005 cited in De Vos et al., 2011). The researcher sought nurses to explore and describe their perceptions regarding family involvement in caring for MHCUs in the long-term mental health institutions of Limpopo Province.

Population was divided into strata or sub-groups as follows: A: Enrolled Nursing Auxiliary; B: Enrolled Nurse; C: Registered Nurse; D: Professional Nurse; E: Operational Managers; F: Nursing Service Managers. Almost 360 (34.6%) nurses were drawn from 1,041 nursing personnel working in long-term mental health institutions at Evuxakeni, Hayani and Thabampoopo to

achieve the greater degree of representativeness. Furthermore, population was stratified according to homogeneous characteristics, such as year of service, rank, qualifications, age, gender and marital status.

3.6.1.2.3 The inclusion criteria

In this study, inclusion criteria for hospitals were mental health care institutions providing long-term mental health services. Inclusion criteria for nurses were all nursing personnel employed at the jurisdiction of selected mental health hospitals, who were working directly with MHCUs considered. Only nurses who were on duty on the days of data collection, both male and female nurses were selected.

3.6.1.2.4 The exclusion criteria

In this study exclusion criteria were all male and female nurses who were on leave or day off during the days of data collection, all nurses who were not interested to participate in the study and all nurses who could not sign the consent form to participate were excluded.

3.6.1.2.5 Sample size

Sample size refers to the number of subjects, occasions, behaviours, or status quo that are scrutinised in a study (Burns & Grove, 2011). Sample size is fundamentally a function of the purpose of the investigation, the quality of the informants, and the type of sampling strategy that is used (Neuman, 2014). In this study, 360 participants were drawn from 1,041 nurses working at long-term mental health institutions Evuxakeni, Hayani and Thabamoopo as indicated in table 1.3.

Table 3.3 Sample size

Mental Health institutions	Number of nurses per institution		Number of participants	
	F	%	F	%
Evuxakeni	217	20.8	91	7.2
Hayani	251	24.1	103	8.3
Thabamooopo	573	55.0	166	19.0
Total	1,041	100	360	34.6

Table 3.3 shows the number of nurses from each institution and those who participated in the study. Of the 217 (20.8%) nurses from Evuxakeni hospital, 91 (7.2%) participated in the study. Of the 251 (24.11%) nurses from Hayani hospital, 103 (8.3%) participated in the study. Of the 573 (55.04%) nurses from Thabamooopo hospital, 166 (19.0%) participated in the study. Therefore, the total number of nurses from all selected mental health institutions were 1,041 and the sample size of this study were 360 (34.59%) participants.

In this study, Slovin's formula was applied to determine the sampling error of the sample. This formula was formulated by Slovin in 1960 to determine the sample size especially if there is uncertainty about the population's behavior (Slovin, 1960 cited in Ryan, 2013). Slovin's formula is used to calculate the sample size (n) given the population size (N) and a margin of error (e). It is computed as $n = N \cdot (1 + Ne^2)$. If a sample is taken from a population, a formula is used to take into account the confidence level and margins of error

(Slovin, 1960 cited in Ryan, 2013). In this study, sampling error of the sample size was determined as follows:

$$n = \frac{N}{1 + Ne^2}$$

In this study, sample size is $n = 360$; total population size is $N = 1041$. To get the confidence level, e , we use the Solvin's formula as follows:

$$\begin{aligned} n &= \frac{N}{1 + Ne^2} \\ 360 &= \frac{1041}{1 + 1041 \times e^2} \\ e^2 &= 0.00182 \end{aligned}$$

$$e = 0.04$$

3.6.1.3 Research instrument

The researcher designed a questionnaire in quantitative data collection efforts. In this study the researcher developed an instrument in relation to existing related literature reviews and instruments used in previous studies to elicit information from nurses. The questionnaire was presented to a research promoter, a statistician and an expert in mental health for review and criticising. The questionnaire was pilot tested and the obligatory corrections were made before continuing with the main study. The research instrument brought about information from two areas. Section A was demographic data of respondents who were working at the selected mental health hospitals of Limpopo province.

Section B consisted of self-assessment questions on nurses' perceptions regarding family involvement in caring for MHCUs in long-term mental health institutions.

3.6.1.4 Pilot study

Pilot study refers to a small scale version or trial run that is conducted to prepare for a major research study (Polit et al., 2009). The main aim was to assess the feasibility of the proposed study and to detect possible flaws in data collection instruments and to develop a contingency plan for inaccuracies that might occur in the main study. The researcher conducted a pilot study in one of the selected mental health institutions where the study took place in order to test practical aspects of the research study. The questionnaire was pilot-tested with 15 nurses working at Hayani Hospital by the researcher and a research assistant.

The respondents were not included in the research project. The outcome of the pilot study informed the researcher about questions and the way they were rephrased. There was some evidence that the researcher had to clarify certain issues such as “some of them” to indicate that not all MHCUs abscond from home back to the institution. The researcher restructured questions to rate nurses’ concern such as family involvement, MHCUs buried as a pauper as major or minor. This increased the validity and reliability of the data collection instrument and also save time for the study during the implementation of the main research project.

3.6.2 DATA COLLECTION

Data collection is the evidence systematically collected in the course of a study (Schneider, Elliott, Wood & Haber 2007). The self-administered survey questionnaire was handed to the nurses on duty. About 380 questionnaires were handed to the respondents who were on-duty. Appointments were arranged with the section managers. Each respondent completed the questionnaire on his/her own without first discussing it with others. However,

360 (75%) questionnaires were completed of which eight questionnaires were spoiled (demographic data was incomplete) and not included in the study. Twelve questionnaires were not returned. The researcher was available in case problems were experienced. Close-ended questions were asked. Close-ended questions gave the respondents the chance of selecting one or more responses from the number provided according to the instructions (Creswell & Clark, 2011).

In addition, it was beneficial when an extensive amount of information about a subject exists and the response opinions were relatively well-known. For example, the respondents understand the meaning of a question better; questions can be answered within the same framework; responses can consequently be compared better with one another. Finally, answers were easier to code and statistically analysed (De Vos et al., 2011; Neuman, 2014).

3.6.2.1 Validity and reliability

Validity and reliability are two statistical properties used to evaluate the quality of a research instrument. **Validity** refers to the extent to which an empirical measure accurately reflects the concepts it is intended to measure (De Vos et al., 2011; Burns & Grove 2012 cited in Lbitoye, 2016). Validity in mixed methods research refers to employing strategies that address potential issues in data collection, data analysis and the interpretation of research results that may compromise the merging or connecting the qualitative and quantitative strands of the study and the conclusions drawn from the combination (Creswell & Clark, 2011). In this study, the researcher ensured validity by conducting a literature review and providing operational definitions of key concepts.

According to De Vos et al. (2011); Heale and Twycross (2015 cited in Lbitoye, 2016), the basic ways to assess the validity of an instrument are face, criterion, content and construct validity. The criterion validity is an approach that defines the extent to which the different instruments extend the same variable (De Vos et al., 2011; Heale & Twycross, 2015 cited in Lbitoye, 2016). In this study, the researcher structured questions on the instrument that were, for the greatest part, modified, and reassembled that link with the objectives of the study. Face validity is the simplest definition of validity (Gravette & Forzano, 2003 cited in De Vos et al., 2011).

This means that at face value, the questionnaire appears to be a relevant measure of the content under discussion in the research. In order to ensure validity of the measuring instrument, face validity means that the instrument applied that appears to measure what it was supposed to measure (De Vos et al, 2011). In this study, the measuring instrument was submitted to experts who judged the instrument on their knowledge and experience in mental health. Content validity refers to the capability of the instrument's items to adequately cover all the content that it should with detail to the variables (De Vos et al, 2011; Heale & Twycross, 2015 cited in Lbitoye, 2016).

In order to ensure content validity the, developed questionnaire was given to some experts in mental health to scrutinize the content in relation to the study objectives. The questionnaire was sent to the experts via email with an information sheet and the objectives of the study. Comments on certain aspects and their relevance were elucidated and revised according to the remarks from the critics. Response options to some questions items were adjusted, while some questions items that seemed to be uncertain were rephrased based on experts' superior suggestions, prior to its usage in the study.

Construct validity refers to the extent in which the instrument can draw inferences about test scores related to the concept being studied (De Vos et al., 2011; Heale & Twycross, 2015 cited in Lbitoye, 2016). The researcher understood the meaning of instrument, what was measured, why it was operated and the way it was structured. Furthermore, construct of the instrument was based on logical relationship among variables and theory underlying it.

Reliability refers to the degree of steadiness or constancy with which the instrument measures the element it is designed to measure (De Vos et al., 2005, 2011; Polit & Beck cited in Cope 2014; Brink et al., 2013). In this study, the researcher ensured that the information in the questionnaire is reliable and valid, based on current research. The instrument was pre-tested by administering the questionnaire to some participants from a target group, 15 nurses were asked to complete the questionnaire before the main study. The researcher also ensured the reliability by developing the questionnaire from existing ones in consultation with the supervisors.

3.6.3 DATA ANALYSIS

Data analysis is the systemic institute and production of research data and the testing of a research assumption using data collected. The purpose of analysis is to diminish data to a comprehensible and interpretable form so that the relationships of research problems can be studied, tested and conclusion drawn (De Vos et al., 2011; Welman et al., 2005 cited in Makhuzeni at al., 2015). Data was analysed by a statistician using Statistical Product and Service Solution version 23 (SPSS).

SPSS is one of the popular statistical correspondences which can perform multifaceted data manipulation and analysis with simple instructions. In this study tables displaying frequency computations and percentages of the values of individual variable; and descriptive data analysis that shows the maximum, minimum, mean and standard deviation of the variables, was used. Finally, the researcher interpreted how the combined results answer the qualitative and quantitative, and mixed methods questions (Creswell et al., 2009).

3.6.4 PHASE THREE: MODEL VALIDATION

3.6.4.1 Population and sampling

3.6.4.1.1 Population

In this study the population were all the professional nurses working at long-term mental health institution at the selected Mental Health Hospitals of Limpopo Province.

3.6.4.1.2 Accessible population

In this study the accessible population was all the professional nurses working at the selected Mental Health Hospitals of Limpopo Province during research study.

3.6.4.1.3 Target population

In this study target population was all the professional nurses working at selected mental health hospitals who experience challenges regarding the involvement of the family members in long term mental health care.

3.6.4.2 Sampling of hospitals

Akinsola (2005 cited in Nuq & Aubert, 2013) defined sampling as the process of selecting representative units of a population study in a research investigation. In this study, purposive sampling was used to select mental health hospitals as each hospital has similar characteristics (provide mental healthcare services) of being selected.

3.6.4.3 Sampling of professional nurses

In this study, non-probability convenience random sampling was used. The researcher wanted professional nurses to validate a developed model to promote family involvement in caring for MHCUs in the long-term mental health institutions of Limpopo Province.

3.6.4.4 The inclusion criteria

In this study, selected mental health hospitals and professional nurses employed at the jurisdiction of selected mental health hospitals, both male and female, who were on duty and managed to attend MDT meeting during data collection, were selected.

3.6.4.5 The exclusion criteria

In this study exclusion criteria were all male and female professional nurses who did not attend MDT meeting and who were on leave or day off on the day of model validation. In addition, all professional nurses who were not interested to participate in the study and who could not sign the consent form to participate were excluded.

3.6.4.6 Sample size

In this study, 18 (8.3%) sample size were drawn from 83 professional nurses working at the Evuxakeni hospital.

3.6.5 DATA COLLECTION

The researcher designed a questionnaire to validate the model in quantitative data collection efforts. Prior arrangement with the hospital management was made. The researcher presented the model and its guidelines on MDT meeting. The researcher considered readily available participants of which 22 self-administered model validation questionnaires and consent forms were handed to the professional nurses who attended the MDT meeting. Each respondent completed the questionnaire on his/her own without first discussing with others. Approximately 18 questionnaires were completed and returned and four were not returned.

3.6.6 DATA ANALYSIS

Data was analysed by a statistician using SPSS version 23. Tables displaying frequency computations and percentages of the values of professional nurses variable; and descriptive data analysis that shows the maximum, minimum, mean and standard deviation of the variables, was used.

3.6.7 ETHICAL CONSIDERATIONS

Ethics are a set of moral principles that is proposed by an individual or group, is widely acknowledged and offers rules and behavioural outlooks about the most appropriate manner towards participants, employers, employees, sponsors, other researchers, assistants and students (Polit & Beck, 2009).

Ethical considerations are also defined as a set of moral principles that are used to guide the planning, implementation and evaluation of any research project suggested by an individual or group (Meyer, Van Niekerk & Naude, 2009). In this study, ethical procedures included approval to conduct the study, quality of the researcher and the research project, confidentiality, anonymity and informed consent.

3.6.7.1 Ethical clearance

The researcher obtained Ethical clearance certificate as permission from the University of Venda Health, Safety and Research Ethics Committee and applied in Limpopo Province Department of Health to conduct the study at Evuxaken, Hayani and Thabamooop Mental Health Hospitals.

3.6.7.2 Approval to conduct the study

The researcher required permission from the Limpopo Province Department of Health to conduct the study at Evuxaken, Hayani and Thabamooop Mental Health Hospitals. Furthermore, the researcher attained informed consent from the participants and observed ethical standards to protect them from physical and mental discomfort.

3.6.7.2 Quality of the Researcher and the Research Project

In this study the identity, qualifications and experience of the researcher was formally introduced to the participants. In all steps of the research project, the researcher adhered to the highest possible ethical standards and did not attempt to research the project beyond the researcher's knowledge skills and experience without seeking guidance and support from more experienced researchers.

3.6.7.3 Confidentiality

All the information that the participants provided were not to be publicly reported in a manner that may identify the participants or be made accessible to parties other than those involved in the research (De Vos et al., 2011). The information provided was neither shared with strangers nor with people known to the participants, such as family members, co-workers, physicians and other health care providers, unless the researcher had been given explicit permission to share the information.

3.6.7.4 Anonymity

Anonymity involves protection of participants' identity (Meyer et al., 2009). The participants' names were not written on the questionnaires provided during data collection.

3.6.7.5 Informed Consent

Informed consent is an ethical principle that requires the researcher to gain voluntary participation of a subject after giving information of the potential risks and/or benefits of participation (De Vos et al., 2011). Informed consent means that participants have sufficient information regarding the research; are capable of comprehending the information; and have the authority of free choice; empowering them to consent voluntarily to participate in the research or decline participation (Polit & Beck, 2009). In this study, informed consent was attained from each participant. A detailed clarification of the study of what was going to transpire was specified to the participants before they were requested to sign the consent.

The participants were notified that they were not forced to participate in the study. In addition, they were advised that they were free to terminate/withdraw from the study at any time. Therefore, the researcher ensured that the research subject's privacy was protected informing and obtaining consent to participate in a study and voluntarily shares private information with a researcher (Burns & Grove, 2011). Therefore, the return of completed questionnaires also reflects their voluntary consent to participate.

The participants were given adequate information regarding the research that they were free to participate and had the power of free choice, enabling them to consent to or decline participation in the research voluntarily. The purpose of the study, objectives and their rights to participate or refuse to participate will be explained. See Annexure D and E.

3.6.8 CONCLUSION

This chapter presents an overview of the research design and model validation methods that guided the scientific activities of the study. The mixed method research design phases one and two utilised in this study with regard to population and sampling; data collection and analysis; trustworthiness and ethical considerations have been discussed. Chapter four discussed data analysis and interpretation of research results

CHAPTER 4

DATA ANALYSIS, INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter discusses an overview of the research design and methods in this study. Both qualitative and quantitative methods used to population and sampling; data collection and analysis; trustworthiness and ethical considerations have been discussed. This chapter discusses data analysis, the interpretations and discussion of family members' perceptions regarding their involvement in caring for MHCUs in long-term mental health institutions; the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions; and nurses' perceptions regarding the family involvement in caring for MHCUs in long-term mental health institutions.

Qualitative and quantitative data analysed separately following each approach and converged. However, in qualitative approach, immersion of data and interaction with data by the researcher occurred, selection of codes and coding was conducted by independent coder Professor Mothiba, from University of Limpopo Department of Nursing Science with the purpose of identifying themes. Statistical information was derived from a sample of 360 respondents who completed questionnaires.

However, some of the respondents chose not to complete certain sections of the questionnaires or certain items within specific sections. The percentages were calculated on the total number of questionnaires received. This was done as a function of SPSS version 23 by Netshivha-Nengovhela, from University of

Venda Department of Statistics. In this chapter the interpretations and discussion of the findings is guided by Thornton’s Model of WPC. The WPC framework is derived from theorists in the fields of nursing, physics, and systems analysis (Thornton, 2013:106). The purpose of this chapter is to analyse, interpret and discuss data collected. Data collection began concurrently, was analysed independently and merged both qualitative and quantitative results on the discussion of findings. In this chapter, the first section discusses qualitative data analysis. Then second section discusses quantitative data analysis as indicated in figure 4.1.

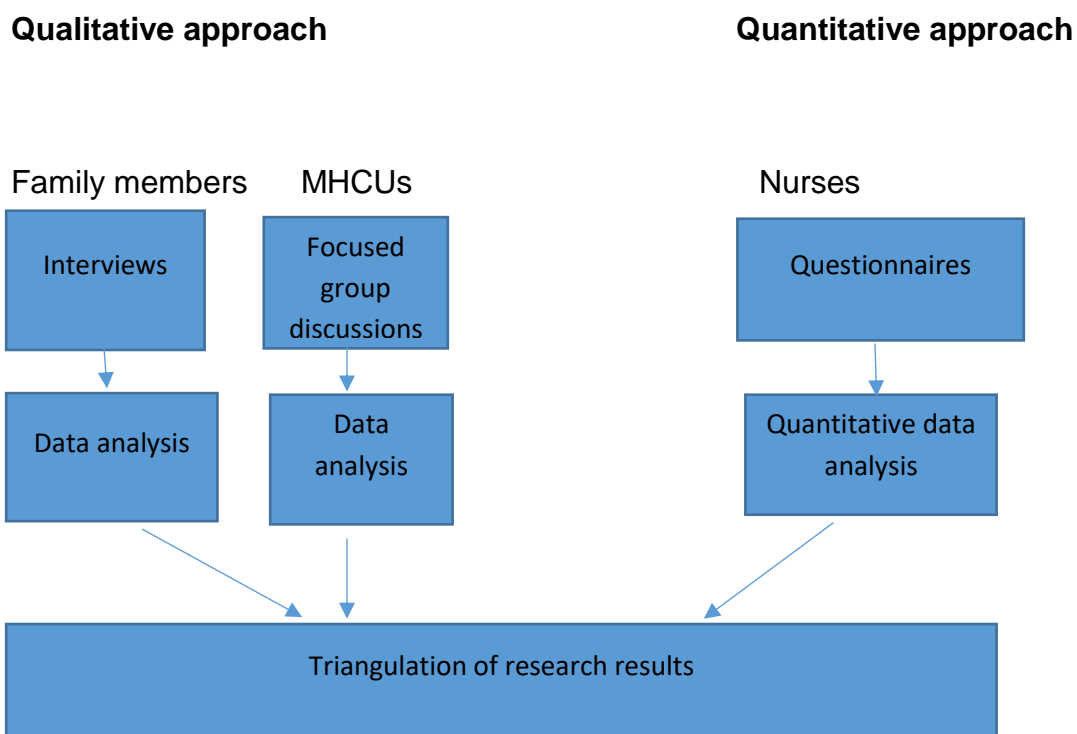


Figure 4.1 Data analysis

4.2. OBJECTIVES OF THIS CHAPTER

The objectives were:

- to analyse and reduce raw data in to categories of themes and sub-themes
- to reflect the views and experiences of participants' quotations
- to discuss the findings through relevant literature control

4.3 QUALITATIVE DATA RESULTS

Unstructured in-depth interview were conducted among 21 family members at their homes after telephonic arrangements has been made. However, the researcher collected data from MHCUs of which six FGDs were used. Data was collected over six month from Mopani, Vhembe and Capricorn Districts. The researcher started at the long-term mental health institutions in order to obtain family contacts of the MHCUs. The qualitative data was conducted in two stages to cover the first thee objectives.

4.3.1 Stage 1

Objective one: to explore and describe the family members' perceptions on their involvement in caring for MHCUs admitted in long-term mental health institutions in Limpopo Province. One open-ended question directed to the family members was as follows:

- *Explain briefly your perceptions regarding involvement in caring for a MHCU who has been admitted to a mental healthcare hospital.*

Objective two: to determine factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province. One open-ended follow-up question directed to the family members was as follows:

- *What factors contribute to poor family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province?*

Objective three: to explore and describe the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province. One open-ended question directed to the MHCUs was as follows:

- *Describe your views regarding the involvement of your family members in your mental health care, treatment and rehabilitation.*

During arrangements, participants were briefed about the interview schedule and their own expectations. The purpose of briefing was to facilitate understanding and to prepare themselves as well as to follow the direction during the interview. Demographic data was obtained from both family members and the MHCUs as indicated in table 4.1.

4.3.2 Demographic data

Table 4.1. The demographic data of family members and MHCUs

Participants	Age	Gender		Occupation		Sub-total
		Male	Female	Employed male	Employed Female	
Family members	18 – 25	1	2	1	-	3
	26 – 40	2	3	2	3	5
	41 – 60	3	6	3	3	9
	< 61	2	2	-	-	4
	Total	9	12	6	6	21
MHCUs	18 – 25	4	2	2	-	6
	26 – 40	22	6	13	4	28
	41 – 60	15	8	8	3	23
	< 61	-	-	-	-	-
	Total	41	16	23	7	57

Table 4.1 displays the demographic data of qualitative family members and MHCUs. Of the 21 participants in this study, 4 were between 18 – 25 years, only 1 male was employed and 2 females were unemployed. Probabilities are that these participants are younger than MHCUs or the same age because both family members and MHCUs ages ranging from 18 – 25 years. Of the 21 participants in this study, 5 were between 26 – 40 years, only 2 males employed and 3 females were unemployed. It might be possible

that these participants might be parents or brothers and sisters of the MHCUs or the same age because both family members and MHCUs ages ranging from 26 – 40 years. Of the 21 participants in this study, 9 were between age 41 – 60 years, all 3 males employed and 3 females were unemployed. Of the 21 participants in this study, 4 were above 61 years, both males were employed and females were unemployed. It might be possible that these participants might be pensioners and unemployed because ages range between 41 – 60. The importance of age relates to the caring is that it might be possible that the other family members who were above 61 could be pensioners.

Therefore, the assumptions are that elderly family members are very passionate in caring for their sick family member. According to Neece, (2014) having a mental illness within the family causes, significant risk factors of stress for families including external family members regardless of age. However, it is likely that the relationship between age and occupation variables is common such that MHCUs' problems lead to escalations in family members' stress, which further worsen the mental illness (Neece, 2014).

However, of the 57 participants in this study, 4 were males and 2 females were between 18 – 25 years, only 2 males had been employed before. Of the 57 participants in this study, 28 were age between 26 – 40 of which 22 were males

and 6 females, 13 males and 4 females which who had been employed before. Of 57 participants of this study, 23 were age between 41 – 60 of which 15 were males and 8 females, 8 males and 3 females were employed before. None of above 61 aged participants participated in the study.

Therefore, age is an important variable since when a person grows older the caring aspects improves. However, in this study age variable indicate that majority, 28 MHCUs were age 26 – 40 and 22 were males. It might be possible that the MHCUs at this age abuses alcohol and substances that leads to admission to the long term mental health institutions. In addition, the fact that none of above 61 age participants participated in the study might be the fact that elderly people also help their families when they are sick to gain power over their over their lives by empowering them (Payne, 2015).

4.3.3 Qualitative research results: FDGs

The following themes emerged from FDGs as indicated in table 4.2.

- Theme 1: Experiences of MHCUs related to the attitude of family members towards the provision of care tor them.
- Theme 2: Observation made by MHCUs towards family members and hospital management.
- Theme 3: Knowledge of family members related to care of MHCUs.
- Theme 4: Challenges resulting from lack of support by family members.

Table 4.2: Themes and sub-themes reflecting the views of MHCUs

Main themes	Sub-themes
1. Experiences of MHCUs related to the attitude of family members towards the provision of care for them	1.1 Narratives related to the behaviour of family members towards MHCUs which causes suffering at multiple levels 1.2 Feelings of rejection experienced by MHCUs from the negative attitudes displayed by family members 1.3 Existing lack of communication between family members and MHCUs experienced 1.4 Lack of consideration and readiness of family members to take MHCUs for LOA is problematic 1.5 Feelings of avoidance experienced by MHCUs from family members 1.6 Existing empty promises experienced by MHCUs from family members
2. Observation made by MHCUs towards family members and hospital management	2.1 Lack of support by family members to MHCUs observed leading to shortened LOA 2.2 Lack of involvement of MHCUs in decision making by family members outlined 2.3 Reasons provided by family members for lack of taking MHCUs to LOA outlined 2.4 Existence of support by hospital management appreciated by MHCUs outlined
3. Knowledge of family members related to care of MHCUs	3.1 Lack of knowledge treatment effects lead to lack of support by family members to MHCUs 3.2 Lack of insight by family members related to behaviour modification education provided to MHCUs in hospital problematic 3.3 Family's lack of knowledge related to the importance of adherence to treatment outlined
4. Challenges resulting from lack of support by family members	4.1 Patients' development of resistance towards rejection by family members problematic 4.2 Existence of ideas that families which are not visiting are dead outlined by MHCUs 4.3 Visiting home viewed as problematic by MHCUs because they are forced to consult THPs

The following themes emerged from interviews as indicated in table 4.3.

- Theme 1: MHCUs families' views and experiences related to involvement in the care of a family member.
- Theme 2: Practices related to carrying for MHCUs at home by family members.
- Theme 3: Practices related to carrying for MHCUs at home by family members.
- Theme 4: Existing challenges in caring for MHCUs by family members.

4.3.4 Qualitative results: family members

Table 4.3: Themes and sub-themes reflecting the perceptions of MHCUs families

Main themes	Sub-themes
1. MHCUs families' views and experiences related to involvement in the care of a family member	1.1 Narratives related to the understanding of how carrying for MHCUs leads to understanding of the illness outlined 1.2 Appreciation to hospital management to keep and care for MHCUs outlined 1.3 MHCUs viewed by family members as a danger to the community 1.4 Caring for MHCUs viewed as a difficult task by the family members 1.5 Lack of visitation of MHCUs by family members in hospital result from fear that patients will request LOA 1.6 Lack of adherence to treatment by MHCUs experienced during LOA 1.7 Destruction of properties by MHCUs when they are at home experienced
2. Practices related to carrying for MHCUs at home by family members	2.1 Description of the reasons for lack of acceptance of MHCUs for LOA by family members 2.2 Reluctance of family members to care for MHCUs at home expressed 2.3 Lack of skills and inability to monitor MHCUs at home outlined 2.4 Reasons of family members not visiting MHCUs in hospital outlined 2.5 An explanation that MHCUs abuses substances during LOA which leads to families reluctant to request them 2.6 Lack of available carers and shared responsibilities at home a reason for not requesting MHCUs for LOA
3. Practices related to caring for MHCUs at home by family members	3.1 Existence of knowledge related to the importance of MHCUs care by family members outlined 3.2 Existence of hospital management's updates about care provided to MHCUs outlined 3.3 Provision of health education on promoting treatment adherence outlined as important
4. Existing challenges in caring for MHCUs by family members	4.1 Difficulty in monitoring treatment adherence by MHCUs 4.2 A description of financial constraints experienced by families of MHCUs 4.3 LOA viewed as a challenge because MHCUs relapse when at home 4.4 Reasons provided for families not ready to take MHCUs for LOA outlined 4.5 Discrimination of MHCUs by community members viewed as a challenge 4.6 MHCUs' refusal of being monitored during LOA problematic 4.7 Fear of families' lack of safety when MHCUs are at home outlined

4.4 QUANTITATIVE RESEARCH RESULTS

Quantitative explorative and descriptive strategy was used in this study to explore and describe perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province. The main aim of explorative and descriptive design was to obtain complete and accurate information which is not known about family involvement in caring for MHCUs in long-term mental health institutions. Data was collected over six months from nurses working at Evuvakeni, Hayani and Thabamoopo hospitals. The quantitative approach was conducted in phase one, stage two covers objective four.

Objective four: to explore and describe the perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

- *What are the perceptions of nurses regarding the involvement of family in caring for MHCUs in long-term mental health institutions in Limpopo Province?*

4.4.1 Demographic data

Table 4.4: Demographic data of nurses

Participants' details		F	%		F	%		F	%		F	%		F	%		F	%
Years of service	<2	21	5.8	2-5	58	16.1	15-10	141	39.2	10-30	37	10.3	>30					
Rank	Enrolled Nursing Assistance	150	41.7	Enrolled Nurse	53	14.7	Registered nurse	22	6.1	Professional Nurse	120	33.3	Operational Managers	13	3.6	Nursing Service Managers	2	3.6
Qualifications	Certificate	189	52.5	Diploma	101	29.9	Degree	67	18.6	Masters	-	-	Doctorate	-	-			
Age	20-25	10	2.8	25-35	98	27.2	35-45	149	41.4	45-55	74	20.7	>55	29	8.1			
Marital status	Single	165	45.8	Married	170	47.2	Divorced	11	3.1	Widowed	14	3.9						
Gender	Male	84	23.3				Female	276	76.7									

Table 4.4 shows the distribution of nurses by year of service that they were providing mental health care services. Of 360 respondents who participated in the study, 21 (5.8%) worked for less than 2 years, 58 (16.1%) worked for 3 to 5 years, 141 (39.2%) worked for 6 to 10 years, 103 (28.6%) worked for 11 to 30 years and 37 (10.3%) worked for more than 30 years. Almost seventy per cent of the respondents in this study worked for more than 10 years. This question was important since the years of experience may also bring the best practice. Probabilities are that respondents who worked for less than 2 years were the ones who might be concerned with the existing situation within the long-term mental health institutions.

Assumptions are that those who worked for less than 2 years were expecting families to visit the MHCUs while admitted. Moreover, probabilities are that those who worked for more than three years and above were used to existing situation within the long-term mental health institutions. Therefore, the longer the employee works in the hospital, the better they can report on their experience and make valuable input for the study. It was found that the majority of the nurses always share their experiences in the nursing profession. This finding is in line with previous studies about challenges experience by nurses on the provision of quality nursing care. In addition, nurses who have worked for many and years have had positive experiences are able to encourage others to pursue careers in nursing (Frimpong, 2016).

The distribution of nurses by rank shows that of 360 respondents in the study, 150 (41.7%) were Enrolled Nursing Assistants, 53 (14.7%) were Enrolled Nurses, 22 (6.1%) were Registered Nurses, 120 (33.3%) were Professional Nurses, (3.6 n=13) were Operational Managers and 2 (6%) were Nursing Service Managers. This question was to be important to ask since various categories of nurses provide caring to patients in different aspects. Probabilities are that the high number of enrolled nursing auxiliary nurses could explained

the fact that they are the primary nurses for the patients twenty-four hours more than other nurses. The distribution of nurses by qualifications shows that of the 360 respondents in this study, majority 189 (52.5%) have certificates, 104 (28.9%) diplomas and 67 (18.6%) degrees. This question sound to be important to ask since of the different nursing services that integrate with qualification in providing health care services.

It might be possible that highest number of enrolled nursing auxiliary nurses could be explain the fact that they are the primary nurses for the patients twenty-four hours more than other nurses. It was identified that nurses with from diploma qualification to the highest, have responsibilities that include supervision of the lower categories in the provision of quality nursing care and administrative roles in a nursing profession (Frimpong, 2016).

Gillen (2012) and O'Donnell (2012 cited in Beauvais, Stewart, DeNisco & Beauvais, 2014) revealed that both nationwide and internationally attrition rates in nursing programs are of concern as they reduce the supply of nurses. However, study conducted in to describe the relationship between emotive intelligence, psychological empowerment, resilience, psychic well-being, and educational attainment in undergraduate and postgraduate nursing suggested that the nursing profession should be troubled about abrasion rates for masters and doctoral nursing programs as well (Beauvais et al., 2014).

The distribution nurses by age shows that of the 360 respondents of this study, 10 (2.8%) were aged from 20 to 25 years, 98 (27.2%) were aged between 26 to 35 years, majority 149 (41.4%) were age from 36 to 45 years, while 74 (20.6%) were age between 46 to 55 years and 29 (8.1%) were aged be above 55 years. Nearly half of the respondents in this study were between 36 to 45 ages. Age was important to this study, as it helped to identify variances and

inputs from different nurses. Probabilities are that the implication of the findings might indicate that most of the respondents were youth hence less respondents were elders approaching retirement age during the period of this study.

The study assumes that elderly nurses were considered to have knowledge, skills, positive attitudes and experience that can assist in mentorship to newly qualified health care providers. Age was also important as it was assumed that it will shed light in relation to how family members are involved. Therefore, nursing requires capable adult nurses who can shape their staff to support each other in a team effort to provide quality health care services. In addition, it was identified that the support from senior nurses might help juniors to succeed in managerial roles because leadership skills are not linked to the skin color of individual nurses (Frimpong, 2016).

The distribution of nurses by gender shows that of the 360 respondents in this study, 276 (76.7%) were females, 84 (23.3%) were males. Gender was important to this study, as it helped to identify variances from both genders, since males and females have different views and perceptions that may be of value. It might be possible that the highest number being female nurses could be the fact that nursing had been a female profession in previous years.

This was supported by a case study report, forming part of the HSRC study indicating that female nurses remain the majority across all nursing categories. For the total number of 196914 nurses, 92.9 percent were female and 7.0% were males (SANC, 2007 cited by Wildschut & Mqolozana, 2009; Rispel, L.C, 2015). However, females being in the majority is a reflection of the point that nursing is a female-conquered profession in South Africa. The 2013 mid-year population estimations in South Africa designated that there were 22 698 male nurses versus 238 000 female nurses employed in different South African

health facilities (SANC, 2014). In addition, it was suggested that the nursing profession should require a high level of expertise is likely to increase the high rate amongst men in nursing. Hence the low rate of male nurses in the nursing profession may be due to a perception that is mainly a female healthcare industry. As a result, it was highlighted that nursing is apparent as a feminine profession, so the caring touch of men in nursing is often sexualized (Evans, 2002; Harding, North, & Perkins, 2008; Stokowski, 2012, cited in Frimpong, 2016).

The distribution of nurses by marital status shows that of 360 respondents in the study, 165 (45.8%) were single, 170 (47.2%) were married, 11 (3.1%) were divorced and 14 (3.9%) were widowed. The implication of the findings possibly indicate that most of the respondents were married during the period of this study. Marital status was important to this study, as married people may be mature and careful in executing their responsibilities. According to Maslach and Schwartz (2007 cited in Thomas, Kohli & Choi, 2014) within the nursing profession, people who are married are often charged with greater responsibilities as they are more capable of caring for a husband, children, in-laws and extended family members than single.

4.5 DATA DISTRIBUTION AND INTERPRETATION OF RESULTS

The aim of this section was to describe perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province. The alarming results were interpreted separately and some items with similar focus were clustered together for easy interpretation of the meanings. The results were interpreted separately and certain items with similar focus were clustered together for easy interpretation of the meanings as indicated in table 4.6.

Table 4.5 Respondents' concerns on family involvement

Nurses concern about challenges regarding family involvement in mental health care	Agree		Disagree	
	Frequency	Percent	Frequency	Percent
	313	86.9	47	13.1
Nurses concern about the involvement of the family members	329	91.4	31	8.6
Nurses concern on the provision of mental health care services	290	80.6	70	19.4
Cases with poor family contacts are referred to the relevant health care provider	317	88.1	43	11.9
Nurses concerned about the involvement of the family members	Major		Minor	
	Frequency	Percent	Frequency	Percent
	301	83.6	59	16.4

Table 4.5 shows nurses concerns regarding family involvement challenges. Of the 360 respondents in the study, majority 313 (86.9%) agreed while 47 (13.1%) disagreed. However, 329 (91.4%) respondents agreed that they are concerned about involvement of the family members, 31 (8.6%) disagreed. Almost 290 (80.6%) respondents agreed that they are concerned about the provision of mental health care services and 70 (19.4%) disagreed. Majority 317 (88.1%) of respondents agreed that cases regarding poor family contact are referred to the relevant health care provider and 43 (11.9%) disagreed. However, majority 301 (83.6%) of the respondents agreed that involvement of the family members is a major concern and 59 (16.4%) disagree

The concerns raised by more respondents are that challenges regarding family involvement, the way family members are involved, the provision of mental health care services and referrals to the relevant health care provider revealed that family involvement was insufficient. Study conducted in South Africa by Manyisa and Aswegen (2017), to describe the working situations in public hospitals, found that nurses were concerned about the working conditions that affect the provision of quality health care services in public hospitals.

The study also found that such concerns have a negative impact on the physical and psychosocial wellbeing of employees. Therefore, the study suggested that various strategies should be developed to improve the quality of health services in public hospitals to alleviate these concerns. It was also suggested that supervisors had to find a way to address issues of low morale weariness and emotional enervation among health care professionals that have been found to be the major prognosticators of job dissatisfaction (Manyisa & Aswegen, 2017). In this study, a developed model will guide nurses to promote family involvement in caring for MHCUs in long term mental health institutions.

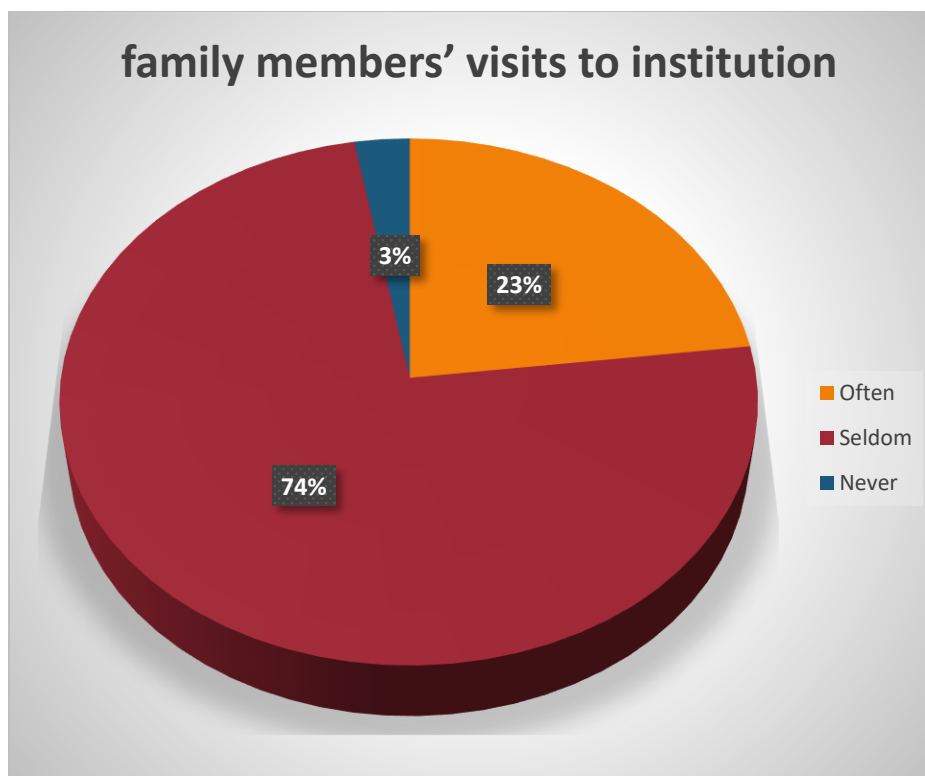


Figure 4.2 Family members visits to institution

Figure 4.2 shows family members visit to institution. Of the 360 respondents of this study, 83 (23.1%) indicated that family members often visits their MHCUs, 267 (74.2%) responded family members seldom visit. However the minority 10 (2.8%) of the respondents indicated that family members never visit their MHCUs. Therefore, study assumptions are that the higher percentages indicating infrequent visits by the family members and never visit their MHCUs reveals that family involvement was poor. ,

A South African study by Temane, Simelane, Poggenpoel, Myburgh (2016), on the exploration and description of the experiences of nurses caring for mentally ill patients in a public mental health institution, found that patients were not visited by their family members. As a result, nurses experienced extremely upsetting impact on their whole being when caring for mentally ill

patients. Nurses also developed a sense of consideration and alternative way of observing life, and experienced a need for positive physical, emotional and spiritual needs to be met. Caring for mentally ill patients not visited by family members was a challenge. The study suggested that nurses need to be equipped to deal with challenges they experience (Temaneet al., 2016).

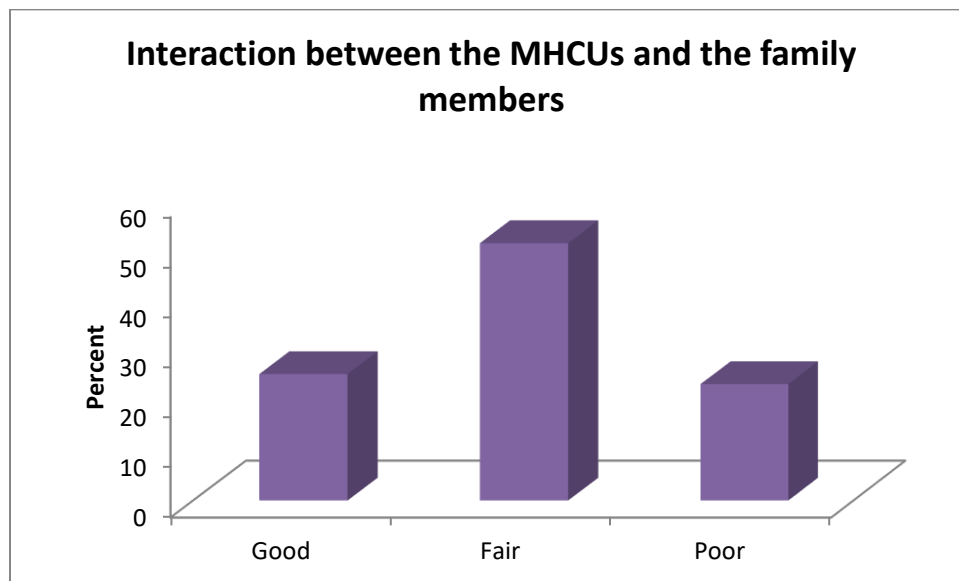


Figure 4.3 interaction between the MHCUs and the family members

Figure 4.3 shows interaction between the MHCUs and the family members in long-term mental health institutions. Of the 360 respondents in this study, 91 (25.3%) indicated that interaction between the MHCUs and the family members was good, majority 185 (51.4%) of the respondents indicated that interaction is fair while 84 (23.3%) respondents indicated that interaction was poor. Probabilities are that poor interaction between MHCUs and family members might be the fact that families were not visiting their loved ones in long-term mental health institutions. As a result family involvement was insufficient. Although poor interaction between patients and family members

was found to have impact towards nurses experiencing inner conflict when caring for mentally ill patients, causing them to feel concerned, disheartened, miserable and heartbroken. This contributed towards nurses losing their energy and enthusiasm to cope with the situation when caring for MHCUs who were not visited. The study also suggested that nurses should have a thorough understanding of mental health and a positive attitude towards patients to ensure that quality nursing care is provided (Temane et al., 2016).

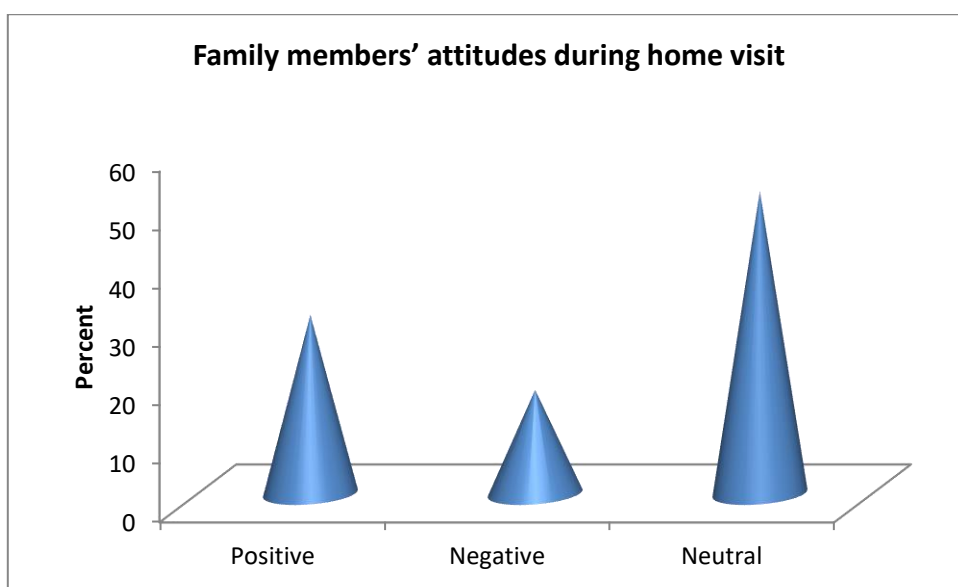


Figure 4.4 Family members' attitude during home visit

Figure 4.4 shows family members' attitudes during home visits. Of the 360 respondents in this study, almost 110 (30.6%) responded that family members' attitudes during home visit was positive. However, 64 (17.8%) responded that family members displayed negative attitudes. Most of the respondents 186 (51.7%) indicated that attitudes of family members seemed to be neutral. It could be possible that family members might think that home visits were conducted to families not visiting their loved ones admitted in long-term mental health institutions.

According to Temane et al. (2016), on the exploration and description of the experiences of nurses caring for mentally ill patients in a public mental health institution, home visits highlights that families need to be involved as they play a significant role in caring for mentally ill patients. Despite that patients need help from the community as well. Moreover, Temane et al (2016) study identified that families could also help out by taking the MHCUs for weekend pass outs. A study identified that families need to be supported by health care professionals when caring for mentally ill patients at home. It was also identified that home visits should be conducted to ensure that family members are guided and supported when the MHCUs are taken for weekend pass outs (Temane et al., 2016).

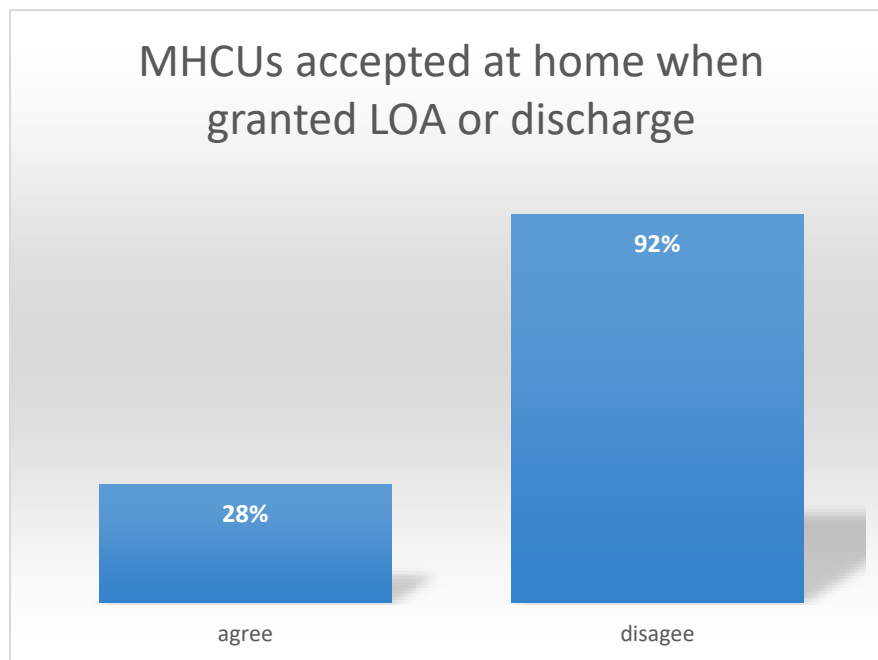


Figure 4.5 Respondents on MHCUs' LOA or discharge

Figure 4.5 shows that MHCUs were accepted at home when granted LOA or discharge. Of the 360 respondents in this study, majority 332 (92.2%) of the respondents agreed, 28 (7.8%) disagreed. Probabilities are that family

members might not accept MHCUs at home when granted LOA or discharge thinking that they are the ones who would be looking after their loved ones forever. Western Cape study by Lorenzo (2012), to address the comprehensive needs of people with mental illness at community level, identified that families and the community as a whole should recognize that MHCUs have the right not to be discriminated against. Authors identified that MHCUs and their family members should be provided with information and support to assist them to accept their MHCUs when granted LOA or discharge (Lorenzo, 2012).

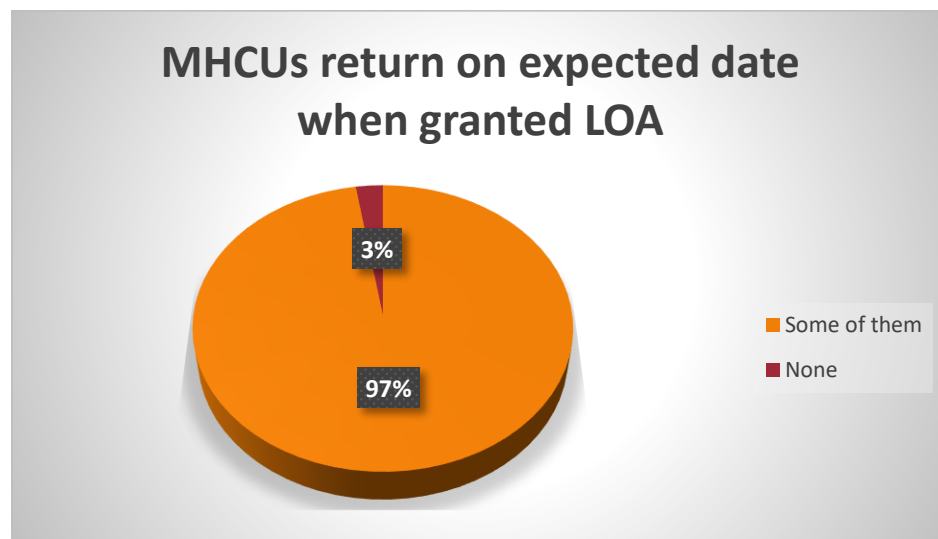


Figure 4.6 MHCUs return on expected date when granted LOA

Figure 4.6 MHCUs return on expected date when granted LOA. Of 360 respondents, 351 (97.5%) indicated that some of the MHCUs return on expected date when granted LOA, 9 (2.5%) responded that none of the MHCUs return on expected date when LOA was granted. Probabilities are that MHCUs might be sent back to the long-term mental health institution before expected date when granted LOA when families experienced difficulties in staying with the MHCUs.

Furthermore, the MHCUs' deviant behavior might be a reason to be returned before the expected date in such situations. However, the community-based rehabilitation (CBR) Guidelines (WHO, 2010 cited in Lorenzo, 2012), reported that for family members to stay with their MHCUs when granted LOA and continue with care at their homes, families should become active participants in the planning of health and rehabilitation interventions. In relation to family involvement, study reported that family members lacked information about the health condition of the person with a disability in their family. Similarly a study conducted by Keikelame and Swartz (2007 cited in Lorenzo, 2012) in Khayelitsha found that family members were poorly informed on mental illness, its predisposing factors and the management thereof. As a result, lack of knowledge led to misunderstanding why MHCUs are granted LOAs.

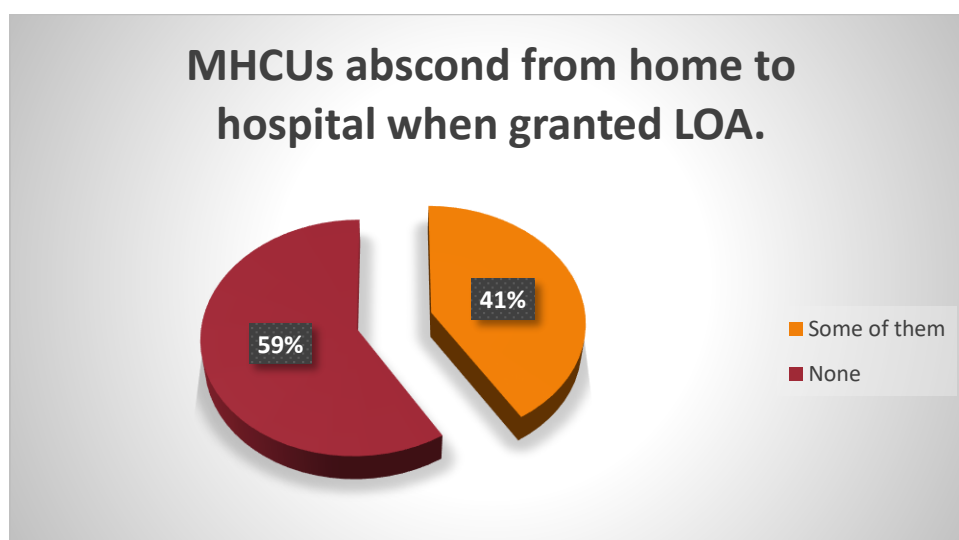


Figure 4.7 MHCUs abscond from home to hospital when granted LOA

Figure 4.7 shows MHCUs absconding from home to hospital when granted LOA. Of the 360 respondents, 148 (41.1%) responded that some of the MHCUs absconded from home to the hospital when granted LOA. Majority 212 (59%) responded that no MHCUs abscond from home to the hospital when granted

LOA. Therefore, study assumptions are that MHCUs might avoid to being treated in traditional ways and feel uncomfortable at home that leads to absconding from home back to the hospital. This reveals that MHCUs feel they would rather stay in long-term mental health institutions in such situations. Study conducted in Namibia by Bartholomew (2015), to explore the significance and nature of mental illness, revealed that the mental illness comprehends the meanings connected with experience of clinical manifestation of psychological discomfort.

Study highlighted the South African history that show that significant most South Africans avoid consulting traditional healers, including traditional mental health care focusing on western medication. Study suggested that traditional healers should be considered as additionally embedded in a sense of interconnectedness, which flows in much of African psychological experiences. *Ubuntu*, was also suggested as a way of being a cornerstone of African philosophical understanding that reflects that people exist through others (Gade, 2011).

4.5.1 Merged data analysis comparison

According to Creswell and Plano Clark (2011) the mixed methods data analysis was conducted to answer mixed methods research questions in order to determine whether the results from both converge and how they converged. Three options for merge data analysis comparison include: side-by-side comparison, joint display and data transformation merged analysis (Creswell & Plano Clark, 2011). In this study, side-by-side table in which both qualitative and quantitative data of two sources were directly compared.

The researcher compared interview data from family members regarding their involvement in mental health care, treatment and rehabilitation; FDGs data from MHCUs regarding the involvement of their family members in mental health care, treatment and rehabilitation with perception of nurses' data on similar information found in both sources of data. In addition, four themes from interviews and FDGs were presented to compare how both sources of data-side-by-side-provide evidence of family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province as indicate in table 4.6.

Qualitative data		Qualitative data
Themes from MHCUs' views	Sub-themes	Perceptions of nurses
1. Experiences of MHCUs related to the attitude of family members towards the provision of care to them	<ul style="list-style-type: none"> -Behaviour of family members towards MHCUs which causes suffering at multiple levels -Feelings of rejection experienced by MHCUs from the negative attitudes displayed by family members 	<ul style="list-style-type: none"> -Concern about challenges regarding family involvement in mental health care -Negative attitudes of family members towards MHCUs -Poor interaction between MHCUS and families
2. Observation made by MHCUs towards family members and hospital management	<ul style="list-style-type: none"> -Lack of support by family members to MHCUs observed leading to shortened LOA -Reasons provided by family members for lack of taking MHCUs to LOA outlined -Existence of support by hospital management appreciated by MHCUs outlined 	<ul style="list-style-type: none"> -MHCUs came back before expected date when granted LOA -MHCUs abscond from home back to the hospital when granted LOA
3. Knowledge of family members related to care of MHCUs	<ul style="list-style-type: none"> -Lack of knowledge treatment effects lead to lack of support by family members to MHCUs -Family's lack of knowledge related to the importance of adherence to treatment outlined 	<ul style="list-style-type: none"> -MHCUS not accepted at home when granted LOA or discharged -MHCUs came back before expected date when granted LOA
4. Challenges resulting from lack of support by family members	<ul style="list-style-type: none"> -Patients' development of resistance towards rejection by family members problematic -Existence of ideas that families which are not visiting are dead outlined by MHCUs 	<ul style="list-style-type: none"> -More cases referred to social workers -MHCUS not visited by family members -MHCUs not having identity Documents -MHCUs buried as paupers when died and family tracing failed

Themes from perceptions of families	Sub-themes	Perceptions of nurses
1. MHCUs families' views and experiences related to involvement in the care of a family member	<ul style="list-style-type: none"> -MHCUs viewed by family members as a danger to the community -Caring for MHCUs viewed as a difficult task by the family members -Lack of visitation of MHCUs by family members in hospital result from fear that patients will request LOA 	<ul style="list-style-type: none"> -More cases referred to social workers -MHCUS not visited by family members -MHCUs not having identity Documents -MHCUs buried as paupers when died and family tracing failed
2. Practices related to carrying for MHCUs at home by family members	<ul style="list-style-type: none"> -Reluctance of family members to care for MHCUs at home expressed -An explanation that MHCUs abuses substances during LOA which leads to families reluctant to request them 	<ul style="list-style-type: none"> -MHCUS not accepted at home when granted LOA or discharged -MHCUs came back before expected date when granted LOA
3. Practices related to caring for MHCUs at home by family members	<ul style="list-style-type: none"> -Existence of knowledge related to the importance of MHCUs care by family members -Provision of health education on promoting treatment adherence outlined as important 	<ul style="list-style-type: none"> -MHCUs abscond from home back to the hospital when granted LOA
4. Existing challenges in carrying for MHCUs by family members	<ul style="list-style-type: none"> -Difficulty in monitoring treatment adherence by MHCUs -LOA viewed as a challenge because MHCUs relapse when at home 	<ul style="list-style-type: none"> -MHCUs came back before expected date when granted LOA

Table 4.5.1. Merged data analysis comparison

Table 4.6 shows side-by-side in which both qualitative and quantitative data of two sources directly compared. However, the presentation becomes a means of conveying the merged results (Creswell & Plano Clark, 2011). It revealed that themes and sub-themes from both MHCUs and families in qualitative approach were related to quantitative approach of the perception of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

4.6 DISCUSSION OF FINDINGS

The researcher conducted data analysis independently following procedures of both qualitative and quantitative approach in order to merge the results. However, the researcher uses convergent analytic approach to merge the two data sets. This study found that in phase one, quotations from the perceptions of family members regarding their involvement in long-term mental health institutions, were answered by quotations from the views of MHCUs regarding the family involvement in their care treatment and rehabilitation. Furthermore, quotations by FDGs were also answered by quotations from interviews. As a result, there are repetitions of quotations in the discussion of findings as the researcher discussed themes integrating quotations that answer each other.

This study found that the qualitative findings are related to quantitative findings to the extent that both answered the research questions. In addition, side-by-side strategy was used to merge data analysis in the form of summary tables so that the reader could see how qualitative and quantitative sources provide the evidence of each topic (Creswell & Plano Clark, 2011). In this study, the researcher merged two data sets of results in an interactive way to indicate the point of interface (Creswell & Plano Clark, 2011).

However, four themes were merged to describe the perceptions of MHCUs regarding the involvement of their family members in mental health care, treatment and rehabilitation: Theme 1: Experiences of MHCUs related to the attitude of family members towards the provision of care to them; Theme 2: Observation made by MHCUs towards family members and hospital management; Theme 3: Knowledge of family members related to care of MHCUs; and Theme 4: Challenges resulting from lack of support by family members.

In addition, four themes were merged to describe the views of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation: Theme 1: MHCUs families' views and experiences related to involvement in the care of a family member; Theme 2: Observation made by MHCUs towards family members and hospital management; Theme 3: Practices related to carrying for MHCUs at home by family members; and Theme 4: Existing challenges in carrying for MHCUs by family members. The researcher brought both qualitative and quantitative data sets together to compare in order to develop a model to promote family involvement in caring for MHCUs in long-term MHCI.

4.6.1 Themes and sub-themes reflecting views of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation

4.6.1.1 Theme 1: Experiences of MHCUs related to the attitude of family members towards the provision of care to them

Participants' experiences related to the attitude of family members revealed that there is poor interaction between the family members and the MHCUs. Participants indicated that family members do not visit them once they have

been admitted. However, participants indicated that family members are not prepared to stay with the MHCUs at home when discharged or granted LOA.

The following statements from the participants provide evidence that MHCUs' experiences related to the attitudes of family members towards the provision of care to them is problematic:

"It is bad, my family and relatives are not coming and there's nothing bad I did."

"I've never been taken for LOA, they always promise me but they don't take me when granted LOA."

Perceptions of nurses regarding the involvement of family in caring for MHCUs revealed interaction between the MHCUs and the family members. Of the 360 respondents in this study, 91 (25.3%) responded that interaction between the MHCUs and the family members is good, 185 (51.4%) responded that interaction is fair and 84 (23.3%) responded that interaction is poor. The study findings report that most of the respondents indicated poor interaction between MHCUs and family members as well as the statements from MHCUs reveals that family involvement is insufficient.

However, Flynn and Preuster (2014) who conducted a study on patient and family-centred care found that interaction between the family and MHCUs when admitted to hospital brings comfort, reduces anxiety and offers reassurance when the patients are admitted. Family members are of assistance when visiting their patients because they may provide useful information about the patients which could serve a great deal. As indicated, the presence of the members bring joy to patients which will lead to speedy recovery. It is evidenced that patients who do not have visitors suffer depression in contrast

to patients who receive visitors. In addition, another reality is that many patients realized that family members do not accept them (Flynn & Preuster, 2014).

4.6.1.1.1 Sub-theme 1.1: Narratives related to the behaviour of family members towards MHCUs which causes suffering at multiple levels

Participants' views regarding the involvement of their family members revealed that MHCUs are concerned about reaction of their family members. This sub-theme was not addressed by the quantitative approach. However, participants indicated that family members are not patient with the MHCUs. The fact that family members do not accept that staying with a mentally ill member needs patience, was also realised by MHCUs themselves. Participants indicated that family members consulted with the social workers to present MHCUs' problems instead of supervising MHCUs to comply with treatment when discharged or granted LOA.

The following statements from the participants show evidence that MHCUs are concerned about the behaviour of their family members which causes suffering at multiple levels:

“They present our problems to the social workers instead of assisting us to take treatment accordingly. They should be patient to us they should be patient, we are mentally ill.” (She cries).

“They should accept that I am mentally ill they should accept and assist as to take treatment when we are in LOA, they should monitor our treatment compliance.”

Probabilities are that MHCUs are worried about the behaviour of their family members who deserted them due to illness. Their concerns are seen by crying each time they talk to nurses about family members. This was supported by

WHO (2014) who emphasized that family building and parenting influences mental and physical health, hence a negative attitude towards mental illness contribute to insufficient support to mental health care. In addition, socioeconomic factors such as lack of secure attachment, neglect, lack of quality stimulation, and conflict, negatively impact on future social behaviour were identified. Therefore, quality of parenting has a significant impact on risk of mental and physical health (WHO, 2014).

Furthermore, the following statement from participants (family members) reflects the behaviour of their family members which causes MHCUs suffering at multiple levels:

“I won’t take him for LOA. He does not have time to bath, he roams around the village aimlessly being dirty. When his illness start. We have to call the police to assist to return to the hospital.”

“I think I won’t be safe. Do you want me to tell you that he wanted to sleep with me? Don’t ask me a lot. The fact is that I am afraid to stay with him. He is too dangerous.”

4.6.1.1.2 Sub-theme 1.2: Feelings of rejection experienced by MHCUs from the negative attitudes displayed by family members

Participants’ views regarding involvement of their family members revealed that MHCUs are concerned about being rejected. Participants indicated that they worries about the family members who reject them while they are in hospital. Participants also indicated that family members are not visiting MHCUs. However participants indicated that MHCUs get worried when fellow MHCUs receive visitors in the form of family members. They also showed concern about their families at home.

The following statements from the participants provide evidence that MHCUs are concerned about existing situations:

“It is bad. When other MHCUs are being visited by their family members it really affect me and end up feel being rejected (crying)”.

“Since they came three years ago they are not coming. It is clear that am rejected”.

Probabilities are that participants' crying might be the sign of showing how they feel about rejection. Study conducted by Bridges, Nicholson, Maben, Pope, Flatley, Wilkinson, Meyer and Tziggili (2013) in Britain to explore relatives' views on and experiences of acute health care suggested that paying visits to MHCUs admitted in long-term mental health is very important, it allays anxiety and provides feelings of worthiness. In addition, study revealed that promoting family visits helped patients feel supported and connected to their family members (Bridges et al., 2013). Of the 360 respondents in this study, 7 (1.9%) respondents indicated that few MHCUs in their unit/ward were visited by family members. However, 81 (22.5%) responded that less than five MHCUs in their unit/ward were visited the family members. Most respondents 234 (65.0%) Indicated that less than ten MHCUs in their unit/ward were visited by the family members.

Furthermore, the following statement from participants (family members) reflects the negative attitudes displayed by them that leads to MHCUs feelings rejected:

“I am afraid to take him when granted LOA.The community members even complained to the “induna”. That is why he came with the letter to indicate that he is no longer wanted at our village.” (Being sad).

“It won't work. He won't take treatment. He is unmanageable at home. I don't have another words to explain that I cannot able to take him home whether is LOA or discharge.”

The sad expression showed by the participant, is a sign that the community members in the village where the MHCU resides are no longer welcoming the patient. Probably because of the behavior of the MHCU before admission. Van Beljouw, Van Exel, de Jong Gierveld, Comijs, Heerings, Stek and Van Marwijk (2014) on their study conducted in VU Medical Centre to get a deeper insight into the mental health concerns of loneliness in MHCUs with depressive symptom.

Study identified that being sad is a depression symptoms. Authors further argued that the strong relationships between depression and solitude increases questions about the particularity of both concepts. This was supported by Member of Executive Council (MEC) of Department of Health Dr Ramathuba on 2018-2019 budget allocation speech on the 10th April 2018, indicating that MHCUs are being rejected by their family members when discharged. She also highlighted that families should accept MHCUs when discharged.

The following statement provide evidence that MEC Dr Ramathuba had concerned with families which reject MHCUs.

“MHCUs are being rejected by their family members when discharged. Let us accept our MHCUs when discharged. None of us are immune to mental illness, rejecting MHCUs when discharged is part of mental illness.”

4.6.1.1.3 Sub-theme 1.3: Existing lack of communication between family members and MHCUs experienced

Participants' views regarding the involvement of their family members revealed that MHCUs are concerned about communicating with their family members. This sub-theme was not addressed by the quantitative data set.

The following statements from the participants provide evidence that MHCUs are concerned about communicating with their families:

“When I phone my family, they say they should be called by institution otherwise they won’t come. Are we not allowed to phone them?”

“I use to make please call me with my fellow MHCUs phone and they phone me. They are no longer responding to my call backs, they are not even coming.”

Findings revealed that participants’ lack knowledge of the power of communication between the MHCUs and the family members. Probabilities are that poor communication might reflect that families avoid to talk to MHCUs forgetting that communication is of significance in emotional support. Eassom, Giacco, Dirik and Priebe (2014) share the same sentiments by warning that non-judgmental communication could facilitate the creation of a therapeutic alliance between staff, families and patients in mental health care (Eassom et al., 2014).

4.6.1.1.4 Sub-theme 1.4: Lack of consideration and readiness of family members to take MHCUs for LOA is problematic

Participants’ views regarding the involvement of their family members revealed that lack of consideration and readiness of family members to take MHCUs when discharged or granted LOA is a great challenge. Participants indicated that family members do not accept living with the MHCUs even when stable on treatment.

The following statement from the participants is evidence that MHCUs are not considered and the family members are not ready to take them for LOA:

*“I am not feeling well, it is clear that I will no longer be accepted at home. ...I have been discharged since two years no one is ready to stay with me.”
(being sad).*

The sad expression showed by the participant, is a sign that the MHCU is no longer accepted at home, probably because of the behavior of the MHCU before admission. A study that explored the factors contributing to MHCUs relapse, revealed that problematic family and peer relationships have impact on deterioration of mental illness. Authors confirmed that family members contributing to relapse may play a significant role in MHCUs' recovery (Thothela, Van der Wath & van Rensburg, 2014).

In addition, of the 360 respondents in this study, majority 351 (97.5%) agreed that MHCUs come back before the expected date when granted LOA, 9 (2.5%) disagreed. This finding might be an indication that family members are not ready to take nor to care for MHCUs at home when discharged or granted LOA. It is shown by family members bringing back the MHCUs to the institution before the end of leave.

Furthermore, the following statement from participants (family members) reflects lack of consideration and readiness of family members to take MHCUs for LOA:

"...I am unable to stay with him at home. He behaves like a pig, he collects unnecessary papers and cloths from nowhere and bring to his room. He also make fire inside his room. I am staying in the location not in the rural villages."

"He refuse to take his treatment. When he has done something wrong, he defend himself by saying that everyone knows that he is mentally ill. I like to visit him, but the hospital is very far, am not rejecting him. I am very old."

Chien, Yeung and Chan (2014) suggest that MHCUs feel that they are not considered, feel rejected and discriminated against, due to decreased level of functioning and inadequate family support. According to Mestdagh and Hansen

(2014), MHCUs feel uncomfortable regarding discharge or being granted LOA. This lead to stigma due to mental illness. Their expectations concerning being discharged or granted LOA with previous experiences as well as own prejudices about how their families deals with mental health, seem to lead towards anticipation of stigma (Mestdagh & Hansen, 2014).

4.6.1.1.5 Sub-theme 1.5: Feelings of avoidance experienced by MHCUs from family members

Participants' views regarding the involvement of their family members revealed that MHCUs feels that family members avoid interacting with them because they are mentally ill. This sub-theme was not addressed by the quantitative data set. Participants indicated that family members give minor reasons to avoid taking MHCUs for LOA hence insufficient housing to accommodate the MHCUs is a contributing factor.

The following statement from the participants is evidence that MHCUs feel that family members avoid interacting with them because of mental illness:

“I am not taken for LOA since admission in 2015. I think they avoid to be closer to me as I am having mental illness.”

“They says that I don’t have a house at home to accommodate me. They don’t care about me.”

Eassom et al. (2014) suggested that the ‘whole team approach’ should be used in order to implement family involvement in mental health care effectively, hence all members of a clinical team should be trained and regularly supervised. Authors further emphasized that family-oriented practice may need to be embraced and included in work routines. This is the best practice that promotes interaction between the family members and the MHCUs (Eassom et al., 2014). In addition, the following statement from participants (family members) reflects that family members avoid taking MHCUs for LOA:

“...My concern is that I won't take him for LOA. My neighbours, colleagues and even the community are not happy when my child is on LOA. They discriminate me saying that there is something wrong I did that is why I have a mentally ill child being a principal.”

Family members report that they cannot take their MHCUs if discharged or granted LOA due to problems they encounter with neighbours. It may be possible that families are avoiding their patients by shifting blame onto other people. Study conducted in Eastern Cape to explore the perceptions of indigenous people and the role of traditional healers in the management of MHCUs, has shown family members have confirmed that it is difficult to accept mental illness like other common medical condition (Tilolo, Magadla & Tshotsho, 2015).

4.6.1.1.6 Sub-theme 1.6: Existing empty promises experienced by MHCUs from family members

Participants' views regarding the involvement of their family members revealed that MHCUs have concern towards existing empty promises from their family members. Participants indicated that MHCUs ask themselves questions that do not have answers hence family members are expected to build trust. Participants indicated that MHCUs are concerned about prolonged stay in hospital that affects their future.

The following statements from the participants are evidence that MHCUs are concerned about existing empty promises made by their families:

“Even if they come, they promise to come back but they are not coming since last year. They are lying being adults. I won't trust them anymore.”

“Since they came and promise to take me for LOA they are not coming. How can they lie to me? They are not faithful.”

However, of 360 the respondents in this study, majority 332 (92.2%) responded that MHCUs went on LOA. However, 28 (7.8%) respondents indicated that families disagree to take MHCUs for LOA when granted. Therefore, probabilities are that family may disagree to take MHCUs for LOA not realizing that the patient is stable and can also see that they are not telling the truth. However, it was suggested that current mental health policy directives should support the development of practice and education initiatives to encourage families to demonstrate openness, respect, and understanding towards MHCUs (McCann & Sharek, 2014).

Furthermore, the following statement from participants (family members) reflects the existing empty promises from family members:

“No one to supervise treatment compliance at home he is staying alone. I will afford to take him during December holiday.”

*“.....I can visit, but it is obvious that he can ask me to take him for LOA. That is why I don't want to visit him frequently.I can visit but I don't know.”
(Being sad).*

The sad expression shown by the participant, is a sign that the family is not ready to take the MHCU. This might be because of the deviant behaviour of the MHCU when granted LOA.

4.6.1.2 Theme 2: Observation made by MHCUs towards family members and hospital management

Participants' views regarding the involvement of their family members revealed that MHCUs observe support provided by both family members and hospital management. Participants indicated that MHCUs observed that insufficient support by family members contributed to failed LOA. Participants also indicated that MHCUs appreciate support by hospital management.

The following statements from the participants are evidence that MHCUs observe lack of support provided by family members:

“Since I visited home with staff for LOA, I have never been visited.”

“When I came back, doctors extended my LOA. They refuse to go back with me. They gave reasons that they will come back. They were not ready to go with me.”

Of the 360 respondents in this study, 110 (30.6%) indicated that family members' attitudes during home visit was positive. However, 64 (17.8%) respondents indicated that family members display negative attitudes. Furthermore, 186 (51.7%) respondents indicated that attitudes of family members seemed to be neutral. Therefore, assumptions are that the highest percentage of family members being neutral reveals that they may need support from health professionals to be engaged in mental health. However, it was suggested that health care providers should establish a bond in order to do regular “follow up” with families as well as observing physical and mental health regularly. In addition, providing support to the MHCUs entails that family members should maintain a positive attitude to consolidate a trusting relationship towards MHCUs (Sarradon-Ecka, Farnariera & Hymansb, 2014).

Furthermore, the following statement from participants (family members) reflects a response of family members towards MHCUs during home visits:

“They came together with my uncle. We prepare food to serve them. My uncle asked the social worker to hurry saying that they should depart because they can miss hospital lunge. He refuse to eat with us saying there is delicious food at the hospital. I am really concerned.”

Yet, MHCUs observe support provided by the hospital management. Participants indicated the positive attitude provided by the hospital hence the MHCU feels accommodated. Participants indicated that the hospital also

contributed towards the provision of identity documents (ID) and birth certificates. However, there are participants who were given names as they did not have an ID or a birth certificate. Participants indicated that the hospital intervened in order to identify MHCUs who were not identified.

The following statements from the participants provides evidence that MHCUs observe the support provided by hospital management:

“I feel good when I’m in hospital. (Being sad). I don’t have parents. Last time I have been told that I have been found somewhere, being dumped, and brought to the hospital. The hospital gave name and surname. I don’t have anything to prove such as ID or birth certificate. Since after staff members took me for LOA, I feel accommodated they accept me at their home.” (She cries).

This was supported by quantitative data set which indicated that of the 360 respondents in this study, 241 (66.9%) responded that MHCUs were given names and surnames whereas 119 (33.1%) respondents reported that MHCUs were given numbers. Yet, patients’ names are of significance in imaging verification to ensure the correct identity of the patient and laterality is correctly labeled. In addition, the presence of the patient’s imaging before, during the operation and post operation verifying the patient’s identity to minimize human error (Cohen, Mandelsohn & Bernstein, 2010; Mendelsohn, D. & Bernstein, M., 2014).

However, of the 360 respondents in this study, 35 (9.7%) responded that all of the MHCUs in their units/wards have birth certificates. Few respondents 25 (1.7%) nurses responded that some of the MHCUs have birth certificates. President George W. Bush introduced the awareness of medical errors and increased the focus on improving the quality of patient care in 2014. In addition, it was found that the patient's identity, and any drug reactions or allergies were uploaded in patients’ records to minimize medical errors (Purnam & Hartati,

2012; Sundari, & Mandiri, 2016). Whilst 67 (18.6%) respondents reported that none of MHCUs were had a birth certificate; of the 360 respondents in this study, 52 (14.4%) reported that all of the MHCUs in their units/wards have ID. Majority 296 (82.2%) respondents, responded that some of the MHCUs have ID. However, 12 (3.3%) respondents indicated that none of the MHCUs are had ID. Therefore, literature suggested that the medical record should contain records and documents about the identity of the patient that is significant in examination, treatment, action, and other services provided to patients in healthcare facilities (Purnam & Hartati, 2012; Sundari, & Mandiri, 2016).

Of the 360 respondents in this study, 258 (71.7%) reported that cases were referred to a social worker until MHCUs got ID. Various authors argued with regard to the referral to MDT hence the MHCUs identity is of significance. Authors indicated that it is the social worker's responsibility to intervene in such situations. Therefore, health professionals and social workers should always develop a "shared" therapeutic plan for the patient even if he/she has been involuntarily hospitalized to improve the quality of mental health care services (Fiorillo, De Rosa, Del Vecchio, Jurjaz, Schall, Onchev, Alexiev, Raboch, Kallisova, Mastrogiani & Georgiadou, 2011; Bhugra, Sartorius, Fiorillo, Evans-Lacko, Ventriglio, Hermans, Vallon, Dales, Racetovic, Samochowiec, & Bennemar, 2015).

However, 82 (22.8%) respondents indicated that family members were involved and applied MHCUs ID. Furthermore, 20 (5.6%) respondents reported that they have accompanied the MHCUs to apply ID. Study assumptions are that the higher percentage indicating cases referred to social workers until MHCUs received ID reveals that family involvement is insufficient.

4.6.1.2.1 Sub-theme 2.1: Lack of support by family members to MHCUs observed leading to shortened LOA

Participants' views regarding the involvement of their family members revealed that MHCUs are brought back to the mental health care institution (MHCI) before expected date while on LOA. Participants indicated that there is lack of support by family members, hence there is insufficient treatment supervision. However, participants indicated that when taken for LOA, MHCUs are often alone and forget to continue with treatment. This causes a relapse and they are brought back before expected date. In addition, participants indicated that MHCUs are being threatened to be brought back to the MHCI if they disagree on certain matters while on LOA.

The following statements from the participants provides evidence that MHCUs are brought back to the MHCI before expected date while on LOA:

"I was staying alone at home. I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment."

I once went for LOA, and come back before that date. I once disagree with my family on certain matters, my parent told me that they will return me back to the hospital if I don't cooperate."

Of the 360 respondents in this study, 351 (97.5%) agreed that MHCUs come back before expected date when granted LOA, 9 (2.5%) nurses disagreed. Probabilities are that MHCUs might come back to the mental health institution before expected date when granted LOA because of unaccepted behaviour, hence lack of support by family members may be leading to shortened LOA. Girard, Driffin, Musso, Naudin, Rowe, Davidson and Lowell (2006 cited in Sarradon-Ecka et al., 2014) state that there is a need to redress the balance in the family-patient relationship in mental health. Therefore, therapeutic relationships are inevitably unequal but this can be lessened by sharing a meal

and the reciprocity that is part of the social relationship between family and patient (Girard et al., 2006 cited in Sarradon-Ecka et al., 2014).

Furthermore, the following statement from participants (family members) reflects that family members' insufficient support to MHCUs leads to shortened LOA:

"I am working in Gauteng, he stays alone at home. He refuse to be assisted by domestic workers and says that his DG is not enough to can pay domestic worker."

"It is not easy to can find a helper to take care in my absence. I'm working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment. Who is going to monitor him while I'm at work because some of treatment is taken during the day?"

4.6.1.2.2 Sub-theme 2.2: Lack of involvement of MHCUs in decision making by family members outlined

Participants' views regarding the involvement of their family members revealed that family members do not involve MHCUs in decision making. This sub-theme was not addressed by the quantitative data set. This study found that only family members are involved in decision making. Of the 360 respondents in this study, majority 314 (87.2%) agreed that in the case of medical illness and procedures, family members are involved and 46 (12.8%) nurses disagree.

It might be possible that the higher percentage indicates that in a case of medical illness and procedures, the hospital involves family members in such situations. Furthermore, participants indicated that MHCUs are not treated with dignity even when stable. However, participants indicated that family members

decide to bring the MHCUs to the MHCI without negotiating with them. Anthony and Crawford (2000 cited in Tambuyzer, Pieters & Van Audenhove, 2011:141; John, 2017) argued that involvement of MHCUs implies, ranging from having a voice, having access to suitable information to sharing a set of basic values. This was supported by Tambuyzer et al, (2014) and John (2017) who stated that involving MHCUs means involvement in decision making and active participation in a range of activities.

The following statements from the participants reveal evidence that MHCUs are not involved in decision making by family members:

“My family members treat me like a psychotic patient, I am not involved in decision making. They don’t negotiated with me about the reasons for bringing me back before expected date.”

“Even if my wife visit me I have to run tuck-shop and when I come back I found them staying with my wife discussing my issues.”

4.6.1.2.3 Sub-theme 2.3: Reasons provided by family members for lack of taking MHCUs on LOA outlined

Participants’ views regarding the involvement of their family members revealed that MHCUs are not taken for LOA; however family members have reasons. This sub-theme was not addressed by the quantitative data set. Participants indicated that when MHCUs are granted LOA, family members make excuses, for instance, that there is no spare house for the MHCUs. Besides that, participants indicated that MHCUs abuses dagga and alcohol while on LOA. In addition, participants also indicated that family members are no longer interested to take MHCUs for LOA because MHCUs relapse due to dagga and alcohol.

Various authors argues that family members need information, assistance and support to best assist MHCUs and cope with the challenges posed to the family system. It was found that the way in which relatives behave toward MHCUs could have important effect on that person's well-being and clinical outcomes (Lucksted, McFarlane, Downing, Dixon & Adams, 2012; Walsh, 2015).

The following statements from the participants reflects evidence that MHCUs are not taken for LOA because of certain reasons provided by family members:

"They says there's no house for me they want to build house for me since 2013."

"When I go home for LOA, I was surprised to be brought back before the expected date. I smoked and even drunk as it was long time not going home."

Furthermore, the following statement from participants (family members) reflects reasons provided by family members for lack of taking MHCUs to LOA:

"As I have said that he is abusing dagga and alcohol when given LOA. He have failed LOA several times. I don't think he can cope when discharged."

*"No. ...I won't take him, may be if I have built an outside room of which I don't know when it is going to be built. That is all. I cannot talk too much."
(Being angry).*

Probabilities are that families might become angry as they were no longer interested in taking MHCUs for LOA because they were aware that MHCUs were going to relapse. It was found that the families need to be involved in mental health care. However, it was also suggested that families should be supported to modify and familiarize themselves toward MHCUs conditions even if the user has committed a serious unlawful offence which warrants detention in a mental health institution (Pule, 2016).

4.1.6.2.4 Sub-theme 2.4: Existence of support by hospital management appreciated by MHCUs outlined

Participants' views regarding the involvement of their family members revealed that MHCUs appreciate the support provided by hospital management. Participants indicated that MHCUs appreciate the way the hospitals intervene to involve family members. Of the 360 respondents in this study, 94 (26.1%) agree that family members are accessible, 20 (5.6%) disagree and 246 (68.3%) indicated that certain members are accessible. Therefore, it was found that negative family dynamics observed among family members contributed to a few research groups that include family psychoeducation to promote family involvement (Lucksted et al., 2012; Walsh, 2015).

In addition, of the 360 respondents in this study, 155 (43.1%) responded that they can access family members through home visit whereas 205 (56.9%) indicated that they can access families telephonically. Probabilities are that the higher percentage indicating family members being accessed telephonically may be an indication that family involvement is insufficient.

The following statements from the participants show evidence that MHCUs appreciate the support provided by hospital management:

"I am feeling good when admitted even my parents are not coming. I then abscond from home back to the hospital. Since then, they are not coming."

The hospital taught us different activities. I am working at the garden of which I'm interested. I feel accommodated at the hospital."

Furthermore, the following statement from participants (family members) reflects that existence of support by hospital management is appreciated by family members:

“The hospital calls me if they want to talk with me. They know that I visit my younger during holidays. I am really satisfied with the way they are caring my younger brother.”

“I am not working. I am depending on my daughter who is married.He once absconded at home until I have been called by the hospital to notify me that my child is back at the hospital.When I go to the hospital he tell the nurses that he is tired of the unhealthy food at home that is why he absconded from home to the hospital.” (She cries).

Therefore, participants crying when the MHCUs abscond from home to the mental health hospital might reflect that the family was ready for their loved ones with mental illness to stay at home. This was supported by Matandela (2014) in the study conducted in South Africa to design support guidelines for mental health professionals caring for MHCUs with suicidal thoughts. It was found that it was difficult for the families to cope after the suicidal incident to the extent that they were unable to sleep since the day of the incident (Matandela, 2014).

4.6.1.3 Theme 3: Knowledge of family members related to care of MHCUs

Participants' views regarding the involvement of their family members revealed insufficient knowledge of family members related to care of MHCUs; although the quantitative data does not address this theme. Participants indicated that lack of knowledge on the effect of treatment contribute to lack of support by family members. However, participants indicated that family members lack of insight related to behaviour modification education provided to MHCUs is a problem. Participants indicated that family members lack knowledge related to

the importance of adherence to treatment. Audenhove (2013 cited in Tambuyzer et al., 2014), Loza and Effat (2017) suggested training for family carers to promote family engagement and that service providers should be equipped with skills to deal with family involvement. In addition, authors argue that mental health institutions need to acquire new skills to involve both client and family members to integrate the values of engagement into daily practice (Audenhove, 2013 cited in Tambuyzer et al., 2014; Loza & Effat, 2017).

The following statements from the participants provides evidence that knowledge of family members related to care of MHCUs is insufficient:

“They are not even aware that nurses always educate about expected behaviour at home.”

“My parents once take me for LOA and told me that they want to try traditional healers as am stable.”

4.6.1.3.1 Sub-theme 3.1: Lack of knowledge on treatment effects lead to lack of support by family members to MHCUs

Participants' views regarding the involvement of their family members revealed that family members are unable to support MHCUs due to lack of knowledge on treatment effects. This sub-theme was not addressed by the quantitative data set. Participants indicated that MHCUs went home for LOA being stable thinking that the mental illness is cured. Participants indicated that MHCUs are not continuing with treatment as there is no one to remind them. However, participants indicated that MHCUs are aware of the bad things they have done at home. Participants indicated that there is a need to be forgiven by asking the researcher to talk to the family members to forgive MHCUs.

However, collaboration among clients, families and providers policy highlighted outlined support, information, education and guidance to family members in order to provide support in the MHCUs recovery. The policy included education and guidance on why information is being shared with family members; protecting the MHCUs' privacy; as well as support available to enhance family counseling opportunities (Chau & Baumann, 2013).

The following statements from the participants are evidence that family members lack knowledge on treatment effects that leads to lack of support to their MHCUs:

“I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment. I think that is why I relapsed and I ended being readmitted to the hospital.”

“May you please talk to my parent to forgive me, I won't repeat what I did. I am their child, they should forgive me. I knows that I once slashed her with the hand.”

Furthermore, the following statement from participants (family members) reflects that lack of knowledge on treatment effects lead to lack of support by family members:

“I think is a punishment to have mental illness within the family. I don't think I can take him again. I am afraid that he can do the same that can left me paying another money. I have nothing to add.”

“...I have a concern about his mental illness. He is a professional pharmacist, he knows better than me. ...I am on antihypertensive treatment because of him.” (Being sad).

Sadness might be a sign that the participant was depressed and also concerned about the MHCUs' knowledge and profession as well as her condition that was precipitated by the MHCUs not complying with the treatment.

4.6.1.3.2 Sub-theme 3.2: Lack of insight by family members related to behaviour modification education provided to MHCUs in hospital problematic

Participants' views regarding the involvement of their family members revealed that family members lack insight related to behaviour modification education provided to the MHCUs. This sub-theme was not addressed by the quantitative data set. Participants indicated that MHCUs are occupied with different activities within the institution, hence they are expected to continue occupying themselves at home when discharged or granted LOA.

Centre for Addiction and Mental Health and Bush (2002) reported that family engagement is not implemented hence health care providers lack knowledge on how to involve family members. This correlates to study by Tambuyzer et al. (2014) suggesting that knowledge, attitudes and skills that service providers, specifically psychiatry residents, need to be competent in supporting and working with families. In addition, stigma has been identified as an ongoing barrier to involve family members (Tambuyzer et al., 2014).

The following statements from the participants are evidence that family members lack insight related to behaviour modification education provided to the MHCUs:

"I am working at the garden of which I'm interested. I feel accommodated at the hospital."

"I am running hospital tuck-shop of which I don't like."

Furthermore, the following statement from participants (family members) reflects lack of insight by family members related to behaviour modification education provided to MHCUs in hospital:

“There is nothing to do to change his mind. (She cries). ...I pray God to help me to cope with this situation. I even asked the social worker to do home visit together with my uncle.”

“...I am unable to stay with him at home. He behaves like a pig, he collects unnecessary papers and cloths from nowhere and bring to his room. He also make fire inside his room. I am staying in the location not in the rural villages. Am afraid that he can burn himself as he abuses dagga and alcohol.”

4.6.1.3.3 Sub-theme 3.3: Family’s lack of knowledge related to the importance of adherence to treatment outlined

Participants’ views regarding the involvement of their family members revealed that family members are unable to supervise MHCUs treatment when granted LOA. This sub-theme was not addressed by the quantitative data set. Participants indicated that MHCUs abscond from home to the mental health institution once they are stable and are expected to consult to traditional healers. In addition, participants indicated that MHCUs perceive that staying in the hospital is of significance to avoid being treated by traditional healers.

Various authors found that adherence is currently reflecting a more progressive approach to questions about why people do not participate in mental health care (Corrigan, Angell, Davidson, Marcus, Salzer, Kottsieper & Stanhope, 2012 cited in Corrigan, Druss, & Perlick, 2014). In addition adherence as treatment

goal has been replaced by psychological models that seek to describe the decision-making process and subsequent health and wellness activity (Fishbein & Ajzen, 2011; Tanner-Smith & Brown, 2010 cited in Corrigan et al., 2014).

The following statements from the participants are evidence that family members lack knowledge related to the importance of adherence to treatment:

“I ended telling them that I am stable because of treatment. I then abscond from home back to the hospital.”

“I think I rather stay in the hospital rather than being treated by traditional healers.”

4.6.1.4 Theme 4: Challenges resulting from lack of support by family members

Participants' views regarding the involvement of their family members revealed that MHCUs experience several challenges resulting from lack of support by family members. Participants indicated that MHCUs develop resistance towards rejection by family members. However, participants indicated that ideas that the family members are dead hence MHCUs are being visited by people they don't know is problematic. In addition, participants also indicated that MHCUs are forced to consult traditional healers.

The following statements from the participants provides evidence that MHCUs experience challenges resulting from lack of support by family members:

“I am not feeling well, it is clear that I will no longer be accepted at home. ...I have been discharged since two years no one is ready to stay with me.”

“I cannot say much about this issue. It is clear that am rejected.”

Of the 360 respondents in this study, majority 340 (94.4%) agreed that in the event of death, family members who reject MHCUs are notified and (5. 206%)

disagree. Therefore, the researcher assumes that the higher percentage indicating family members being notified in case of death reveals that the hospital involves family members in such situations. Similar studies by Barke, Nyarko and Klecha, 2011; and Semrau, Evans-Lacko, Koschorke, Ashenafi and Thornicroft (2015) argued that rejection is a serious problem affecting MHCUs, their families as well as health care personnel providing mental health services. Furthermore, the more MHCUs feels rejected, they develop low self-esteem and general social rejection (Barke et al., 2011; Semrau et al., 2015).

4.6.1.4.1 Sub-theme 4.1: MHCUs' development of resistance towards rejection by family members problematic

Participants' views regarding the involvement of their family members revealed that MHCUs developed resistance because of being rejected by family members. Participants indicated that MHCUs are no longer accepted at home. However, participants indicated that MHCUs feels accommodated within the long-term mental health institution hence family members are not visiting them. Participants indicated that MHCUs believe that they will be visited the time their children have grown up.

The following statements from the participants provides evidence that MHCUs developed resistance of being rejected by family members:

"I feel good even if they are not coming."

"I will stay in the hospital until my son grow up to eighteen years."

Of the 360 respondents in this study, 216 (60.0%) responded that MHCUs not being happy when discharged was a major concern and 144 (40.0%) responded that it was a minor concern. Probabilities are that MHCUs might not be happy when discharged due to developed resistance of being rejected by family members and feel comfortable at the long-term mental health institution. However, it was found that MHCUs are likely to be vulnerable to feeling rejected

and invalidated hence lack of family support from their families may contribute to MHCUs experiencing mental health services in a positive way, regardless of the quality of the service that is received (Morris, Smith & Alwin, 2014).

Furthermore, the following statement from participants (family members) reflects MHCUs' development of resistance towards rejection by family members:

“They came together with my uncle. We prepare food to serve them. My uncle asked the social worker to hurry saying that they should depart because they can miss hospital lunch. He refuse to eat with us saying there is delicious food at the hospital. I am really concerned.”

“He also told staff members that they should tell the security not to allow me to enter the gate. He is my biological uncle. I think he is happy at the hospital.”

4.6.1.4.2 Sub-theme 4.2: Existence of ideas that families which are not visiting are dead outlined by MHCUs

Participants' views regarding the involvement of their family members revealed that MHCUs' worried about their family members who are not visiting and they get the idea that the families might have deceased. Participants indicated that MHCUs have the idea that their family members are dead, hence MHCUs are asking themselves questions that do not have answers. However, participants indicated that MHCUs should have been informed if their family members had died.

The following statements from the participants provides evidence that MHCUs may have the idea that families who are not visiting are dead, and this is problematic.

“I have the problem, I am visited by the people whom I don’t know, and does it mean that my family members died?”

“I think that I should even went to the funeral because not so long my fellow MHCUs went to this brother’ funeral.”

Of the 360 respondents in this study, 248 (68.9%) responded that in a case of death, cases were referred to a social worker for family tracing for six month. However, 31 (8.6%) reported that family members were being traced for one year and 81 (22.5%) indicated no time frame to trace family members. Study assumptions are that in cases referred to social worker where the families were traced for a long period, may be due to the fact that family members had deceased in such situations. Study by Tambuyzer et al. (2014) found that MHCUs are willing to be informed and involved in their family issues. However, the attitude of MHCUs willing to be informed about their families confirms that there is a need to trace their families immediately after noticing that the MHCU is no longer visited (Tambuyzer et al., 2014).

Furthermore, the following statement from participants (family members) reflects existence of ideas that families which are not visiting are dead:

“I was young when he admitted in the hospital. (Being sad). ...My mother passed away, when I visit him he say he don’t know me. I want his pension that is why I visited him.”

4.6.1.4.3 Sub-theme 4.3: Visiting home viewed as problematic by MHCUs because they are forced to consult traditional healers

Participants’ views regarding the involvement of their family members revealed that MHCUs are being forced to consult traditional healers. Participants indicated that family members believe in traditional healers hence the MHCUs abscond from home to the MHCI to avoid consulting traditional healers. However, participants indicated that MHCUs are aware that mental health

treatment has effect on their stability hence they thought they can stay at the MHCU forever rather than being treated by *sangomas*.

The following statements from the participants are evidence that MHCUs being forced to consult traditional healers while on LOA is problematic:

“My parents once take me for LOA and told me that they want to try traditional healers as am stable.”

“I ended telling them that I am stable because of treatment. I then abscond from home back to the hospital.”

Of the 360 respondents in this study, 148 (41.1%) responded that some of the MHCUs abscond from home to the hospital when granted LOA and few 9 (2.5%) reported that none of the MHCUs abscond from home to the hospital when granted LOA. Probabilities are that MHCUs might abscond from home to the hospital when granted LOA due insufficient support at home and feeling comfortable in long-term mental health institution in such situations.

Tambuyzer et al. (2014) argued that improving the responsiveness of services to the needs of patients is of significance. However, MHCUs have freedom of choice in the market perspective hence they are not able to decide on the contents of the services. In addition, authors outlined basic values within democratic perspective, in which MHCUs can decide upon the contents of the services, encompasses human rights, citizenship and empowerment as well as a focus on the therapeutic value of being involved (Tambuyzer et al., 2014).

Furthermore, the following statement from participants (family members) reflects visiting home is viewed as problematic by MHCUs:

“...I went to ‘sangoma’ to try to get help about my brothers’ mental illness as he is no longer wanted by the community members.I took him there

and paid R5000 of which I am owing another R7000.He did not complete the course at the 'sangoma'."

4.6.2 Conclusion remarks

Conclusion remarks of this study are made in line with Thornton's Model of self-realization that is the essence of nurses and arises from the spiritual field and the field of Love (Thornton, 2013). In this study WPC is based on the concepts of therapeutic partnering; and caring as sacred practice.

- **Therapeutic partnering**

From the discussion, this study found that there is poor interaction between the family members and the MHCUs. However, the views of MHCUs regarding the involvement of family members revealed that MHCUs feel rejected. MHCUs indicated that family members are not visiting them when they have been admitted. Family members are not ready to stay with the MHCUs at home when discharged or granted LOA. In this regard, nurses have concerns about poor interaction between the family members and the MHCUs.

This gives nurses' a therapeutic role of partnering with family members in order to improve the quality of mental health care services. In addition, caring for MHCUs, their unique physical, mental, emotional, and social/relational patterns requires family members to be involved. Therefore, therapeutic partnering nurses' role manifests unique physical, mental, emotional, and social/relational patterns that are interrelated, inseparable, and continually evolving family members (Thornton, 2013).

- **Caring as sacred practice**

Data from MHCUs indicated that there is lack of support by family members that contributes to failed LOA. MHCUs also indicated that family members are unable to support MHCUs due to lack of knowledge on treatment effects. There was evidence that MHCUs appreciate support by hospital management. In this

study Thornton's Model revealed that MHCUs are significant individuals who needs to be treated with greater respect. Therefore, in caring for MHCUs, the physical health, mental health and the social care needs should be supported to enhance MHCUs to recover and return to their own homes. Hence is a significant aspect that involves family members (Thornton, 2013).

4.6.3 Themes and sub-themes reflecting the perceptions of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation

4.6.3.1 Theme 1: MHCUs families' views and experiences related to involvement in the care of a family member

Participants' perceptions and experiences regarding involvement revealed that families understand that caring for MHCUs leads to understanding of the illness. Participants indicated that families appreciate the way the hospital management provides mental health care. However, participants indicated that families caring for MHCUs during LOA as problematic.

The following statements from the participants are evidence that families have experiences related to involvement in the care of MHCUs:

"To be involved in caring our family members help us to understand the causes of mental illness."

"It is good to be involved in caring of my brother. It helps me to equip knowledge on how to continue with treatment while he is discharged."

Of 360 respondents in the study, majority 301 (83.6%) agreed that involvement of the family members is a major concern and 59 (16.4%) disagreed. Probabilities are that the concern about family involvement, and higher percentage of referrals is evidence that family involvement is insufficient in such situations. Various authors argued that families of MHCUs experience burdens

on several life domains (Vermeulen, Lauwers, Spruytte, Van Adenhove, Mangro, Saunders & Jones, 2015). Authors indicated that family members are unable to cope with the constant anxiety of caring, they feel isolated and lonely. However, authors found that a family's worries about relapse, such that it puts their safety at risk, the caring role affects their own physical health negatively. In addition, worries about the financial situation of the person they care for is problematic, hence concern about the MHCUs becoming too dependent on them in the future (Vermeulen et al., 2015).

4.6.3.1.1 Sub-theme 1.1: Narratives related to the understanding of how caring for MHCUs leads to understanding of the illness outlined

Participants' perceptions and experiences regarding involvement revealed that families were satisfied about the Mental Health Care services provided to the MHCUs. However, participants indicated their positive attitudes towards being involved in Mental Health Care.

The following statement from the participants are evidence that family members feel satisfied about the Mental Health Care services provided to their MHCUs:

"It helps us as a family to understand how my younger brither is getting help in the hospital. It also help us to understand why my younger brother is mentally ill."

"I am happy to be involved in caring of my child. It helps me to understand and follow-ups on my child's illness. We thought that my child is bewitched while studying at Technical College."

Participants indicated that their level of understanding regarding mental illness has increased. Of the 360 respondents in the study, majority 290 (80.6%) agreed that they have concerned about the provision of mental health care services and 70 (19.4%) disagreed. Vermeulen et al. (2015) reconfirms, families acknowledge the information and advice that is offered in caring for

MHCUs is of significance. Authors emphasized the need for additional support by mental health systems may improve the quality of mental health services. Therefore, authors recommended advancing a paradigm to recognize the views of family members as a resource and a partner in the care requirements of MHCUs around the world (Vermeulen et al., 2015).

4.6.3.1.2 Sub-theme 1.2 Appreciation to hospital management to keep and care for MHCUs outlined

Participants' perceptions and experiences regarding involvement revealed that families were satisfied with the mental health care services. Participants indicated that their knowledge and understanding about mental illness has increased. Of the 360 respondents in the study, majority 329 (91.4%) agreed that they are concerned about involvement of the family members, 31 (8.6%) nurses disagreed.

The following statement from the participants provides evidence that family members feel satisfied when involved in Mental Health Care services provided to their MHCUs:

“I wish my child can be reviewed at this institution. I am ready to supervise him on treatment compliance.”

“It is good to be involved in caring of my brother. It helps me to equip knowledge on how to continue with treatment while he is discharged.”

However, there was a little knowledge about the mental illness; participants indicated that they are aware of how mental illness is being treated. This was supported by Vermeulen et al. (2015) who highlighted a similar picture with respect to information and advice provided to families. Authors indicated that families should find information about where to consult when there is a need. Apart from satisfaction, authors indicated that families should be given information on who to contact in case of an emergency. In addition, families

should be satisfied with information given on how the illness of their relative develops, where and why the MHCU is admitted in a longer-term mental health institution (Vermeulen et al., 2015).

4.6.3.1.3 Sub-theme 1.3 MHCUs viewed by family members as a danger to the community

Participants' perceptions and experiences regarding involvement revealed that MHCUs seem to be dangerous to self, family and community members when relapsed. Participants indicated that MHCUs behaviour of being dangerous discourages family members to take MHCUs when discharged or granted LOA. However, participants also indicated that alcohol and substance abuse seem to contribute to such behavior.

The following statements from the participants are evidence that MHCUs are too dangerous to self, family and the community:

“He is so destructive. He wanted to kill his sister with a spade, he also stepped one of the community member without a reason.”

“He threatened community children with a knife and also took groceries from the tuck-shop.He threatens everyone in the community.”

Of the 360 respondents in this study, majority 332 (92.2%) responded that some of the MHCUs went for LOA when granted. However, 28 (7.8%) reported that families disagree to take MHCUs for LOA when granted. It might be possible that MHCUs' behaviour contribute to families disagreeing to take MHCUs for LOA.

This correlate to study conducted by Ryan, Williams and Courtney (2013) in America on relationship between mental ill patients and their families. Study revealed that higher prevalence of substance use among MHCUs, along with certain other factors contributes to families refusing to take their loved ones

with mental illness when discharged from the hospital. Hence, the expected adolescent behaviour towards parenting styles more strongly is accentuated more strongly when an adolescent has mental illness. Study suggested that high quality physical services should be provided. Hence regular monitoring for risk factors and tackling unhealthy life styles is of significance (Ryan et al., 2014).

4.6.3.1.4 Sub-theme 1.4 Caring for MHCUs viewed as a difficult task by the family members

Participants' experiences regarding involvement revealed that families seem to have difficulties in having MHCUs at home when granted LOA. Participants indicated concern of families that there is a need to supervise MHCUs on treatment while on LOA. Participants indicated that MHCUs are unmanageable at home.

The following statements from the participants are evidence that family members have concern about having MHCUs at home:

“He don't want to take treatment saying he is a traditional healer, he is dangerous to the community. I am afraid to take him when granted LOA.”

“He refuse to be assisted by domestic workers and says that his DG is not enough to can pay domestic worker. When am back from Gauteng and try to cook his food he don't eat. He says that I can poison him.”

Of the 360 respondents in this study, majority 351 (97.5%) agreed that some of the MHCUs come back before expected date when granted LOA, 9 (2.5%) disagreed. According Vermeulen et al. (2015) family members are expected to be present, close by and available when the mentally ill patient is at home. In addition, the family home has become an additional place for treatment. Therefore, the family is frequently solicited as soon as the patient is discharged; even though he or she is often still in a fragile state, and the responsibility for

medication often falls on the family members (Vermeulen et al., 2015:10). Furthermore, the following statement from participants (MHCUs) reflects caring for MHCUs is viewed as a difficult task by the family members:

“May you please talk to my brother to forgive me, I won’t repeat what I did. I know that it will be not easy. Social worker have tried to talk to him but it seems as he does not understand.”

4.6.3.1.5 Sub-theme 1.5 Lack of visitation of MHCUs by family members in hospital result from fear that MHCUs will request LOA

Participants’ perceptions regarding involvement revealed that MHCUs’ attitude discourages family members from visiting MHCUs when admitted for long-term mental health care. However, participants indicated that MHCUs expect family members to request LOA. Participants indicated that family members are being manipulated to also buy tobacco and dagga that is restricted in the hospital.

The following statements from the participants provides evidence that MHCUs attitude towards their family members contribute to poor interaction with the MHCUs:

“.....I can visit, but it is obvious that he can ask me to take him for LOA. That is why I don’t want to visit him frequently.”

“I was visiting him. When I visit, he becomes angry saying he want to go home. I am afraid to take him being angry. (Being angry). I think I won’t be save.”

Of the 360 respondents in this study, 7 (1.9%) reported that only one MHCUs in their unit/ward was visited by family members. However, 81 (22.5%) responded that less than five MHCUs in their unit/ward were visited by family members. Majority 234 (65.0%) respondents reported that less than 10 MHCUs in their unit/ward were visited by the family members and 38 (10.6%) indicated that all MHCUs in their unit/ward were visited by the family members.

Various authors found that family members may hesitate to visit their loved ones in order to avoid participating in mental health services, hence they experience practical barriers that limit their ability to attend programmes (Haselden, Dixon, Overley, Cohen, Glynn, Drapalski, Piscitelli, & Thorning, 2017). In addition, the issue of visiting the MHCUs within the hospital was also supported by former MEC Muthambi on her annual visit in December 2017 at Evuxakeni Hospital who emphasize that families should visit their loved ones within the hospital to promote interaction.

The following statement from MEC reflects that visiting MHCs is of significance:

“It is nice to be visited at home, that is why our MHCUs are happy because they have visitors.”

This correlates to what (MHCU) Mr Mtileni said when highlighting the significance of family visit in his speech representing all MHCUs admitted in the institution. The following statement from Mr Mtileni also reflects that MHCUs need their families:

“We feel very happy to be visited by the department because some of us does not have families to visit them. To be visited means a lot to us, we are proud of being visited today.”

Therefore, probabilities are that the developed model may encourage families to visit the MHCUs, hence the quality of mental health services may also improve. Flynn and Preuster (2014) highlighted the policy that revealed (section 6) that *“patients have the ability to restrict or limit visitors at any time during their hospitalization”*. In addition, section 7 of the policy also indicate that *“the hospital reserves the right to restrict and/or limit visitation based on clinically necessary or reasonable considerations”*. Moreover, section 10 of the policy says that *“on entering a unit, visitors will be asked to identify all items which they are bringing for patients. A search of these items is conducted by staff”*.

Furthermore, the following statement from participants (MHCUs) reflects lack of visitation of MHCUs by family members in hospital results from fear that MHCUs will request LOA:

“My family members came several times every month but they don’t want to take me for LOA. I feel rejected. When I ask them about LOA they say they will arrange, it seems as they are not ready”.

4.6.3.1.6 Sub-theme 1.6 Lack of adherence to treatment by MHCUs experienced during LOA

Participants’ perceptions and experiences regarding involvement revealed that family members seem to be ready to supervise MHCUs on treatment when granted LOA and/or discharged. This sub-theme was not addressed by the quantitative data set. However, participants indicated their concern that MHCUs gives unnecessary reasons to avoid taking treatment. Participants indicated their concern that MHCUs refuse to do follow-ups at a clinic for their treatment while at home, postponing dates until they relapse. These revealed that family members have a great challenge in supervising MHCUs treatment while granted LOA and/or discharge.

Different authors argued that family members of persons with mental illness experience moderate to high levels of burdens (Caqueo-Urizar et al., 2014; Awad & Voruganti, 2013; Maldonado et al., 2005; Magliano et al., 1998; De Rick et al., 2000 cited in Vermeulen et al., 2015). This was supported by Chan (2011 cited in Vermeulen et al., 2015) who indicated that most families are poorly prepared for the increasing demands they face. However, research evidence consistently shows that family members generally lack adequate help

and support from health care providers when the patient is at home (Chan, 2011 cited in Vermeulen et al., 2015).

The following statements from the participants provides evidence that family members have concerns about MHCUs adherence to treatment:

“He end up refusing to take his treatment saying he is not mentally ill. It really discourages us to take him for LOA.”

“The problem is that he does not want to be supervised on treatment. He says that we should not take part on monitoring treatment compliance, we are not nurses.”

Furthermore, the following statement from participants (MHCUs) reflects lack of adherence to treatment by MHCUs experienced during LOA:

“I went for LOA last years, I was staying alone at home. My brother is working at Johannesburg. I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment. I think that is why I relapsed and I ended being readmitted to the hospital.”

4.6.3.1.7 Sub-theme 1.7 Destruction of properties by MHCUs when are at home experienced

Participants' views and experiences regarding involvement revealed that MHCUs destruct properties when granted LOA. Participants indicated that MHCUs' behaviour when relapsed discourages family members to take MHCUs home when discharged or granted LOA. However, participants indicated that MHCUs' destructive behaviour affects family members' financial status. The following statements from the participants are evidence that MHCUs were destructive to the extent that family members' are financially affected.

“My brother is destructive at home, he burned his house and even the neighbour’s house. I am paying R300.00 every month for the neighbour’s house that he burned of which it will take long to finish instalment.” (Being sad)

“I think he can stay at the hospital because he destructed even to the Central Business District stores around.”

Of the 360 respondents in this study, 110 (30.6%) reported that family members’ attitude during home visits is positive. However, 64 (17.8%) responded that family members display negative attitudes, majority 186 (51.7%) indicated that attitudes of family members seem to be neutral. Probabilities are that the highest percentage of family members being neutral reveals that the deviant behaviours of MHCUs contribute towards families’ attitudes during home visits. It was found that negative views concerning possible deviant behaviours of MHCUs such as unpredictable behaviors may affect the safety of the individuals in general (Chien et al., 2012).

4.6.3.2 Theme 2: Practices related to caring for MHCUs at home by family members

Participants’ perceptions regarding involvement revealed that family members have difficulties in caring for MHCUs at home. Participants indicated that families described reasons for lack of acceptance of MHCUs for LOA. However, participants expressed that reluctance of family members to care for MHCUs at home is problematic. Participants indicated that families lack skills and the inability to monitor MHCUs at home. In addition, participants outlined reasons of family members not visiting MHCUs in hospital.

The following statements from the participants provides evidence that carrying for MHCUs at home by family members is problematic:

“My concern is that he abuses dagga and alcohol when given LOA that is why he fails LOA several times.”

“We are unable to manage him at home, he abuses dagga and alcohol that disturb the treatment.”

Of the 360 respondents in this study, 5 (1.4%) agreed that MHCUs exceed LOA and 355 (98.6%) disagreed. Therefore, it could be possible that carrying for MHCUs at home by family members is problematic in such situations. This is similar to study conducted by Hsiao, Klimidis, Minas and Tan (2006 cited in Chien, 2012) that revealed that an increase of families of MHCUs perceived burden of care may lead to negative self-concept of their families such as diminished self-worth. In addition, authors indicated that enhanced feelings of shame and guilt reveal that families’ expressed emotion and caregiving burdens are the important factors pertaining to stigmatization experience in caring MHCUs (Hsiao et al., 2006 cited in Chien, 2012).

4.6.3.2.1 Sub-theme 2.1: Description of the reasons for lack of acceptance of MHCUs for LOA by family members

Participants’ perceptions regarding involvement revealed that family members have reasons for lack of acceptance of MHCUs for LOA. This sub-theme was not addressed by the quantitative data set. Participants indicated their concern that there is a need to supervise MHCUs on treatment while on LOA. The fact that family members work far from their homes appears to be a contributing factor that restricts them from complying when MHCUs have been granted LOA.

The following statements from the participants are evidence that family members have reasons for not accepting MHCUs at home:

“My concern is that there is no one at home who can take care of him when the hospital give him chance to be at home. I’m working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment. Who is going to monitor him while I’m at work because some of treatment is taken during the day?”

“The problem is that I am unable to manage him at home. When discharged, he mixes treatment with dagga.”

According to Vermeulen et al. (2015), MHCUs homes have become an additional place for treatment. Authors suggested that the family should be frequently solicited as soon as the MHCU is discharged and often still in a fragile state. Therefore, the responsibility for continuing with medication often falls on the family members (Vermeulen et al., 2015).

Furthermore, the following statement from participants (MHCUs) reflects description of the reasons for not taking MHCUs for LOA:

“I went for LOA last years, I was staying alone at home. My brother is working at Johannesburg. I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment. I think that is why I relapsed and I ended being readmitted to the hospital.”

4.3.6.2.2 Sub-theme 2.2 Reluctance of family members to care for MHCUs at home expressed

Participants’ perceptions and experiences regarding involvement revealed that family members were reluctant to care for MHCUs at home. Participants’ concern about MHCUs revealed that family members understand that mental illness requires them to take part when the MHCUs are granted LOA. Participants further indicated that LOA failed if they relapsed and returned back to the hospital before expected date.

The following statements from the participants are evidence that families become reluctant to care for MHCUs at home:

“My concern is that he abuses dagga and alcohol when given LOA that is why he fails LOA several times.”

“We are unable to manage him at home, he abuses dagga and alcohol that disturb the treatment.”

Of the 360 respondents in this study, majority 351 (97.5%) agreed that MHCUs come back on expected date when granted LOA and 9 (2.5%) disagreed. Probabilities are the fact that MHCUs may come back before expected date due to unacceptable behaviour that leads towards families being reluctant in such situations. Various authors argued that families of MHCUs are often stressed and tired, and need engaging and reassuring (Jurgens, Clissett, Gladman, & Harwood, 2012; Bloomer, Digby, Tan, Crawford. & Williams, 2016).

Authors suggested that families need to give and receive information about the care of the MHCUs, and offered the opportunity to participate in care whilst in hospital. Therefore, understanding the perspective of the families, and recognizing elements of the cycle of discontent, could help nurses to anticipate families' needs, enable relationship building, to minimize dissatisfaction or conflict (Jurgens et al., 2012; Bloomer et al., 2016).

Furthermore, the following statement from participants (MHCUs) reflects reluctance of family members to care for MHCUs at home:

“I once been discharged, then I abuses dagga. When I go home for LOA, I was surprised to be brought back before the expected date. I smoked and even drunk as it was long time not going home”.

In addition, informing family members about the care of the MHCUs is of significance in the provision of mental health services. Pillay (2017) reported that of 143 MHCUs who died at Life Esidimeng hospital revealed that stigma influences the community and health decision-makers to grip people MHCUs in low esteem, subsequent in their reluctance to capitalize resources to improve the quality of mental health services.

Moreover, the issue of Life Esidimeng remains on daily SABC news, reporting families were interviewed. Makhubele also reported at Mungana-Ionene FM at “Tiko-a-xi-etleli” news that family members confirmed to the media that Gauteng Department of Health not informed them on the decisions made on December 2015 regarding their loved ones. This was reported to be unusual, as it was the first event where authorities took a state department to court, in order to face such a unilateral resolution (Pillay, 2017). The study assumptions are that a developed model to promote family involvement will be useful to guide all health professionals to improve the provision of comprehensive quality mental health services.

4.6.3.2.3 Sub-theme 2.3: Lack of skills and inability to monitor MHCUs at home outlined

Participants’ perceptions and experiences regarding involvement revealed that families lack skills and inability to monitor MHCUs at home. However, the quantitative data set was not addressed in this sub-theme. Participants indicated that the reaction of MHCUs towards family members revealed that MHCUs’ attitude discourages family participants to take them when granted LOA. Participants indicated that families are being discriminated against because of being uneducated.

The following statements from the participants are evidence that families lack skills and the inability to monitor MHCUs at home:

“The problem is that he does not want to be supervised on treatment. He says that we should not take part on monitoring treatment compliance, we are not nurses.”

“I have a concern about his mental illness. He is a professional pharmacist, he knows better than me. He abuse dagga saying he has knowledge of treatment than me. When I talk to him, he tell me to pray until he quit from dagga.”

Therefore, the researcher assumes that the negative attitudes that the MHCUs have towards uneducated family members is a great challenge. According to Torrey, Zdanowicz, Kennard, Lamb, Eslinger, Biasotti and Fuller (2014), the main reason to refuse treatment is that MHCUs are not aware of their illness and think that they are not sick. However, MHCUs who refuse treatment can be persuaded to accept it by patiently working with them or by offering them a reward if they do so; although there are options which vary by state depending on the laws of that state (Torrey et al., 2014).

When continuing to refuse treatment, the most effective of these options are assisted outpatient treatment (AOT); conditional release; and mental health courts. In addition, AOT is a form of outpatient commitment in which mentally ill individuals are told by court order that they can live in the community as long as they follow their treatment plan, but if they do not do so, they can be involuntarily returned to the hospital (Torrey et al., 2014). Furthermore, this is in accordance with the MHCA 17 of 2002 that has been implemented in South Africa to promote mental health care services.

Furthermore, the following statement from participants (MHCUs) reflects reluctance of family members to care for MHCUs at home:

“They should not reject me they should accept that I am mentally ill they should accept and assist as to take treatment when we are in LOA they should monitor our treatment compliance. They present our problems to the social workers instead of assisting us to take treatment accordingly. They should be patient to us, they should be patient, we are mentally ill.” (She cries).

Participants’ cry is a sign of emotional concern about accepted as mentally ill patient who need patience. Probabilities are that the participant’s families may lack skills to deal with the situation and that is why they report problems to the social workers for help.

4.6.3.2.4 Sub-theme 2.4 Reasons of family members not visiting MHCUs in hospital outlined

Participants’ perceptions and experiences regarding involvement revealed that families have reasons for not visiting MHCUs in hospital. This sub-theme was not addressed by the quantitative data set. Participants indicated that the reaction of MHCUs towards family members revealed that MHCUs’ attitude discouraged family members from visiting MHCUs when admitted for long-term mental health care.

The following statements from the participants provides evidence that MHCUs attitudes towards their family members contribute to poor interaction with the MHCUs while admitted for long-term mental health care.

“He also told staff members that they should tell the security not to allow me to enter the gate. He is my biological uncle. I think he is happy at the hospital.”

“We are unable to pay visit, he manipulate us to hide dagga when visiting the hospital saying that he don’t like cool drink and snakes that we are bringing at the hospital.”

Flynn and Preuster (2014) highlighted the policy that revealed (section 6) that *“patients have the ability to restrict or limit visitors at any time during their hospitalization”*. In addition, section 7 of the policy also indicates that *“the hospital reserves the right to restrict and/or limit visitation based on clinically necessary or reasonable considerations”* (Framptom, & Guaastello, 2014).

Furthermore, the following statement from participants (MHCUs) reflects reluctance of family members to care for MHCUs at home:

“I have the problem, I am visited by the people whom I don’t know, does it mean that my family members died?”

4.3.6.2.5 Sub-theme 2.5 An explanation that MHCUs abuse substances during LOA which leads to families reluctant to request them

Participants’ perceptions regarding involvement revealed that family members MHCUs abuses substances during LOA which lead to families reluctant to request them. MHCUS abuse substances to the extent that even when taking treatment accordingly. MHCUs relapse and become aggressive.

The following statements from the participants are evidence that alcohol and substance abuse contributes to undesirable MHCUs’ behaviour:

“He abuses “nyawupe” and dagga and become aggressive to his father. We thought that my child is bewitched while studying at Technical College. We are unable to manage him at home, he abuses dagga and alcohol that disturb the treatment.”

“He mashes treatment with dagga that is why we cannot manage him at home.”

According to Sarradon-Ecka et al. (2014), it is difficult to build relationships of trust with homeless persons as the harsh conditions of life on the streets lead

to distrust of others. However, this distrust is magnified when the person suffers from persecutory delusions, a frequent symptom of psychotic disorders, which the MHCUs often suffer (Sarradon-Ecka et al., 2014). Furthermore, the following statement from participants (MHCUs) reflects an explanation that MHCUs abuse substances during LOA which leads to families reluctance to request them:

“My family members treat me like a psychotic patient, I am not involved in decision making. I abuse dagga and alcohol while am at LOA. They don’t negotiated with me about the reasons for bringing me back before expected date.”

4.6.3.2.6 Sub-theme 2.6 Lack of available carers and shared responsibilities at home a reason for not requesting MHCUs for LOA

Participants’ perceptions regarding involvement revealed a lack of available carers and shared responsibilities at home, hence families are not requesting MHCUs for LOA. Participants indicated that MHCUs stay alone at home as participants are working far from home; this seems to contribute to families not requesting LOA for MHCUs.

The following statements from the participants provides evidence that family members have concern about MHCUs staying alone:

“My concern is that there is no one at home who can take care of him when the hospital give him chance to be at home. I’m working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment.”

“He stays in the river even during rainy season to avoid taking treatment. I will afford to take him during December holiday.”

Of the 360 respondents in the study, 301 (83.6%) agreed that involvement of the family members is a major concern and 59 (16.4%) disagreed. Probabilities

are that concerns about the family involvement may be related to lack of available carers and shared responsibilities at home. It was found that families experience emotional burdens through lack of personal time, of putting the needs of the MHCUs they care for ahead of their own needs (Vermeulen et al., 2015).

4.6.3.3 Theme 3: Knowledge of family members related to the care of MHCUs

Participants' perceptions regarding involvement revealed that families were satisfied with the knowledge they received related to the care of MHCUs; although the quantitative data set was not addressed in this sub-theme. Participants indicated that their knowledge and understanding about mental illness had increased. However, participants indicated that they are aware of how mental illness is being treated. Mestdagh and Hansen (2014) support the view that in order to reach the standards of a dignifying mental health care system, much more needs to be taken into consideration, including the principles of respectful care. Authors clarify that involving both MHCUs and family members in stigma awareness could be crucial in order to make such an effort accurate and efficient (Mestdagh & Hansen, 2014).

The following statements from the participants are evidence that families feels satisfied with the knowledge they received, related to the care of MHCUs:

"To be involved in mental health care help us to understand mental illness. The way our child is going to be assisted and also to continue with treatment at home."

"To be involved in his caring help us to understand that there is nothing wrong we did to God."

4.6.3.3.1 Sub-theme 3.1 Existence of knowledge related to the importance of MHCUs care by family members outlined

Participants' perceptions regarding involvement revealed that families have knowledge related to the importance of continuous caring for MHCUs. This sub-theme was not addressed by the quantitative data set. Participants indicated that nurses educate the family members on the importance of taking treatment as prescribed. In addition, participants indicated the fact that being educated about the importance of treatment compliance equips families with relevant information as they were unable to manage MHCUs while on LOA. This was supported by Taylor, Wells, Howell and Raphael (2012) and Mai (2016) who stated that family members of individuals with mental illnesses need information, assistance and support to best assist their ill family member and cope with the challenges posed to the family system.

The following statements from the participants provides evidence that family members have knowledge related to the importance of continuing with care of MHCUs:

"I agree that the hospital allow us to know everything regarding our family member who is admitted. The nurses even educate us on how to assist our member regarding taking treatment."

"It is good to be involved in caring of my brother. It helps me to equip knowledge on how to continue with treatment while he is discharged. It also help us to do follow up to the clinic when discharge. We are unable to manage our child without relevant information."

4.6.3.3.2 Sub-theme 3.2 Existence of hospital management's updates about care provided to MHCUs outlined

Participants' views regarding involvement revealed that hospital managements update families about care provided to MHCUs. This sub-theme was not

addressed by the quantitative data set. Participants indicated that they are also being educated on causes of mental illness. Participants indicated that the education that they receive from nurses helps them to understand that there is nothing wrong they did to God. However, the main goal in working with families is to help them develop the knowledge and skills instrumental in promoting the recovery of their family member while eschewing family dysfunctional etiological theories of the past (Jewell, Downing, & McFarlane, 2009 cited in Taylor et al., 2012).

The following statement from the participants provides evidence that family members feel satisfied about education regarding causes of mental illness:

“To be involved in caring our family members help us to understand the causes of mental illness. It is very important to know how our child is being treated. To be involved in his caring help us to understand that there is nothing wrong we did to God”.

4.6.3.3.3 Sub-theme 3.3 Provision of health education on promoting treatment adherence outlined as important

Participants' perceptions regarding involvement revealed that families feel of satisfied about health education on promoting treatment adherence. Participants indicated that nurses educate the family members on the importance of taking treatment as prescribed. However, education regarding treatment seems to be of significance during discharge and LOA. Participants indicated that they are free to ask anything related to the MHCUs' treatment. Participants also indicated that being educated about the importance of treatment compliance equips them with relevant information as they were unable to manage MHCUs while on LOA. Of the 360 respondents in this study, majority 336 (93.3%) agreed that MHCUs are happy when discharged and 24 (6.7%) disagreed.

Study assumption are that MHCUs might be happy when discharged because of their willing and needs to stay with their family members in such situations. This was supported by Taylor et al (2012) who stated that family members of individuals with mental illnesses need information, assistance and support to best assist their ill family member and cope with the challenges posed to the family system.

The following statements from the participants are evidence that families feel satisfied about education regarding importance of treatment compliance:

“I agree that the hospital allow us to know everything regarding our family member who is admitted. The nurses even educate us on how to assist our member regarding taking treatment”.

“It is good to be involved in caring of my brother. It helps me to equip knowledge on how to continue with treatment while he is discharged. It also help us to do follow up to the clinic when discharge. We are unable to manage our child without relevant information”.

However, the following statement from participants (MHCUs) reflects that family members are not aware that nurses always educate family members about expected behaviour of MHCUs at home:

“They are not even aware that nurses always educate about expected behaviour at home, importance of taking treatment as well as what to be done when relapsed.”

4.6.3.4 Theme 4: Existing challenges in caring for MHCUs by family members

Participants’ perceptions regarding involvement revealed that families have challenges in caring for MHCUs. Participants indicated that family members experience difficulties in monitoring MHCUs’ compliance. However, participants indicated that financial constraints experienced by families of

MHCUs seem problematic. Participants indicated the fact that LOA is viewed as a challenge because MHCUs relapse when at home. The following statements from the participants are evidence that there are challenges in caring for MHCUs:

“I will take him for LOA. But I know that he will come back before the expected date. It really discourages me to take him for LOA. The very same day, he cannot sleep without going outside to smoke. I cannot say a lot.”

“The problem is that I am unable to manage him at home. When discharged, he mixes treatment with dagga.”

Of the 360 respondents in this study, 313 (86.9%) agreed that they are concerned about challenges regarding family involvement in mental health care and 47 (13.1%) disagreed. Probabilities are that concern about the family involvement may be caused by the fact that nurses are the ones who witness that challenges regarding involvement of families in caring for MHCUs is problematic. According to Payne, Abel, Guthrie and Mercer (2013) social problems coupled with multiple stresses, makes coping difficult for families who sometimes struggle to support MHCUs. Authors suggested that better models to promote family involvement should be developed in the MHCI (Payne et al., 2013).

4.6.3.4.1 Sub-theme 4.1 Difficulty in monitoring treatment adherence of MHCUs

Participants' perceptions regarding involvement revealed that families experience difficulties in monitoring MHCUs treatment compliance. Participants indicated that MHCUs stay alone at home as they are working far from home. Participants indicated that there is no one to supervise the MHCUs in their absence.

The following statements from the participants are evidence that monitoring MHCUs treatment compliance is problematic:

“My concern is that there is no one at home who can take care of him when the hospital give him chance to be at home. I’m working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment.”

“He stays in the river even during rainy season to avoid taking treatment. I will afford to take him during December holiday.”

Of the 360 respondents in this study, majority 329 (91.4%) agreed that they are concerned about involvement of the family members and 31 (8.6%) disagreed. Study assumptions are that nurses may be concerned about the family involvement because they are aware that monitoring MHCUs treatment compliance at home is a great challenge. Authors argued that family members experience emotional burdens through lack of personal time, of putting the needs of the person they care for ahead of their own needs (Vermeulen et al., 2015).

Furthermore, the following statement from participants (MHCUs) reflects that families experience difficulty in monitoring treatment adherence of MHCUs:

“I went for LOA last years, I was staying alone at home. My brother is working at Johannesburg. I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment. I think that is why I relapsed and I ended being readmitted to the hospital.”

4.6.3.4.2 Sub-theme 4.2 A description of financial constraints experienced by families of MHCUs

Participants’ perceptions regarding involvement revealed that families’ concern about MHCUs revealed that family members like to take their MHCUS when granted LOA. However, participants indicated that being unemployed is a great challenge as they are unable to buy enough food when the MHCU is on LOA.

Participants indicated the concern that they are unable to pay MHCUs' funeral cover when the grant has been stopped and even when the MHCU does not qualify for a grant.

The following statement from the participants are evidence that family members have concerns about financial support:

“...I decided to take him to my house, the challenge is that I am not working, not yet qualified to get grant, may be after three years. I am also unable to visit him at the hospital because of money.”

“No income at home, who is going to pay his funeral covers as the grant has been stopped?”

Of the 360 respondents in the study, 340 (94.4%) agreed that in case of death, family members who reject MHCUs are notified and 20 (5.6%) nurses disagree. Probabilities are failing to trace families who reject the MHCUs and not notify them about the death might contribute to MHCUs being buried as a pauper in such situations. Therefore, it might be possible that being unemployed also contributes to insufficient effort on being involved in caring for their MHCUs when admitted for long-term mental health care. Authors found that family members are most concerned about the financial situation of their mentally ill they care for at home. Family members also worry about having to cover the extra costs of caring in the context of their own financial situations (Vermeulen et al., 2015).

4.6.3.4.3 Sub-theme 4.3 LOA viewed as a challenge because MHCUs relapse when at home

Participants' perceptions regarding being involved in mental health care revealed that MHCUs' relapse while on LOA really contributes to insufficient effort of the family members to be involved. Participants indicated that MHCUs fails LOA due to relapses. However, participants indicated that nurses educate the MHCUs together with the family about the expected behavior when granted

LOA. The following statements from the participants provides evidence that MHCUs' behaviour seem to discourage family members from taking them when discharged or granted LOA:

“When he get his grant he started to be exhausted on credits, abuse dagga. When the (machonisi) creditors remind him about his credits, he started to be aggressive saying that he has mental illness.”

“The problem that makes him to be readmitted is that he abuses dagga and alcohol, I think it disturb treatment to work effectively.”

Of the 360 respondents in this study, majority 351 (97.5%) agreed that MHCUs come back before expected date when granted LOA and 9 (2.5%) disagreed. Therefore, it could be possible that MHCUs come back before the expected date may be due MHCUs' relapse while on LOA. Various authors state that creating an environment supportive of children and families facing mental health challenges requires that primary care practices address stigma (Foy, Kelleher, Laraque & American Academy of Pediatrics Task Force on Mental Health, 2010; Hodgkinson, Beers, Southammakosane, Lewin, 2014).

Authors suggested that psychiatrists should reflect with their MDT on the important role they can all play in making families comfortable to share and address mental health concerns. However, nurses can examine their own knowledge and attitudes towards mental health. MDT can affirm that mental illnesses can be controlled and that MHCUs can achieve recovery through continuous treatment (Foy et al., 2010; Hodgkinson et al., 2014).

4.6.3.4.4 Sub-theme 4.4 Reasons provided for families not ready to take MHCUs for LOA outlined

Participants' perceptions regarding involvement revealed that families have reasons for not being ready to take MHCUs for LOA. This sub-theme was not

addressed by the quantitative data set. Participants indicated that the reaction of MHCUs towards family members is a challenge. However, participants also indicated that MHCUs neglect themselves and that discourages family members from taking them when granted LOA. Participants indicated that MHCUs have negative attitudes towards continuing with treatment when discharged or granted LOA.

However, MHCUs gives reasons that discharge is an indication that they are stable, there is no need to continue with treatment. This was supported by Vermeulen et al. (2015) who indicated that family members worries about MHCUs negative attitudes contributed to relapse, such that it puts their safety at risk. In addition, family members feel that the role of caring badly affects their own physical health.

The following statements from the participants are evidence that MHCUs have negative attitude towards their family members:

“My uncle says that discharge means that doctors saw that he is no longer ill. He refuses to take his treatment saying that he has been discharged from the hospital”.

“I won’t take him for LOA, He does not have time to bath, he roams around the village aimlessly being dirty”.

4.6.3.4.5 Sub-theme 4.5 Discrimination of MHCUs by community members viewed as a challenge

Participants’ perceptions regarding involvement revealed that families’ experience stigma. Although the quantitative data set was not addressed in this sub-theme. Participants indicated that having a mental illness within the family seems to have done caused something that lead towards discrimination. According to Chan (2011) strengthening the families' social network may

represent a useful strategy to alleviate family's care burden. Social support is considered to be of great value in families who experience the burden associated with caring of MHCUs. In addition, it is globally recognized that families with MHCUs are being challenged by social systems (Chan, 2011; Zauszniewski & Bekhet, 2014).

The following statement from the participants provides evidence that family members were being discriminated against:

“My neighbours, colleagues and even the community are not happy when my child is on LOA. They discriminate me saying that there is something wrong I did that is why I have a mentally ill child.”

“I use to lock the gate so that my child will not be able to go out. It does not help they also laugh when they saw him roaming in the yard. (Being sad). I am really depressed.”

4.6.3.4.6 Sub-theme 4.6 MHCUs’ refusal of being monitored during LOA problematic

Participants’ perceptions regarding involvement revealed that families’ views regarding treatment showed that they seemed to be ready to supervise MHCUs on treatment when granted LOA and discharge. However, participants indicated their concern that MHCUs give unnecessary reasons to avoid taking treatment. Participants indicated their concern that MHCUs refuse to do follow-ups at a clinic for the treatment while at home, postponing dates until they relapse. This revealed that family members have a great challenge on supervising MHCUs treatment while granted LOA and discharge.

The following statement from the participants provides evidence that family members have concerns about supervising MHCUs’ treatment, even if they are ready:

“My brother refuse to do follow-ups at clinic for the treatment while at home, saying that he will go next week until he relapse.”

“I am unable to supervise his treatment. He say he loose appetite while taking treatment. He mashes treatment with dagga that is why we cannot manage him at home.”

Chan (2011) and Zauszniewski et al. (2014) indicated that inadequate professional services for helping the families is problematic hence families simply fail to offer the desired care by themselves. Therefore, this results in families under great stress giving up and rejecting the MHCUs who would become outcast socially (Chan 2011:347; Zauszniewski et al., 2014).

Furthermore, the following statement from participants (MHCUs) reflects their refusal of being monitored during LOA problematic:

“I once disagree with my family on certain matters, my parent told me that they will return me back to the hospital if I don’t cooperate. I am surprise to be brought back. In fact it seems as to have mental illness is a punishment. We don’t have to say something at home we must be quiet while on LOA.”

4.6.3.4.7 Sub-theme 4.7 Fear of families’ lack of safety when MHCUs are at home outlined

Participants’ perceptions regarding involvement revealed that families as well as community members are not safe when MHCUs are on LOA. Participants indicated that MHCUs’ deviant behaviour is problematic. Participants indicated that MHCUs are dangerous to the extent that the community worried about their presence.

The following statement from the participants are evidence that MHCUs are dangerous:

“He broke church windows more than four houses within the community.He killed one cow of the famous funeral society.He wanted to throw a child in the toilet at his mothers’ sisters’ funeral.”

“He is dangerous to the community. I am afraid to take him when granted LOA.The community members even complained to the “induna”. That is why he came with the letter to indicate that he is no longer wanted at our village.” (Being sad).

Of the 360 respondents in this study, majority 332 (92.2%) reported that some MHCUs went for LOA when granted; 28 (7.8%) responded that family disagree to take MHCUs for LOA when granted. Therefore, the researcher assumes the fact that family disagreeing to take MHCUs for LOA when granted may be contributed by MHCUs deviant behavior. Seligman and Csikszentmihalyi (2014) suggested that mental health support services should prioritize interventions that can help families to avoid violent behaviour. Yet, services working together is a positive way to manage and identify risk.

It was identified that several experts have tried to develop violent risk assessment tools that take into account mental health as one of many factors. It was found that if violent risk is accurately assessed, support can be put in place to prevent violence. However, Syed (2013 cited in Seligman & Csikszentmihalyi, 2014) argued that it was very difficult to assess violence completely hence these events are not very common. Therefore, an assessment tool was developed to predict MHCUs at risk of committing violence (Seligman & Csikszentmihalyi, 2014). Besides the fact that some themes and subthemes of qualitative approach were not quantitatively supported, the quantitative results also were not supported by qualitative results. Regarding cases with poor family contacts.

Of the 360 respondents in this study, majority 317 (88.1%) agreed that cases are referred to the relevant health care provider and 43 (11.9%) disagreed. Of the 360 respondents in the study, 126 (35.0%) responded that family members' contacts are available, and they are ready to be involved. However, 175 (48.6%) responded that family members' contacts are available, but family members are not ready to be involved. Approximately 53 (14.7%) respondents responded that family members' were contacts not available. Probabilities are that the absence of MHCUs family contact contributes to MHCUs being buried as a pauper. However, the history of psychiatry outlined by Boulton and Black (2010) revealed that MHCUs who died in MHCI were cared for through private funding provided by family or friends, rather than at the expense of the parish authorities. Authors found that in St Martin in the Fields, of 112 MHCUs, 61 were paupers.

However, the true proportion of paupers is currently higher than eighteenth century. In addition, pauperism was thus found to be associated with lack of ability to trace families and close relatives. Study revealed none of those MHCUs buried as paupers had been traced by family members (Boulton, & Black, 2010; Boulton & Schwarz, 2014). Furthermore, 6 (1.7%) respondents reported that family members' contacts were available, but MHCUs refuse to involve their family members. Probabilities are that the higher percentage of family members' are contacts available, but MHCUs refusing to involve family members contributes towards them being rejected. However, of the 360 respondents in this study, 94 (26.1%) agreed that family members are accessible and 266 (73.9%) disagreed.

The study assumptions are that the higher percentage indicating that members are not accessible reveals that the nature of involving families emerged as a barrier to families becoming involved and caused problems during treatment.

Furthermore, of the 360 respondents in this study, 314 (87.2%) agreed that in case of medical illness and procedures, family members are involved and 46 (12.8%) disagreed.

It might be possible that the higher percentage indicating that in case of medical illness and procedures, family members are involved reveals that the hospital involves family members in such situations. Moreover, of the 360 respondents in this study, 257 (71.4%) agreed that in case of medical illness and procedures, family members are involved and 103 (28.6%) disagreed. The MHCA 17 of 2002 revealed that legislation also regulates the family members to be involved in the planning of mental health care services (South Africa, 2002). Study assumptions are that the higher percentage indicating that it is easy to find family members to sign a consent form reveals that the hospital involves family members in such situations.

With regard to MHCUs who died in long-term mental health institutions, of the 360 respondents in this study, 340 (94.4%) agreed that in case of death, family members are notified and 20 (5.6%) disagree. Probabilities are that the higher percentage indicating family members being notified in case of death reveals that the hospital involves family members in such situations. However, study conducted in Netherlands by Detering, Hancock, Reade and William (2010 cited in Brinkman-Stoppelenburg, Rietjens & Van der Heide, 2014) to determine the effectiveness of different types of advanced care planning, revealed that families of MHCUs who died in mental health institutions were interviewed and found to be satisfied with overall mental health care as well as the information provided.

Furthermore, families were more satisfied with the quality of the patient's death from their perspective and the belief that the patient would also have been satisfied with the quality of care they receive at death (Detering et al., 2010 cited in Brinkman-Stoppelenburg et al., 2014). Of the 360 respondents in this study, 334 (92.8%) reported that in case of death, cases were referred to social worker for family tracing and 26 (7.2%) responded that MHCUs are buried as a pauper without tracing family members.

In addition, Boulton and Black (2010); Boulton and Schwarz (2014) revealed that pauperism was thus associated to lack of ability to trace families and close relatives. Study revealed none of the MHCUs buried as paupers had been traced by family members (Boulton & Black, 2010; Boulton & Schwarz, 2014). Probabilities are that the reason for cases referred to social worker for family tracing in case of death, may indicate that the hospital tried all means to involve family members in such situations.

Of the 360 respondents in this study, 148 (41.1%) agreed that MHCUs were buried as a pauper without tracing family members and 212 (58.9%) disagreed. Probabilities are that MHCUs might be buried as a pauper after six months failing to trace family members. Moreover, of the 360 respondents in this study, 114 (31.7%) agreed that family members visited to trace MHCU being buried as a pauper and 246 (68.3%) disagreed. Study by Boulton and Black (2010); Boulton and Schwarz (2014) revealed that none of the MHCUs being buried as paupers have been trace by family members. The study assumptions are that family members might visit the mental health institution to trace the MHCUs and are successful if the mental health institution had records of him or her being buried as a pauper.

Of 360 respondents in the study, 270 (75.0%) reported that the issue of MHCUs buried as a pauper is participants' major concern whereas 90 (25.0%) responded it was a minor concern. Probabilities are that the concern about MHCUs being buried as a pauper might be related to lack of MHCUs family contact details. With regard to MHCUs discharge, of 360 respondents in the study, 216 (60.0%) reported that MHCUs who were not happy when discharged was a major concern and 144 (40.0%) indicated that it is a minor concern.

However, Detering et al. (2010) and Brinkman-Stoppelenburg et al. (2014) identified that feelings of rejection, perceived by MHCUs when discharge from MHCI have also been identified in patients. Authors suggested that MHCUs should receive information about their condition to minimize a lack of feeling of readiness for discharge (Detering et al., 2010; Brinkman-Stoppelenburg et al., 2014). It might be possible that MHCUs may be angry when discharged because they were not ready to be discharged and also feel comfortable being admitted in long-term mental institutions.

Of the 360 respondents in this study, 241 (66.9%) indicated that MHCUs were happy when fellow MHCUs are visited by family members; 119 (33.1%) disagreed. Study conducted by Bench and Day (2010) in Britain to identify factors which impact progress and recovery of critical illness, found that MHCUs expressed positive feelings about visitation of families in the mental health institutions and feelings of excitement associated with mental health care. Probabilities are that MHCUs being happy when visited by family members is evidence that they need to stay with their family members in such situations.

4.6.4 Conclusion remarks

Conclusion remarks of this study are made in line with Thornton's Model of self-realization hence the essence of nurses and arises from the spiritual field and the field of Love (Thornton, 2013). In this study WPC is based on the concepts of therapeutic partnering; and caring as sacred practice.

- **Therapeutic partnering**

From discussions it was noted that families appreciate the way the hospital management provides mental health care. However, participants indicated that families caring for MHCUs during LOA is problematic. In this regard, nurses have concerns about families failing to care for MHCUs during LOA. Participants also indicated that family members experience difficulties in monitoring MHCUs' compliance. However, participants indicated that financial constraints experienced by families of MHCUs seem problematic. Participants indicated the fact that LOA was viewed as a challenge because MHCUs relapse when at home.

In this regard, nurses have concerns about MHCUs' relapsing while at home that leads to the individual being brought back to the hospital before expected date. This gives nurses' a therapeutic role of partnering with family members in order to improve the quality of mental health care services. Although a person and environment are in a state of constant mutual process, there is no distinction from an energetic perspective (Thornton, 2013). Therefore, in caring for MHCUs, family members should pay visits to the mental health care institutions in order to interact with them.

- **Caring as sacred practice**

Data from families described reasons for lack of acceptance of MHCUs for LOA. However, participants expressed that reluctance of family members to care for MHCUs at home was problematic. Participants indicated that families lack skills and lack the ability to monitor MHCUs at home. In addition, participants outlined reasons of family members not visiting MHCUs in hospital. Therefore, family members should be involved in enhancing MHCUs to be treated with greater respect. In addition, the physical health, mental health and the social care needs are significant aspect that requires family members to be involved so that MHCUs care recover and return to their own homes (Thornton, 2013).

4.6.5 CONCLUSION

This chapter presents the data analysis discussion and interpretations of the findings. Data analysis began concurrently and analysed independently as indicated in table 4.2 and table 4.6. The researcher uses convergent analytic approach to merge the two data sets. This study found that the qualitative findings are related to quantitative findings to the extent that both answered the research questions. The next chapter will discuss the concept analysis in which the researcher clarifies and distinguishes the definition of the concepts.

CHAPTER 5

CONCEPT ANALYSIS

5.1 INTRODUCTION

Chapter four outlined data analysis and the discussion of research results. This chapter discussed the concept analysis phase three utilised in this study. In this chapter, the researcher clarifies and distinguishes the definition of the concept “*family involvement in caring for MHCUs*” in order to share the meaning of this concept with the readers as well as with the participant. The researcher adapted the eight steps in the Walker and Avant method to clarify and distinguish the definition of the main concepts as follows: select a concept; determine the purpose of analysis; identify all the uses of the concept; determine the defining attributes; contrast the model case; contrast additional cases, borderline, related, contrary, invented and illegitimate cases; identify antecedents and consequences; and define empirical references.

5.2 OBJECTIVE

- To analyse the concept “*family involvement in caring for MHCUs*” adapted the eight steps in the Chinn and Kramer (1999 cited in Barker, 2013) and Walker and Avant (1995 cited in Santos, Souza, Gutiérrez, Maria, & Barros, 2013) method.

5.3 CONCEPT ANALYSIS

Walker and Avant (2013) defined concept analysis as a strategy that allows researchers to examine the attributes or characteristics of a concept. According to Walker and Avant concept analysis is a formal, linguistic exercise to

determine those defining attributes. However, the analysis itself should be thorough and more precisely, the end product is always tentative. The purpose and use of concept analysis is to distinguish the defining attributes of a concept from its irrelevant attributes (Walker & Avant, 2013).

Some authors have indicated that concept analysis is useful in refining different meaning concepts in a theory and clarify concepts that are prevalent in nursing practice (Chinn & Kramer, 1999 cited in Barker, 2013; Walker & Avant 1995 cited in Santos et al, 2013; Walker & Avant, 2013). In this study the researcher adapted the eight steps in the Walker and Avant Method to clarify and distinguish the definition of the main concepts because it seems to be the most influential model in nursing science (Nuopponen, 2010).

In addition, the researcher adapted the Walker and Avant Method in order to render precise theoretical and operational definitions in the study. This helped the researcher to clarify nursing terms that are popular phrases. Furthermore, concept analysis also assists the researcher to develop an instrument and nursing diagnosis (Chinn & Kramer, 1999 cited in Barker 2013; Walker & Avant, 2013). The definition of the main concepts are as follows:

- selecting a concept
- determining the purpose of analysis
- identifying all the uses of the concept
- determining the defining attributes
- contrasting the model case
- contrasting additional cases, borderline, related, contrary, invented and illegitimate cases
- identifying antecedents and consequences
- defining empirical references

5.3.1 Selecting a concept

According to Walker and Avant (2013) concept selection is the most difficult step that should be done carefully to avoid primitive terms that can be defined by giving examples only. Some authors have also indicated that concept selection should reflect the topic or area of greatest interest to the researcher (Nuopponen, 2010; Walker & Avant, 2013). In this study the researcher selected a concept from the area of interest associated with the researcher's clinical area. The researcher selected the concept "*family involvement in caring for MHCUs*" as the key of the study.

Therefore, "*caring*" was selected as part of the concept "*family involvement in caring for MHCUs*" instead of nursing. However, the term "*nursing*" generally represented a helping process with primary focus on interpersonal interaction between the nurse and other individuals. In this study, the word "caring" was selected as central to the essence of nursing (Chinn & Kramer, 1999 cited in Barker, 2013). The researcher adapted Chinn and Kramer's and Walker and Avant's guidance to assure naming that is necessary and valuable for nursing purposes.

5.3.2 Determining the purpose of analysis

Chinn and Kramer (1999 in Barker, 2013) and Walker and Avant (2013) stated that the purpose of concept analysis is to set boundaries to limit becoming hopelessly lost in the process. In this study, the researcher determined the purpose of concept analysis as follows:

- To distinguish between ordinary and scientific usage of the same concept.
- To clarify meaning of an existing concept.

- To develop an operational definition, or something similar (Walker & Avant, 2014).
- To define the meaning of a concept “*family involvement in caring for MHCUs*”, its attributes and the meaning of the related terms with different meanings, in order to clarify the concept (Chinn & Kramer’s, 1999 cited in Barker, 2013).

5.3.3 Identify all the uses of the concept

According to Walker and Avant (2013), it is important to identify all uses of a concept when collecting empirical data for the analysis. In this study the researcher clarified concepts using dictionaries, theses, colleagues and literature control, to promote further understanding among other disciplines. In this study, the researcher operationalized concepts “*family involvement in caring for MHCUs*” to guide the discipline so as not to lose useful information (Chinn & Kramer, 1999 cited in Barker, 2013).

Table 5.1 Sources for literature review

Author(s)	Year	Type of article	Search terms	Inclusion criteria
Lopez, M.E. & Caspe, M.	2014	<i>Family Involvement Network of Educators</i>	Family-involvement	All articles and studies that deals with issues of family involvement.
McMillan, R., Mclsaac, M. & Janssen, I.	2016	<i>School Community Journal</i>	Family-participation	
Gooding, Cooper, Blaine, Franck, Howse, & Berns.	2011	<i>Educational Review</i>	Family-inclusion	
Cohen-Mansfield, J., Thein, K., Dakheel-Ali, M. & Marx, M.S.	2010	<i>Psychiatry research</i>	Family-engagement	
Cape, B.F.	2005	<i>Baillier's nurses' dictionary</i>	Family Blended family Extended family Extended nuclear family Nuclear family Child-headed family	
Wehmeier, S.	2005	<i>Oxford Advanced Learner's Dictionary of Current English</i>	Involvement Participation Engagement	
Roland,	2014		Caring	
South Africa	2002		Mental health care users	

Therefore, the researcher proceeded with the process of defining conceptual meaning by using multiple resources from literature review (Walker & Avant, 2013). The concept “*family involvement in caring for MHCUs*” has four elements: “*family*”, “*involvement*”, “*caring*” and “*MHCUs*”.

Family

“*Family*” is derived from the British word “*familee*” which refers to a group related by blood or marriage especially a husband, wife and their children (Wehmeier, 2005).

Taxonomic category an order of family include:

“*Blended family*” refers to a family unit composed of a married couple and their offspring, including some of previous marriage (Cape, 2005).

“*Extended family*” refers to a nuclear family and those close relatives, such as the children’s grandparents, aunts and uncles (Cape, 2005).

“*Extended nuclear family*” refers to a nuclear family who nevertheless make frequent social contact with the extended family group despite geographical distance (Cape, 2005).

“*Nuclear family*” refers to a couple and their children by birth or adoption, who are living together and are more or less isolated from their extended family (Cape, 2005).

“*Single parent family*” refers to a lone parent and offspring living together as a family unit (Cape, 2005).

“*Child-headed family*” refers to households in which the oldest member living in the house is under the age of 18.

- “*Orphaned, abandoned, or neglected children*” who live in a household in which the oldest member is under the age of 18 and where there is no

adult supervision and support. (South African Government, 2005 cited in Morantz, Cole, Vreeman, Ayaya, Ayuku, & Braitstein, 2013.). Bird (2013) defined “*Child-headed family*” as a household in which the parent, guardian or care-giver of the household is terminally ill, has died or has abandoned the children in the household.

- No adult family member is available to provide care for the children in the household.
- A child over the age of 16 years has assumed the role of care-giver in respect of the children in the household and it is in the best interest of the children in the household (Bird, 2013).

The researcher selected the concept “family” to include all taxonomy categories definition of family. However, Tambuyzer et al. (2014) defines family as caregivers of all those in the circle of care, including family members and other significant people who provide unpaid support to an individual living with a mental health problem or illness. In the literature, family is defined as a group of interacting persons who recognise a relationship with each other, based on a common parentage, marriage and/or adoption (South Africa, 2011 cited in Nduna, & Sikweyiya, 2015). In this study “family” means parents, guardian, children and next of kin, including any relatives closer to the MHCUs.

Involvement

“*Involvement*” is derived from the British verb “*involve*” and refers to making somebody take part in something.

- To say or do something to show that somebody took part in something with intent.
- “Involvement” refers to the act of taking part in something you care about.
- Act of giving a lot of time and attention to something you care about (Wehmeier, 2005).

Synonyms are:

- Participation
- Engagement

The researcher selected the concept “*involvement*” because families are involved when they support and participate in their child’s mental health care, create home environments that support the child and collaborate with the broader community to provide resources/services to help community mental health agencies succeed (Dostaler & Cannon, 2011 cited in Tambuyzer et al., 2014). In the literature, involvement refers to the act of taking part in something you care about (Wehmeier, 2005). In this study “involvement” means having a primary decision-making role in caring for MHCUs who are admitted in long-term mental health hospitals.

Family-involvement

“*Family-involvement*” was also selected to verify whether the combination of concepts “*family*” and “*involvement*” can have the same meaning when combined. Ferris (2008 cited in Chrisman, Chua, Pearson & Barnett 2012) defined “*family-involvement*” in mental health as the family that has a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

- Choosing supports, services, and providers
- Setting goals
- Designing and implementing programmes
- Monitoring outcomes
- Partnering in funding decisions

- Determining the effectiveness of all efforts to promote the mental health and well-being of children and youth (Ferris, 2008 cited in Chrisman et al., 2012).

The concept “*family-involvement*” was selected as it is essential to involve parents in treatment decisions and progress meetings. However, family members are often responsible for making decisions that support the recipient’s recovery on mental health services. Family involvement is a key element of a child’s success, especially for children in residential treatment (Chrisman et al., 2012).

In education, various authors generally defined “*family involvement*” as the parents’ or caregivers’ security in the education of their children, to more detailed ones that identify parental involvement as parents’ behaviours in home and school setting destined to support their children’s educational development” (Nokali, Bachman, & Votruba-Drzal, 2010; Nokali, Nermeen, Heather, Bachman & Votruba-Drzal, 2010 cited in Wilder, 2014). Epstein (1995 cited in Baker, Wise, Kelley & Skiba, 2016) defines family–school involvement in the manner in which family members are involved in their child’s education as follows:

- Parenting to support children’s education.
- Communicating with the schools.
- Volunteering in children’s schools and extracurricular activities.
- Assisting with homework and learning opportunities in the home.
- Participating in decision-making within the schools.
- Collaborating between the school and community (Epstein & Salinas, 2004; Epstein & Sanders, 2006 cited in Baker et al., 2016).

In addition, parental involvement has been accepted as being present in the school construction, centred on the notion that schools and teachers should

advise parents to be involved in learning (Hornby & Lafaele, 2011; Jeynes, 2013 cited in Baker et al., 2016). Therefore, “*family involvement*” was first incorporated into national policy in 1984 when the Child and Adolescent Service System Program (CASSP) principles were adopted. Therefore, “*family involvement*” was included as a guiding principle in the 2001 Report of the Surgeon Generals’ Conference on Children’s Mental Health and the President’s New Commission on Mental Health in 2003 (Chrisman, Chua & Pearson., 2012).

Synonyms are:

Family-participation

Family-engagement

In addition, the sources that use all terminology such as “*family-involvement*”, “*family-participation*” and “*family-engagement*” has been reviewed. In sports, “*family-participation*” refers to a family’s ability to participate in the child’s health-related organised sport (McMillan, Mclsaac & Janssen, 2016). “*Family inclusion*” refers to involving family members at all levels of health care, providing professional education, policy making and program development (Gooding, Cooper, Blaine, Franck, Howse, & Berns, 2011). However, “*family engagement*” refers to the act of being employed or involved with an external stimulus, which has been linked to decreased boredom, positive emotions, alertness, interest and decreases in agitation/problem behaviours in this population.

Moreover, “*family-engagement*” is significant in social activities hence the existence of a supportive social environment can have progressive effects on excellence of quality of life and functional capability (Cohen-Mansfield, Thein, Dakheel-Ali, & Marx, 2010). However, the focus of this study was to lean toward the collaborative practice of family involvement, regardless of any term used (Walker & Avant, 2013).

Caring

“*Caring*” is derived from the British noun “*ker*” which refers to the process of caring for somebody or something.

- Attention or thought that you give to something that you are doing so that you do it well and avoid mistakes or damage (Wehmeier, 2005).

“Caring” refers to being helpful and showing that you care about other people (Wehmeier, 2005). According to Mann (2014) the definitions of caring include the global concept of showing concern and empathy with others.

Synonyms are:

Kindness

Empathy

Gentle

Friendly

Generous

The concept “*caring*” was selected because it is viewed by the nursing profession as an essentially applicable concept underlying nursing practice (Watson, 2008 cited in Mann, 2014). In addition, caring behaviours have been documented in the literature as a significant link to holistic nursing, critical thinking, and the nursing process (Hill & Watson, 2011 cited in Mann, 2014). Caring is a feeling and it exhibits empathy and concern of others that requires actions (Lachman 2012 cited in Roland, 2014). In this study, “caring” means providing mental healthcare services to patients with mental illness in a mental health hospital.

Mental

Wehmeier (2005) defined “*Mental*” as connected with or happening in the mind.

- Involving the process of thinking
- Connected with the state of health of the mind or with the treatment of illness of mind.

Synonyms are:

Mentally ill

Psychological

Psychiatric

Insane

Neurotic

Psychotic

Disturbed

Unstable

The concept “*mentally ill*” was selected as a first concept in the synonyms to verify whether it has the same meaning as “*mental*”. However, Wehmeier’s (2005) explanation of “*mentally ill*” relates the same meaning as “*mental*”. The concept “*mentally ill*” refers to suffering from illness of the mind, especially in a way that affects the way you think and behave. Therefore, when the person is mentally ill, it is referred to as having “*mental illness*” which is a term used describing a number of disorders of the mind that affect the emotions, perceptions, reasoning or memory of individuals e.g., psychosis and neuroses (Wehmeier, 2005).

Health

According to WHO (2000 cited in Cope, 2014) health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

- The condition of a person's body or mind
- A state of being physically and mentally healthy
- The work of providing medical services

User

"User" is derived from the noun *"use"* which refers to the act of using something. Therefore, the concept *"user"* refers to the person or thing that uses something.

- A person who uses illegal drugs

The researcher selected the concept *"user"* because it refers to a person using health services at a health establishment (South Africa, 2002).

Mental Health Care users

The concept *"Mental Health Care users"* was also selected to verify whether the combination of concepts *"Mental, Health, Care"* and *"users"* can have the same meaning when combined. Therefore, *"Mental Health Care users"* refers to a person receiving care, treatment and rehabilitation services or using health services at health establishment aimed at enhancing the mental health status of a user (South Africa, 2002). Different authors outlined the concept *"Mental Health Care users"* in different but relate meaning.

According to Rose, Evans, Sweeney and Wykes (2011) "MHCUs" refers to a person receiving mental health services. However, Aston and Coffey (2012 cited in Le Boutillier, Chevalier, Lawrence Leamy, Bird, Macpherson, Williams & Slade, 2015) refer the "MHCUs" as the person receiving mental health services

to treat and care for people with mental health problems. In this study “MHCUs” refers to a person with mental illness, admitted in a mental health hospital to receive care, treatment and rehabilitation.

5.3.4 Determining the defining attributes

Walker and Avant regard the determination and defining of attributes as the “heart of concept analysis”. The researcher decided to choose more than one meaning and continue analysing concepts using different meanings (Walker & Avant, 2013). In this study, the researcher identified attributes through literature control and express its different meanings, then categorises the characteristics that appears frequently throughout the analysis process. Identified characteristics of “*family involvement in caring for MHCUs*” which were found repeatedly are “family-participation” and “family-engagement”. Characteristics for “*caring*” are kindness, empathy, gentle, friendly and generous. For “*mental*” are: “mentally ill”, “psychological”, “psychiatric”, “insane”, “neurotic”, “psychotic”, “disturbed” and “unstable”. Identified characteristics of “*care*” which were found repeatedly are: take care of, caution, prudence, discretion and wariness.

Family involvement

“*Family-participation*” is selected as often synonymous with “*involvement*”. Tambuyzer (2014) defined “*family-participation*” as family members being engaged and encouraged to participate in the diagnosis, treatment and recovery process of the adult with mental illness, with due regard for the rights of the person living with mental illness and for their confidentiality and privacy. According to Thornton (2013) a model of whole-person caring can be used with other models of care such as patient- and family-centered care and relationship-based care. It was found that the integration of organisational values was

increased in participating in the model of whole-person caring programme (Thornton, 2013). Therefore, *“Family-participation”* means:

- A circle of care and support offering enduring commitment to care for one another related either biologically, emotionally or legally and takes into account those who the client identifies as significant to his/her well-being” (Dostaler & Cannon, 2011 cited in Tambuyzer et al., 2014).

“Family-engagement” is selected as often synonymous with involvement. Tambuyzer et al. (2014) defined *“Family-engagement”* as motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing things for the better. Therefore, *“family-engagement”* means:

- Anything that keeps families working in the long run and sometimes a slow process of positive change (Tambuyzer et al., 2014).

Caring

Kindness: is selected as often synonymous with *“caring”* which refers to caring about other (Wehmeier, 2005).

Empathy: refers to the ability to understand another person’s feeling and experience (Wehmeier, 2005).

Gentle: refers to telling somebody to be careful (Wehmeier, 2005).

Friendly: refers to behaviour in a kind and pleasant way because you like somebody or you want to help them (Wehmeier, 2005).

Generous: refers to kind in the way you treat people, willing to see what is good about somebody or something (Wehmeier, 2005).

Mental

Mentally ill: refers to suffering from mental illness of mind especially in a way that affects the way you think and behave (Wehmeier, 2005).

Psychological: refers to connection with person's mind and the way in which it works (Wehmeier, 2005).

Psychiatric: refers to relating to mental illness (Wehmeier, 2005).

Insane: refers to suffering from a serious mental illness and unable to live in normal society (Wehmeier, 2005).

Neurotic: refers to suffering from or connected with neurosis (a mental illness in which a person suffers strong feelings of fear and worry) (Wehmeier, 2005).

Psychotic: a serious mental illness in which thought and emotions lose connection with external reality (Wehmeier, 2005).

Disturbed: mentally ill, especially because of very unhappy or shocking experiences (Wehmeier, 2005).

Unstable: having emotions and behaviour that are likely to change suddenly and unexpectedly (Wehmeier, 2005).

Care

Take care of: means to look after or care for someone who is very young, very old or sick or something that needs keeping in good condition (Wehmeier, 2005).

Caution: means care that you take in order to avoid danger or mistakes (Wehmeier, 2005).

Prudence: means being sensible and careful when you make judgement or decision; avoiding unnecessary risk (Wehmeier, 2005).

Discretion: care in what you say or do in order to keep something secret or avoid causing embarrassment or difficulty for somebody (Wehmeier, 2005).

Wariness: means care when dealing with somebody or something because you think there may be a danger or a problem (Wehmeier, 2005).

5.3.5 Contrasting the model case

Wilson (1963 in Walker and Avant, 2013) suggests that the model case is one in which the analyst can say “well”, if that is not an example of it. In addition, a model case may be constructed by the researcher or may be actual case examples from real life. According to Walker and Avant (2013) the researcher should begin to develop a model case while developing the list of defining attributes. In this study, the researcher developed a model case that represent a real life example of the use of the concept that includes all the critical attributes of the concept (Walker & Avant, 2013). In addition, a real life scenario on how the concept was used, included all the attributes of the concepts.

“...I feel happy when involved in caring for my younger brother. It helps us as a family to understand how my younger is getting help in the hospital. It also help us to understand why my younger brother is mentally ill. ...I like to stay with him. My concern is that there is no one at home who can take care of him when the hospital give him chance to be at home. It is not easy to can find a helper to take care in my absence. I’m working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment. Who is going to monitor him while I’m at work because some of treatment is taken during the day? The hospital calls me if they want to talk with me. They know that I visit my younger during holidays. I am really satisfied with the way they are caring my younger brother.”

In this case the brother expresses his feelings regarding being involved in caring for his younger brother. The father explained also the significance of being

involved in mental health care. He further explained the reasons of not visiting the MHCU in the hospital was the disadvantage of taking the MHCU to Johannesburg and therefore, not able to supervise his brother's treatment. He also raised questions to support that there was a need to monitor the MHCU while he is at work because treatment is also taken during the day. In addition, family members and nurses can create a healing and nurturing environment for the MHCUs. Therefore, the researcher assumes that implementing the whole-person of caring model may increase nurse, patient and family member's satisfaction as well as integration of organisational values while strengthening the workforce within the mental health institutions (Thornton, 2013).

5.3.6 Contrasting additional cases, borderline, related, contrary, invented and illegitimate cases

Walker and Avant point out that "an analysis cannot be completed until there are no overlapping attributes and no contradictions between the defining attributes and the model case" and have divided contrast additional cases into borderline, related, contrary, invented, and illegitimate cases (Walker & Avant, 2013). According to Walker and Avant borderline cases are those examples or instances that contain some of the critical attributes of concepts being examined but not all of them. However, Walker and Avant stated that these cases help the researcher to clarify thinking about the defining or attributes of concept of interest (Walker & Avant, 2013).

Walker and Avant defined related cases as instances of concepts that are related to the concept being studied but do not contain critical attributes and in some way are connected to the main concepts. In addition, related cases demonstrate similar ideas to the main concept but differ slightly when examined closely. Researchers define contrary cases as those that clear examples of "not the concept". According to Walker and Avant contrary cases are helpful to

analysts as researchers express issues differently. In addition authors have indicated that contrary cases give the researcher information about what the concept should have as defining attributes (Walker & Avant, 2013). In this study, the researcher compared the defining attributes and decide which characteristics or attributes additional cases used to the concept of interest. The researcher identified attributes that have an effect on making the model case stronger (Walker & Avant, 2013).

“My brother is destructive at home (crying). I went to “sangoma” to try to get help about my brothers’ mental illness as he is no longer wanted by the community members. I took him there and paid R5000 of which I am owing another R7000, He did not complete the course at the “sangoma” because of his distractive behaviour. He abuse dagga and alcohol. He broke church windows more than four houses within the community. He killed one cow of the famous funeral society. He wanted to throw a child in the toilet at his mothers’ sisters’ funeral. He threatened community children with a knife and also took groceries from the tuck-shop. He threatens everyone in the community. He don’t want to take treatment saying he is a traditional healer, he is dangerous to the community. I am afraid to take him when granted LOA. The community members even complained to the “induna”. That is why he came with the letter to indicate that he is no longer wanted at our village.”

In this case the sister of the MHCU displayed her emotional concern about the distractive behaviour of her brother. She even consulted traditional healers trying to get help. The MHCU failed to comply with the instructions of the traditional healers because of his destructive behaviour. The sister expressed her feeling of being afraid to take the MHCU when granted LOA as the MHCU is no longer wanted at the village. Yet, a person’s behaviour can improve through the use of relaxation techniques.

It is of significance to involve family members at every level of the mental health care process. Therefore, it was found that applying models that improve the quality of care and increase patient satisfaction promote positive patient outcomes (Thornton, 2013).

5.3.7 Identifying antecedents and consequences

In this step Walker and Avant (2013) found that antecedents and consequences are helpful in further refining the critical attributes theoretically. Antecedents and consequences were identified from the reviewed literature and health care providers who have experience involving family members in caring for MHCUs.

Antecedents “family involvement in caring for MHCUs”

According to Walker and Avant (2013), antecedents are events that must occur prior to the occurrence of the concept. Antecedents helped the researcher to identify the underlying assumptions about the concepts of *“family involvement in caring for MHCUs”*. The researcher identified “family therapy”, “home visits” and “psychoeducation”. However, the whole-person caring model implies that an ability to perceive reality with more clarity, acceptance of self and others, engaging in relationships that are wholesome and loving as well as a closer connection to God/spirit, hence should be integrated into the highest potential aspects in mental health care (Thornton, 2013). Antecedents of this study were defined in this chapter earlier. The researcher focuses on essential antecedents of managing MHCUs. The researcher also described the consequences of *“family involvement in caring for MHCUs”*.

Consequences “*family involvement in caring for MHCUs*”

Consequences are events that occur as a result of the occurrence of the concept. In this step the researcher used consequences to determine neglected ideas, variables or relationships that may direct new research fruitfully (Walker & Avant, 2013). According to Thornton (2013) the relationship between people with the same common mission and purpose, promote healing and wellness hence reducing the incidence of chronic disease and creating a healthier society. In addition, therapeutic activities encourages and supports MHCUs in developing their own practice and plans mental health care services (Thornton, 2013).

In this study the researcher identified predisposing factors of the events and activities that have the effect on “*family involvement in caring for MHCUs*” as illustrated in table 5.2. Consequences of “*family involvement in caring for MHCUs*” include: family interacting with MHCUs, MHCUs going home when discharged or granted LOA, MHCUs not absconding from to home when discharged or granted LOA, treatment compliance, recovery of mental illness and MHCUs being accepted by community members as illustrated in table 5.2.

Table 5.2: Terms, attributes, uses, antecedents and consequences of “family involvement in caring for MHCUs”

Terms	Attributes	Uses	Antecedents	Consequences
Family involvement	Family-participation	Family members being engaged and encouraged to participate in the diagnosis, treatment and recovery process of the adult with mental illness, with due regard for the rights of the person living with mental illness and for their confidentiality and privacy.	<p>Family involvement process:</p> <p><u>Phase one</u> conducting situational analysis</p> <p><u>Phase two</u> Developing collaborative strategies</p> <p><u>Phase three</u> Implementing collaborative strategies</p>	<ul style="list-style-type: none"> - Sufficient interacting between families and MHCUs - MHCUs being accepted at home when discharged or granted LOA - Sufficient relationship between families and MHCUs as evidenced by families often visiting MHCUs when admitted in long-term mental health institutions - MHCUs to be supervised and comply with treatment at home when discharged or granted LOA
	Family-engagement	Motivating and empowering families to recognize their own needs, strengths, and resources and to take an active role in changing things for the better.		
Caring	Kinder	Caring about other		
	Empathy	The ability to understand another person’s feeling and experience		
	Gentle	to tell somebody to be careful		
	Friendly	Behavior in a kind and pleasant way because you like somebody or you want to help them		
Mental	Generous	Kind in the way you treat people, willing to see what is good about somebody or something		
	Mentally ill	Suffering from mental illness of mind especially in a way that affects the way you think and behave		
	Psychological	Connected with person’s mind and the way in which it works		
	Psychiatric	Relating to mental illness		
	Insane	Suffering from a serious mental illness and unable to live in normal society		
	Disturbed	Mentally ill, especially because of very unhappy or shocking experiences		
Health	Unstable	Having emotions and behavior that are likely to change suddenly and unexpectedly		
	Health	A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity		
Care	Take care of	Look after or care for someone who is very young, very old or sick or something that needs keeping in good condition		
	Caution	Care that you take in order to avoid danger or mistakes		
	Discretion	Care in what you say or do in order to keep something secret or avoid causing embarrassment or difficulty for somebody		
	Wariness	Care when dealing with somebody or something because you think there may be a danger or a problem.		
User	User	A person using health services at health establishment		

5.3.8 Define empirical references

According to Walker and Avant empirical references are classes or categories of actual phenomenon that demonstrate the existence of the concept itself (Walker & Avant, 2013). According to Nuopponen (2010) this is the last step in the Walker and Avant Model that brings together the critical attributes and their empirical referents in the real world. However, Walker and Avant indicated that empirical references are useful in developing instruments as they are theoretically linked to the base of the concepts and contribute to the content and construct validity of the instruments. In this study, the researcher clustered the phenomena that demonstrate the occurrence of the concepts that are useful in clinical practice to provide clear, observable phenomena and which are effective in developing instruments (Walker & Avant, 2013).

In addition, the model of whole-person caring, the field of healing implies that MHCUs experience a deep level of caring and a feeling of being healed. Hence, the health care provider also benefits from the positive effects that are generated through the field of healing because they are an inseparable part of the energy field (Thornton, 2013). For the family involvement to be effective and efficient, the process should be practically emphasized within the mental health institutions. Therefore, identified antecedents will influence the consequences of family involvement as discussed in chapter 6 that include:

- Sufficient interaction between families and MHCUs
- MHCUs being accepted at home when discharged or granted LOA
- Sufficient relationship between families and MHCUs as evidenced by families often visiting MHCUs when admitted in long-term mental health institutions
- MHCUs to be supervised and comply with treatment at home when discharged or granted LOA

5.4 CONCLUSION

Chapter five discussed concept analysis using the eight steps in the Walker and Avant method. This chapter clarifies and distinguishes the definition of the concept “*family involvement in caring for MHCUs*”. This concept was defined using various sources. These gave clarity on the family involvement model that will be initiated to improve the quality of mental health. The next chapter focuses on model development.

CHAPTER 6

MODEL DEVELOPMENT

6.1 INTRODUCTION

The previous chapter discussed concept analysis using the eight steps in the Walker and Avant method to clarify and distinguish the definition of the identified concept. Chapter six focuses on model development. This chapter outlined how to integrate concept analysis results and also to form the building blocks of the model (Dickoff, James & Wiedenbach, 1968). Model development will be guided by objectives and the WPC framework of Thornton (2013).

6.2 OBJECTIVES OF THIS CHAPTER

The objectives of this chapter were:

- to classify concepts using the identified concepts from empirical data
- to develop a model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

According to Dickoff et al. (1968) conceptual framework is used to integrate the result of the concept analysis and form the building blocks of the model. In this study, the researcher classified concepts using alarming results as well as the identified concepts from empirical data a model to promote family involvement was conceptualised using the six areas as described by Dickoff et al. (1968) as follows:

6.3. SIX AREAS

6.3.1 Context: mental health institution, family and cultural beliefs

Dickoff et al. (1968) define to the “context” as the setting, location, the physical structure of ward or unit, hospital, or medical centre, time, space, or structure that constitutes different elements of the situation in which the activity occurs. However, the authors noted that the physical elements are arranged in a manner to support a “patient-centred” approach that unifies all activities in which the “agent” is functioning towards achieving a goal for the benefit of the “recipient”. In this study, the contexts were mental health institution and the family. According to Van der Merwe (2013), WPC theory present convincing arguments concerning the vital importance of integrated body-mind-spirit healing when caring for patient admitted in the hospital to which the families should be involved. In this model, the mental health institution, the family and cultural beliefs are contexts considered to be the first field of the manifest universe.



Figure 6.1 Mental health institution, family and cultural beliefs context

- **Mental health institution context**

MHCI is the context where the MHCUs receive mental health care, treatment and rehabilitation. Mental health institution comprises of the MDT with different roles and characteristics depending on specific profession. Yet, the MDT members are involved throughout the process of provision of mental health care services hence family members play a significant role in this activity. From the discussion of data analysis, it was found that both MHCUs and the family members appreciate the way the mental health institution provides mental health care services. It is therefore of significance to understand the mental health institution context in order to overcome the dynamics that affect involvement of the family members in care, treatment and rehabilitation of MHCUs.

- **Family context**

Family is the context in which the MHCUs receive continuous mental health care, treatment and rehabilitation when granted LOA or discharged. In this context family members have specific roles so that the MHCUs may continue with treatment at home to maintain a stable condition. From the discussion of data analysis, it was found that MHCUs experience challenges when discharged or granted LOA. In addition, it was also found that a family experiences challenges while MHCUs are discharged or granted LOA. Therefore it is very important to understand the mental health institution context in order to overcome the dynamics that affect involvement of the family members in the continued care, treatment and rehabilitation of MHCUs while discharged or granted LOA.

- **Cultural beliefs**

Cultural beliefs is the context amongst the families of MHCUs can influence the effectiveness of family involvement. From the discussion of data analysis, it was found that families believe that MHCHs were bewitched and also that they have done something bad that resulted in the mental illness. Therefore, different cultural beliefs may influence the families to consult even the traditional healers while the MHCUs are discharged or granted LOA.

6.3.2 Agent

Dickoff et al. (1968) revealed that an “agent” can be a person who performs the activity such as providing health care services within the hospital. However, researchers have indicated that the nature of the agent stimulates activities that are creative, constructive and significant within performance that is aimed at goal achievement (Dickoff et al., 1968 cited in Lebesse, 2009; Maputle 2010; Boderick, 2011). In this study the agents were health professionals as they perform a comprehensive functional MDT role to contribute specifically in attendance to patients for the goal of quality patient care. In this model, the metaphor of a WPC diamond represents the foundation of nursing spiritual nature. Therefore, self-realization is the essence of agents and arises from the spiritual field and the field of Love (Thornton, 2013).



Figure 6.2 Agents

- **Health professionals as agents**

MDT members (psychiatrists, psychiatric nurses, psychologists, social workers, and occupational therapists) are the agents of this model. Health professionals are agents because their therapeutic role in mental health, thus nursing care is provided continuously within the mental health institutions for 24 hours each day. Researchers found that nurses play significant multifaceted roles and provide mental health care services in various contexts. Study by Blythe and White (2012) revealed that the role of the mental health nurse with regards to physical health care, intervention, and attaining the necessary knowledge also involves the families of mentally ill patients. In this study, it was found that nurses

are also concerned about the existing insufficient family involvement. From the discussion of data, it was indicated that the existing insufficient family involvement also affects their provision of quality mental health care services.

In addition, nurses were agents of this model because they are the ones who receive information from MHCUs complaining that families are not visiting them while admitted in the long-term MHCI. Hence MHCUs feel they are being rejected. From the discussion of findings, family members also outlined existing challenges in caring for MHCUs and also described reasons for not accepting MHCUs. Therefore, nurses as agents of this model have a significant role to support both the MHCUs and the family members. Moreover, this model will promote the involvement of the family members hence the quality of mental health care services will also improve by applying this model.

According to ANA (2013 in Thornton, 2013) nurses are foundational to integrative medicine, hence defined the holistic nursing as all nursing practice that has healing the whole person as its goal. In addition, nurses are essential to integrative and holistic care as they understand the interrelatedness of the mental, emotional, spiritual, physical and relational aspects of a person as well as recognizing the inseparability of these aspects from cultural and environmental influences (Thornton, 2013).

6.3.3 Recipient

According to Dickoff et al. (1968) a “recipient” is a person who benefits from the activity. These researchers noted that the “recipient” is significantly active in receiving the activities from the “agent” because there is always some interaction between the two. In this study, the “recipients” are MHCUs and families.

Recipient

MHCUs Families

Figure 6.3 Recipient

- **MHCUs as primary recipients**

MHCUs as recipients will benefit from this model because the goal of activities that happen between the agent and the recipient is to ensure that the family members are involved in redressing the existing situation. However, discussion of findings revealed that MHCUs' experience several challenges resulting from lack of support by family members. This study also found that MHCUs develop resistance towards rejection by family members. Therefore, MHCUs should acknowledge the significance of involving family members in their mental health care, treatment and rehabilitation. In addition, MHCUs should be assisted by agents to accept that family involvement in mental health care is of significance.

- **Family members as secondary recipients**

Family members including all taxonomy categories definition of family were the secondary recipients of this model. Researchers have explored to understand the role of family members in the management of mental disorders. It was found that family members contributed to the development of mental disorders over the past decade. When an individual is affected by mental illness, the whole family is also affected (Kochher & Bhakhry, 2015). In this study, it was also found that the mental illness of one family member affects the whole family. Therefore, family as recipients are the first individuals to identify mental illness at home and seek help. Family members play significant role in providing information to the nurses on how mental illness started.

From data analysis, families also indicated their experiences related to involvement in caring of MHCUs. Therefore, the researcher identified that family members as secondary recipients and are of significance in this model.

6.3.4 Dynamics

Dynamics are the energy sources for the activity (Dickoff et al., 1968 cited in Lebesse, 2009; Maputle 2010; Boderick, 2011). The authors noted that “dynamics” are taken to comprise the attractive personality of influence as an energy origin and an attribute associated with capacity to execute activities. However, in relation to performance, the authors specify that activities should be “purposeful”, “goal-directed”, have “stimulus” or direction. Dickoff et al. (1968) confirm this approach and describe it as embracing openness to relevant empirical reality as it exists in the literature and/or evidence. In the present study dynamics are the collaborative activities essential for achieving comprehensive quality mental health care that include poor interaction between the MHCUs and families, MHCUs not accepted at home when discharged, MHCUs returned back to the hospital before expected date when granted LOA and MHCUs not visited by family members.

Dynamics

- Poor interaction between MHCUs and families
- MHCUs not accepted at home when discharged
- MHCUs returned back before expected date when granted LOA
- MHCUs not visited by family members

Figure 6.4 Dynamics

6.3.5 Process/procedures

According to Dickoff et al. (1968 cited in Boderick, 2011) a procedure is the guiding technique of the activity. The authors agreed that a “procedure” does not determine the activities in detail, but offers to guide instructions or patterns on how the activity is to be performed (Boderick, 2011). In the present study procedures encompass three phases which are further discussed in model development: conducting situational analysis, developing collaborative strategy and implementation of collaborative strategy.

Procedure

Batho pele principles, human rights, MHCUs rights,

PROCEDURE

Phase 1: Conducting situational analysis

- Care
- Therapeutic relationship
- Therapeutic empowerment
- Compassion

Phase 2: Developing collaborative strategies

- Mutual participation
- Competence
- Communication

Phase 3: Implementing collaborative strategies

- MHCA
- Mental health policies
- Courage
- Commitment

Figure 6.5 Procedure

According to Walker and Avant (2013) a model development process description is a means of articulating broad frameworks for practice to reflect the core values of nursing as a profession, and has extrinsic value in as much as it conveys the science of nursing, which is a core attribute to the development of nursing as a profession. The empirical referents are processes by which the concept of competency can be measured (Walker & Avant, 2014). The researcher categorised activities that include 6Cs of the National health System (NHS): care, compassion, competence, communication courage and commitment (McAndrew, Chambers, Nolan, Thomas & Watts, 2014); to describe the process of the model to promote family involvement in caring for MHCUs in long-term MHIs of Limpopo Province using Batho by implementing Pele principles, considering human rights and MHCUs' rights within the MHCA are as follows:

- **Batho Pele principles**

Batho Pele principles framework reveals that citizens as customers of the public services should be considered first (South Africa, 1995 in Mabunda 2014). It is therefore of significance for MDT members to understand this framework when involving family members. In addition, treating the citizens as a customers in the MHI implies that MDT members should listen to both families and MHCUs' views; treating them with respect; ensure that the promised level and quality of services is according to the standards of mental health care services. Moreover, application of Batho-Pele principles should become a norm for all nurses providing mental health care services at specialised mental health institutions. However, the WPC theory revealed that the aspects of a person as well as recognizing the inseparability of these aspects from cultural and environmental influences the provision of health care services. Therefore, the developed model will also emphasize healing/harmony, exploring meaning and source of symptoms similar to WPC by involving family members in caring for MHCUs.

- **Human rights**

Human right to health means that everyone has a right to the highest attainable standard of physical and mental health which includes access to all medical services, sanitation, adequate food, decent housing, healthy working conditions and clean environment (South Africa, 1996). Therefore, mental health care as human right can be delivered effectively in to strengthen family involvement, thus the objective skilled health professionals have responsibility to develop policies considering human right to health care services. In addition, human rights may influence the MHCHs to disrespect agents forgetting responsibilities. Hence legislation regulated the family members as secondary recipients to be involved in the development of mental health policy and legislation, as well as planning mental healthcare services.

- **MHCUs' rights**

Chapter III of the Mental Health Care Act, 17 of 2002, on the rights of people with mental illness, stipulates that mentally ill people have rights in addition to any rights under other legislations that include: respect, human dignity and privacy, consent to care, treatment and rehabilitation services and admission to health care establishments, unfair discrimination, exploitation and abuse, determinations concerning mental health status, disclosure of information, limitation on intimate adult relationship, right to representation, discharge report and knowledge of rights (South Africa, 2002). Therefore, these rights may influence the MHCHs to disrespect agents hence legislation regulated the family members to be involved in the development of mental health policy and legislation, as well as planning mental healthcare services.

6.3.5.1 Phase one: conducting situational analysis

This is the initial stage in which the researcher conducted situational analysis in order to determine the feasibility of the model by making appointments with both family members and nurses to clarify their expectations towards MHCUs and significance of the model. The agents and recipients re-examined the meaning of caring to unfold what they already know about family involvement. Identified activities involves care, mutual relationship, therapeutic empowerment and compassion.

- **Care**

The meaning of care was clarified according to McAndrew et al. (2014) to increase the knowledge and understanding of family involvement. Mental health care was clarified as core business of NHS, and care delivered helps the MHCUs to improve the mental health of the society as a whole. Caring defines what the agents do, hence recipients of care expect it to be right for them, consistently, throughout every stage of their life (McAndrew et al., 2014).

- **Mutual relationship**

Mutual relationship amongst individuals involved is of significance. Nurses are the main sources to establish a rapport between both MHCUs and family members. Nurses should maintain nurse-patient and nurses-family relationship to the extent that MHCUs-family relationship is established to build trust that will improve the quality of mental health care services.

- **Therapeutic empowerment**

Therapeutic empowerment amongst individuals involves provision of mental health care services can affect the manner in which family involvement is conducted. Nurses should display their ability to empower and foster hope that

will encourage both MHCUs and families to develop self-esteem. Therapeutic empowerment is the fundamental element in the provision of mental health care services hence nurses should be holistic, collaborative and MHCUs-focused for the family involvement to be fruitful.

- **Compassion**

The meaning of compassion was also clarified according to McAndrew et al. (2014) to increase the knowledge and understanding of family involvement. Compassion was clarified on how family involvement in MHI should be provided through relationships based on empathy, respect and dignity (McAndrew et al., 2014). Therefore the researcher believes that cultural beliefs and stigma towards mental illness influence the way in which family involvement should take place. Cultural belief towards mental illness tend to prevent families from being involved in caring for their loved ones with mental illness, since they believe that they did something wrong to God.

In addition, stigma towards mental illness also tends to prevent families from being involved in mental health as family members with a mentally ill person are being stigmatised of punishment from God. During this phase the agent and recipient re-examine issues on family involvement and are given time to present their findings and discuss so that everyone should give their input. Solutions to overcome the barriers to family involvement presented are discussed. Hence personal consultation is allowed for issues that cannot be shared and require confidentiality. The facilitator notified the participants to identify dynamics that could hinder the effectiveness of family involvement. The facilitator further encouraged the participants to discuss dynamics emerged from individual and group discussions to clarify values promoting family involvement.

6.3.5.2 Phase two: developing collaborative strategy

This is the second phase in which the researcher developed collaborative strategy by identifying activities and selecting the key stakeholders (family members and nurses) to initiate the process of family involvement. The information from empirical data is shared with stakeholders to create and strengthen the interpersonal relationships between agents and recipients; and also increase self-awareness, openness, trust and communication. Identified activities include mutual participation, competence and communication.

- **Mutual participation**

Mutual participation amongst nurses, MDT members, family members and MHCUs is very important. Nurses' attitude towards participation in family involvement may affect other individual involved. Nurses as the main sources in provision of mental health care services should display interest on participation and be active to the extent that all individuals involved should have an interest in family involvement and participate actively.

- **Competence**

The facilitator encouraged agents to demonstrate cultural competence, when providing mental health care in a manner that is culturally appropriate for MHCUs and their families. In addition, competence is considered to encompass knowledge, skills and personal attributes but also recognizes contextual aspects of competence, including political, technical and structural factors (McAndrew et al., 2014).

- **Communication**

Communication skills amongst individuals involved in the provision of mental health care services can affect the way family involvement is conducted. Nurses as well as MDT members should be able to communicate with both MHCUs and

family members to the extent that problems are identified and appropriate intervention is planned. Nurses should be able to listen reflectively and respond to both MHCUs and family members' non-verbal and verbal communication. Communication was emphasised to promote sufficient and effective caring relationships between the agents and recipients. The facilitator encouraged agents to develop effective communicate skills to overcome difficulties between MHCUs and their families regarding family involvement as well as the significance of good communication that can motivate families to be involved in caring for their loved ones who have mental illness.

The researcher further clarified the definition of family involvement as the ability of family members to have a primary decision-making role in caring for MHCUs who are admitted in long-term mental health institutions. Participants were also notified about the dynamics involved in the second phase and also given time to discuss issues to overcome those dynamics. The facilitator encouraged the participants to provide inputs to promote family involvement in such situations.

6.3.5.3 Phase three: implementation of collaborative strategy

In this phase, the researcher ensured that stakeholders carry out identified activities though adopting the management principles of planning, organising, leading and control. Identified activities encompass effective and sufficient implementation of policies, MHCA, courage and commitment.

- **MHCA**

MHCA 17 of 2002 that governs the provision of mental health care services when an individual with mental illness is declared to be a MHCU. This Act comprises of various Acts and rights of which MHCUs should be informed when admitted in the long-term mental health institutions. It is of significance for the MDT members

to understand this Act in order to address both family and MHCUs on the significance of this Act.

- **Mental health policies**

Admission policy addressing activities which the families should be notified immediately the patient is declared to receive mental health care, treatment and rehabilitation is of significance. Family involvement policy should be developed to improve the quality of mental health care, treatment and rehabilitation. In addition, family therapy guidelines should form part of the policy to address how families should be involved effectively. Discharge policy should be reviewed to include activities which the families should be notified of before a MHCU is discharged.

- **Courage**

The facilitator clarified to the participants about the significance of courage to enable the agents to behave correctly towards recipients being cared for, to express their concerns and also to have the personal strength and vision to innovate and to embrace new ways of promoting sufficient and effective of family involvement (McAndrew et al., 2014).

- **Commitment**

The facilitator encouraged agents about commitment to recipients as a cornerstone of provision of quality mental health care, treatment and rehabilitation. Participants are also encouraged to build on commitment to ensure that the MHCA and policies are implemented to improve the mental health care and experience of family involvement. Hence taking action to make vision and strategy a reality for all and meet the health, care and support challenges ahead (McAndrew et al., 2014). Participants were also notified about the dynamics involved in the third phase and also given time to discuss issues to overcome those dynamics. The facilitator encouraged the participants to provide inputs to promote family involvement in such situations.

6.3.6 Terminus

According to Wehmeier (2005), a terminus is a point where something stops or reaches its end. Dickoff et al. (1968 cited in Lebesse, 2009; Boderick, 2011) define “terminus” as the goal outcome of the activity. The authors elaborate the goal as the “performance” of the “agent” to consider how best to describe an activities end point” (Dickoff et al., 1968 cited in Boderick, 2011). In this study, terminus of effective and efficient family involvement encompasses:

- Families often visiting MHCUs
- Sufficient interaction between MHCUs and families
- MHCUs accepted at home
- Successful LOA
- Treatment supervision when granted LOA or discharged

Terminus

EFFECTIVE AND EFFICIENT FAMILY INVOLVEMENT

Families often visiting MHCUS
-Sufficient interaction between MHCUS and families
-MHCUS accepted at home
-Successful LOA
-Treatment supervision when granted LOA or discharge

Figure 6.6 Terminus

6.3.6.1 Families often visiting MHCUs

The researcher identified family often visiting MHCUs in order to interact and support their loved ones. Hence the significance of routine contacts helps both families and MHCUs to discuss and share their expectations of each other. In addition, family visits to the mental institution develop positive attitudes amongst the health professionals' workforce and improves the quality of mental health services significantly (Morris et al., 2014).

6.3.6.2 Sufficient interaction between families and MHCUs

The researcher identified family interaction with MHCUs in order to promote the relationship aspects of care and family involvement which impact on continuity of care when the MHCUs are discharged or granted LOA. Hence, building relationships is an important element in the care, treatment programme (Newman, O'Reilly, Lee and Kennedy, 2015).

6.3.6.3 MHCUs accepted at home when discharged or granted LOA

The researcher identified MHCUs accepted at home when discharged or granted LOA. Hence, when the MHCUs are admitted to hospital for long-term mental health care, it is of significance to enable their care, treatment and rehabilitation; and then when discharged within a specified time frame to remain on the community treatment orders (CTO) (Maughan, Molodynski, Rugkasa, & Burns, 2014).

6.3.6.4 Successful LOA

The researcher identified successful LOA as trial for discharge and also evidence that the MHCUs could stay at home when discharged. However, it was

found that the success of LOA minimizes increased frequency of regular contacts that may, reflect the insufficient process of the CTO. In addition, LOA is an opportunity for MHCUs to be in contact with their families and the community. However, contacts such as crisis or periods of intense short-notice contact, may reflect relapse and be considered an outcome. Therefore, records on the frequency of community contacts may be an indication that CTO is insufficient (Maughan et al., 2014).

6.3.6.5 Treatment supervision when granted LOA or discharged

The researcher identified treatment supervision when granted LOA or discharged as a terminus in which MHCUs' recover, and encourages health professionals to collaborate with families. In addition, treatment supervision may enhance relationships between families and MHCUs characteristics. In addition, when the family supervise the MHCU on treatment, they communicate daily. Therefore, communication and, interaction among them may help to suggest targets and pathways for recovery (Nicholson, 2014 in Price-Robertson, Manderson & Duff, 2013).

6.4 DESCRIPTION OF THE MODEL

The description of the model is set out using the components as given by Chinn and Kramer (2008) to include the purpose, context, concept, structure and process of the model. Various authors defined a model as a set of interrelated relational statements about the phenomena that is useful for description, explanation, prediction, and prescription or control (Hempel, 1965; Dickoff et al., 1968; Reynolds, 1971; Hardy, 1974; Chinn & Jacobs, 1987 cited in Walker & Avant, 2013). Chinn and Kramer (2008) describe the structural forms of models as "powerful devices for shaping our perceptions of reality". The authors mention that description of a model may be expressed by different structures that

integrate with each other. In this study the model and its structures were described according to Chinn and Kramers' guidelines (1999) as follows:

- Goal
- Concepts
- Relationships
- Context
- Structures
- Process/procedures

6.4.1 Goal

According to Boderick (2011) the purpose for the development of a nursing practice model is to provide a schematic outline that represents the scope of professional nursing care. Chinn and Kramer (2008), indicated that the purpose of a model is the key element in describing the scope of the model. The purpose addresses reasons why the model is developed (Chinn & Kramer, 1999). In this study, the purpose of this model was to promote family involvement in caring for MHCUs at the selected district of Limpopo Province.

6.4.2 Concepts

According to Chinn and Kramer (1999), when the concepts are identified, conceptual and theoretical definitions are merged. In addition as theoretical definitions form bases that reflect empirical indicators, operational definitions are of significance to convey the general meaning of the concept (Chinn & Kramer, 1999; Walker & Avant, 2013).

Furthermore, conceptual and theoretical definition clarifies the meaning of the concepts within the model (Chinn & Kramer, 1999; Walker & Avant, 2013). In this study, the definition of the concepts was based on concept identification from concept analysis (Dickoff et al., 1968).

6.4.3 Relationships

According to Chinn and Kramer (1999 cited in Kim, 2010; Walker & Avant, 2013), a relationship statement refers to a description, explanation, or prediction of the nature of the interaction between the concepts of a model. In addition, relationship statement clarifies how concepts are linked together and how they give structures to the model (Chinn & Kramer, 1999; Walker & Avant, 2013). In this study, the nature of relationships amongst the attributes, antecedents and consequences provided the link between the concepts that refer to concepts analysis.

6.4.4 Context

Chinn and Kramer (2004; 2008: cited in Boderick, 2011) explain that the context of the model conveys insight into the background of socio-political circumstances that triggered and influenced the creation of the model. Therefore, the context of the model is a brief portrayal of the main attributes that assist gaining greater perspective ahead of the detailed attributes that follow in the structural and process descriptions of the model (Boderick, 2011). In this study, the model includes the mental health institution setting in which the model will be formulated and family members as societal trends and underpinning philosophical ideas that gave form to the purpose as to why the model was developed.

6.4.5 Structures

According to Chinn and Kramer (2005 cited in Mkhize, 2009) structures of the model are determined by the identified concepts and relationship between the concepts. In this study the researcher designed a schematic representation of the nature of structures of the model determined by the identified concepts and relationship between the concepts such as arrows, suitable diagrams, to provide a description of the model.

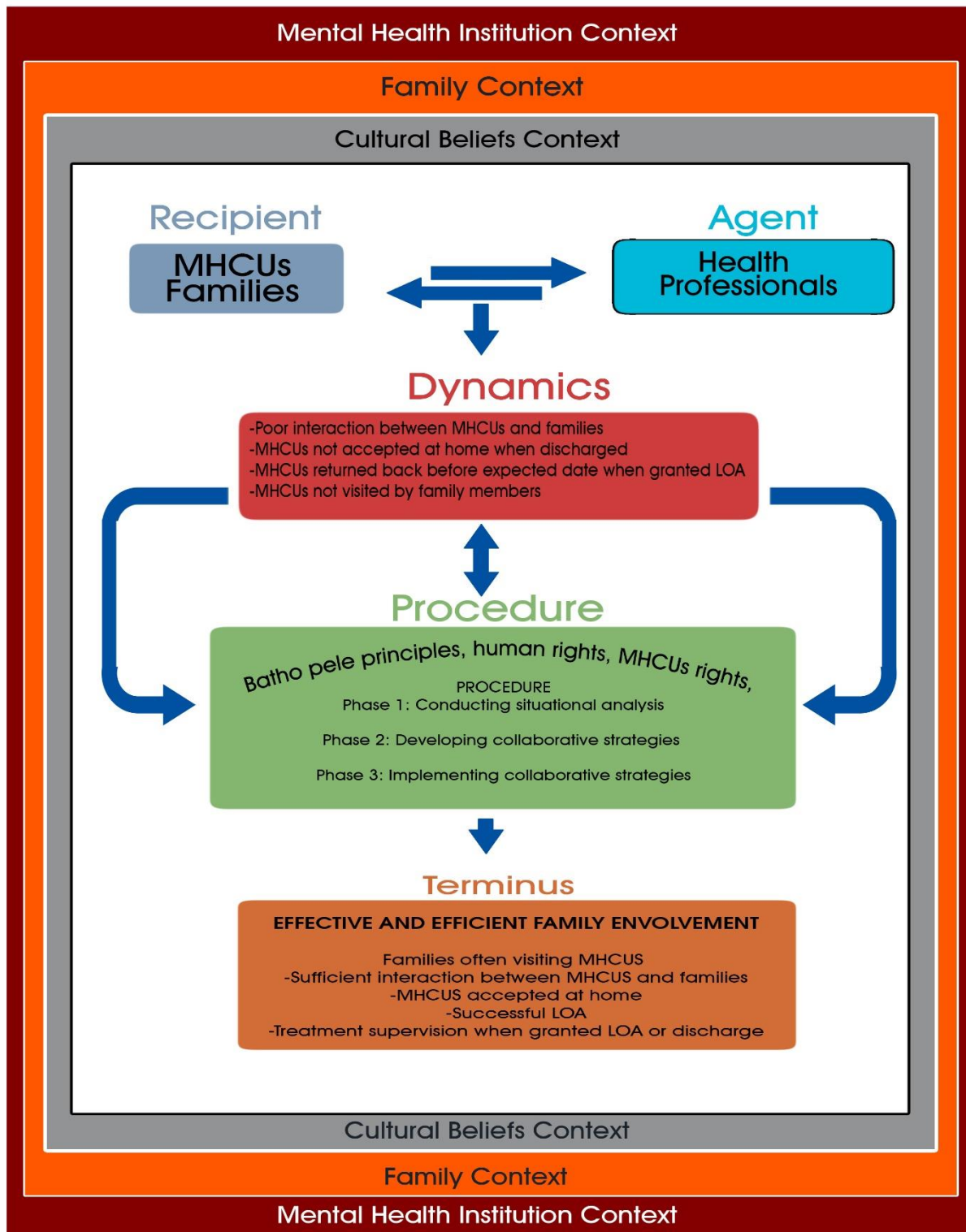


Figure 4.8 A model to promote family involvement in caring for MHCUs in long-term mental health institutions

6.4.6 Assumptions

According to George (2011) assumptions are testimonials or opinions that are extensively acknowledged and dominant constituents of a model (Chinn & Kramer, 2008; George 2011). In this study the assumptions upon which the model was based are the following:

- Both agents and recipients had their own beliefs and sense towards family involvement in caring for MHCUs in long-term mental health institutions.
- Attitude of both agents and recipients and cultural beliefs has impact on how family involvement could be commenced within the mental health system.
- MHCUs have mental health needs that should be met through efficient and sufficient family involvement, regardless of any influences that can obstruct the process from being fruitful.

6.5 GUIDELINES TO OPERATIONALIZE THE MODEL

According to Chinn and Kramer (1999) application of the model is a final step in model development. However, application of the model encompasses formulating guidelines to describe how the model is going to be operationalized. Guidelines were formulated in relation to data analysis and conceptualisation of context where family involvement was expected to take place. In this study, guidelines to operationalize a model to promote family involvement are as follows:

- Guidelines for mental health institution context
- Guidelines for family and cultural beliefs context
- Guidelines for agents
- Guidelines for recipients
- Guidelines for procedure
- Guidelines for outcome of family involvement

6.5.1 Guidelines for mental health institution context

- In-service training should be conducted in order to orientate the staff to determine the feasibility of a model.
- Nurses as the core business of mental health care should participate actively to identify areas that need immediate appropriate intervention.
- Nurses should demonstrate cultural competence, when providing mental health care in a manner that is culturally appropriate for MHCUs and their families.
- Nurses should display communication skills to both MHCUs and family members to the extent that problems are identified and appropriate intervention is planned.
- Nurses should listen reflectively and respond to both MHCUs and family members' non-verbal and verbal communication.
- Nurses should ensure that their role is performed to the extent that the mental health of the society as a whole is improved.
- Nurse-patient and nurses-family relationships should be maintained to the extent that MHCUs-family relationship is established to build trust.
- Nurse should be able to empower and foster hope that will encourage both MHCUs and families to develop self-esteem.
- Nurse should understand the Mental Health Act to the extent that they can explain to both the family and MHCUs the significance of this Act.
- Nurses should be committed to ensure that the MHCA and policies are implemented to improve the mental health care and experience of family involvement.

6.5.2 Guidelines for the family and cultural beliefs context

- Mental health awareness should be conducted in order to orientate the family members about the developed model.
- Family therapy should be conducted to strengthen the role of family in mental health care.

- Family members should be able to clarify their expectations towards MHCUs and significance of long-term mental health.
- Family members should be able to express their cultural beliefs related to mental illness.
- Health professional should be able to enhance values clarification regarding cultural beliefs.
- Family members participate actively to the extent that they make decisions in a mental health treatment plan.
- Family members should trust the health professional to the extent that they are able to communicate openly and express their feelings and concerns about being involved in mental health services.
- Family members should ensure that their relationship with MHCUs is based on empathy, respect and dignity.

6.5.3 Guidelines for the agents

- **Health professionals**
 - Health professionals as agents because they are with the MHCUs for 24 hours a day should ensure that information received from families and MHCUs is recorded to plan appropriate intervention.
 - Health professionals should be holistic, collaborative and MHCUs-focused for the family involvement to be fruitful.
 - Health professionals should ensure that mental health care delivered helps the MHCUs to improve the mental health of the society.
 - Health professionals should facilitate the relationship between the MHCUs and family members in order to achieve the goal of family involvement.
 - Health professionals should ensure that there is sufficient mutual relationship between both MHCUs and family members to promote the continuous participation in family involvement.
 - Health professionals should inform the family about the Mental Health Act and policies immediately the MHCUs are admitted in the hospital.

- Health professionals should have the personal strength and vision to innovate and to embrace new ways to promote sufficiency and effectiveness of family involvement.

6.5.4 Guidelines for the recipients

- **MHCUs**

- MHCUs as recipients should demonstrate a positive attitude towards both staff and family members.
- MHCUs should be clear on the significance and their expectations regarding family involvement.
- MHCUs should be clear on the role of family members in mental health care services.
- MHCUs should participate actively by expressing their feelings regarding family involvement so that appropriate interventions could be planned.
- MHCUs should be clear on the strengths and weaknesses of treatment compliance.

- **Family members**

- Family members as the first individuals to identify mental illness at home and seek help should ensure that they provide collateral information about the MHCUs for base line data.
- Family members should be continuously involved in mental health care, treatment and rehabilitation plan of their loved ones.
- Family members should be willing to learn from health professionals to improve their knowledge and understanding towards mental illness.
- Family members should be responsible to ensure that MHCUs continue with treatment when discharged or granted LOA.

6.5.5 Guidelines for procedure

Guidelines to implement the developed model encompasses describing the process to be followed to initiate family involvement. The process to implement the model is can be achieved by implementing Batho Pele principles, considering human rights and MHCUs rights within the MHCA that incorporates three phases as follows:

➤ **Phase one: conducting situational analysis**

This is the initial stage in which situational analysis is conducted in order to determine the feasibility of a model by making appointments with both family members and nurses to clarify their expectations towards MHCUs and significance of the model.

- **Care**

Nurses should ensure that mental health care delivered helps the MHCUs to improve the mental health of the society.

- **Mutual relationship**

Nurses should ensure that there is sufficient mutual relationship between both MHCUs and family members.

- **Therapeutic empowerment**

Nurses should be holistic, collaborative and MHCUs-focused for the family involvement to be fruitful.

- **Compassion**

Nurses should ensure relationship between the MHCUs and family members is based on empathy, respect and dignity.

➤ **Phase two: developing collaborative strategy**

This is the second phase in the developed collaborative strategy by which activities are identified and selecting the key stakeholders (family members and nurses) to initiate the process of family involvement.

- **Mutual participation**

Nurses should display interest in participation and being active to the extent that all individuals involved should have interest in family involvement and participate actively.

- **Competence**

Nurses should demonstrate cultural competence, when providing mental health care in a manner that is culturally appropriate for MHCUs and their families.

- **Communication**

Nurses should communicate with both MHCUs and family members to the extent that problems are identified and appropriate intervention is planned. Nurses should listen reflectively and respond to both MHCUs and family members' non-verbal and verbal communication.

➤ **Phase three: implementation of collaborative strategy**

In this phase, stakeholders carry out identified activities though adopting the management principles of planning, organising, leading and control.

- **MHCA**

Nurses should understand the Mental Health Act to the extent that they can explain to both the family and MHCUs the significance of this Act. Nurses should inform the family about the Mental Health Act when the MHCUs are admitted in the hospital.

- **Mental health policies**

Admission policy

Admission policy should address activities whereby the families should be notified immediately the mentally ill patient is declared to receive mental health care, treatment and rehabilitation.

Family involvement policy

Family involvement policy should be developed to improve the quality of mental health care, treatment and rehabilitation. Nurses should ensure that there are family therapy guidelines that form part of the admission policy to address how families should be involved effectively.

Discharge policy

Discharge policy should include activities which the families should be notified of before the MHCU is discharged.

- **Courage**

Nurses should have the personal strength and vision to innovate and to embrace new ways to promote sufficiency and effectiveness of family involvement.

- **Commitment**

Nurses should be committed to ensure that the MHCA and policies are implemented to improve the mental health care and experience of family involvement. Nurses should take actions to make vision and strategy a reality for all and meet the health, care and support challenges ahead.

6.5.6 Guidelines for the outcome of family involvement

Guidelines in terms of the outcome of the model describes how efficient and sufficient family involvement will be achieved after the implementation of the model. Participants should identify and develop strategies to engage each other so that the family involvement may be fruitful. The following are evidence to ensure that family involvement is achieved:

- Participants should share their responsibilities towards promoting family involvement in mental health services.
- Families should be engaged in mental health by often visiting their loved ones.
- Families should show their willingness to participate actively by interacting with both health professionals and MHCUs with confidence.
- Nurses should demonstrate their role by facilitating mutual relationship between families and MHCUs.
- MHCUs should demonstrate their willingness to be supervised and comply with treatment at home when discharged or granted LOA.

6.6 CONCLUSION

This chapter outlined model development of which activities were categorised using the six areas as described by Dickoff et al. (1968). The model and its structures were described according to Chinn and Kramers' guidelines (1999). Family involvement was viewed as a standard operating procedure to improve the quality of mental health care services. The next chapter will discuss the validation of the model.

CHAPTER 7

MODEL VALIDATION, JUSTIFICATION OF THE ORIGINAL CONTRIBUTION TO THE BODY OF KNOWLEDGE

7.1 INTRODUCTION

The previous chapter outlined model development using the six areas as described by Dickoff et al. (1968); the description of the model and its structures as well as how the model is going to be operationalized. Chapter 7 discusses validation and justification of the model. This chapter discusses the model evaluation in order to achieve objectives of the study as outlined in chapter 1. Justification of the study was also discussed in order to outline how family involvement contributes to mental health care.

7.1.1 Objectives of this chapter

The objective of this chapter was:

- To validate the model against its rationale and purpose as outlined in chapter one.
- To outline the contribution of the family involvement in mental health care.

Validation refers to the act of evaluating appropriateness in accordance with what is known about the system of a model and sufficient results that can serve as a solid basis for decision making (Vemer, Ramos, Van Voorn & Feenstra, 2016). According to Chinn and Kramer (1999) once the model is described, the researcher should pose critical question to provide information on how the model might serve certain purposes. In addition, the researcher should have insight on how the model will be used and how it might be improved further. This was supported by Chinn and Kramer (2014 cited in Aluko, 2016) who argued that realistic knowledge can be legitimated through validation. However, theory-validating research has a very precise sense and would involve particular methods to be used. Approaches are designed to determine how perfectly the

theory represents practical phenomena and their relationships. In addition, theoretic statements can be interpreted into questions or/and hypotheses, hence no one study can investigate the completeness of a theory (Chinn & Kramer, 2014 cited in Aluko, 2016). In this study, the researcher adopted Chinn and Kramer (1999) to validate the model by posing the following questions:

How clear is the model?

How simple is the model?

How general is the model?

How accessible is the model?

How important is the model?

In addition, the researcher responded to questions by describing the critical reflection of the process that contributes to critical insight and gives direction for development of a model (Chinn & Kramer, 1999).

7.1.2 How clear is the model?

According to Chinn and Kramer (1999) clarity refers to how well the theory can be understood and how consistently ideas are conceptualised. However, authors refer semantic clarity and consistency to the understandability of theoretical meaning of the concepts. Structural clarity and consistency reflects the understandability collaboration of concepts within the whole model. In this study, the researcher considered semantic clarity, semantic consistency, structural clarity and structural consistency to determine how the model is (Chinn & Kramer, 1999).

Semantic clarity

The researcher defined concepts using terms that have common meaning within the health profession (Chinn & Kramer, 1999).

Sematic consistency

The researcher used concepts in a way that is consistent with the definition of concepts. Furthermore, the researcher used basic assumptions to clarify the meaning of other components of the model (Chinn & Kramer, 1999).

Structural clarity

The researcher described elements of structures in the model and their relationships to provide a clear understanding of how the structures integrate with each other (Chinn & Kramer, 1999).

Structural consistency

The researcher consistently used different structures in the model to guide discussion of issues. The structure also served as a conceptual map that enhances clarity of the model (Chinn & Kramer, 1999).

7.1.3 How simple is the model?

Chinn and Kramer (1999) define simplicity as the minimal number of elements within the descriptive category, particular concepts, as well as their relationship. In this study, major concepts such as mental health care, family members and MHCUs, together with their interrelationship, was used as a general guide to practice (Chinn & Kramer, 1999).

7.1.4 How general is the model?

According to Chinn and Kramer (1999) generality refers to the breadth of the scope of concepts and purpose within the model. This study addressed the importance of involvement of the patients' family in mental health care.

7.1.5 How accessible is the model?

According to Chinn and Kramer (1999) accessibility addresses the extent to which concepts within the theory can be identified and the way the expected outcome can be achieved. In this study, the definition of concepts was the clues to the accessibility of the model, and refers to the definition of concepts.

7.1.6 How important is the model?

According to Chinn and Kramer (1999) the importance of the model depends on the professional and personal values in nursing practice, education and research. This study addresses the extent to which family involvement contributes to the improvement on the provision of quality mental health care, treatment and rehabilitation.

7.2 METHODOLOGY FOR VALIDATION PROCESS

7.2.1 Sampling

A quantitative probability stratified random sampling was used to select respondents, 18 (21%) respondents were selected from 83 professional nurses for validation of the developed model. Professional nurses, advanced psychiatric nurses and operational managers who attended the MDT meeting were selected. Various authors found that selecting health professionals to validate the model in practice promoting health related goals, was referred to be practice-based evidence in health care literature (Motch, 2008; Satterfield, 2009; Willin, 2009, cited in Chinn & Kramer 2014).

7.2.2 Data collection

The newly developed model referred to as “*A model to promote family involvement in caring for MHCHs in long-term mental health institutions*” was presented to MDT members and validated based on its structures representation of simplicity, exactitude, suitability and applicability. The researcher developed a validation instrument in the form of a checklist (see annexure H). A model structure and its guidelines to implement the model were handed to the respondents to refer to while the researcher was presenting. The researcher clarified to the respondents where necessary and allowed the respondents to sign the consent form. Questionnaire comprises of two section, demographic data and data distribution (see table 7.1). The researcher advised the respondents to complete the questionnaire without discussing with each other. 18 questionnaires were completed and brought back immediately.

7.2.3 Results of model validation

7.2.3.1 Demographic data

Table 7.1 Section A: Demographic data for Participants in model validation

Participants' details	F	%
Professional Nurse	9	50
Advanced Psychiatric Nurse	3	16.6
Operational Manager	6	33.4
Total	18	100

7.2.4 Data distribution

Table 7.2 Section B: Data distribution

Section B: Data distribution					
1. Is the model clear?	Agree		Disagree		Comments
	F	%	F	%	
	18	100	-	-	
2. Does the model provide a clear understanding of how the model is going to be implemented?	18	100	-	-	Well presented
3. Does the model guide clear explanation/process on how family involvement should be promoted in mental health?	18	100	-	-	Well presented
4. Does the model present sufficient dynamics/underlying forces that affect the process of family involvement?	18	100	-	-	Well presented
5. Is there anything that you can add or remove?	-	-	18	100	Well presented
6. Is the process in the model consistent to the extent that it can be practically applied?	18	100	0	-	Well presented
7. Does the model clearly describe nurses' role in mental health care?	18	100	-	-	Well presented
8. Does the model display the need for in-service training?	10	55.6	8	44.4	Well presented In-service training Communication
9. Is the model simple to understand?	18	100	-	-	Well presented
10. Does the model addressed the importance of family involvement in mental health care?	18	100	-	-	Well presented
11. Is the model accessible?	18	100	-	-	Well presented
12. Do you think this model is important?	18	100	-	-	Well presented
13. Does the model address the extent to which family involvement contribute to the improvement on the provision of quality mental health care, treatment and rehabilitation?	18	100	-	-	Well presented

7.2.5 Responses of model validation

Table 7.1 shows responses of model validation. Of the 18 (100%) respondents in this study, 9 (50%) were professional nurses, 3 (16.6%) were advanced psychiatric nurses and 6 (33.4%) were operational managers agreed that the model is clear and commented that the model and guidelines were well presented. All 18 (100%) respondents agreed that the model was clear on the explanation/process on how family involvement should be promoted in mental health. All 18 (100%) respondents agreed that the model presented sufficient dynamics/underlying forces that affect the process of family involvement.

However, all 18 (100%) respondents disagreed to add or remove anything presented. In addition all 18 (100%) respondents agreed that the process in the model consistent to the extent that it can be practically applied. All 18 (100%) respondents agreed that the model clearly describe nurses' role in mental health care. Of the 18 respondents, 10 (55.6%) respondents agreed that the model displayed the need for in-service training and 8 (44.4%) disagreed. Hence they commented that the model and guidelines were well presented and there is a need for in-service training.

Moreover, 18 (100%) respondents agreed that the model was simple to understand. However, 18 (100%) respondents agreed that the model addressed the importance of family involvement in mental health care; 18 (100%) respondents agreed that the model is accessible. Furthermore, 18 (100%) respondents agreed that they think this model is important; 18 (100%) respondents agreed that the model addresses the extent to which family involvement contributes to the improvement on the provision of quality mental health care, treatment and rehabilitation.

Therefore it can be concluded that all professional nurses contracted on the model developed and guidelines proposed to implement the model. Probabilities are that professional nurses' response revealed that they reached consensus that a model to promote family involvement should be implemented in long-term mental health institutions. This was supported by Chinn and Kramer (2014) who said that nurses' perceptions have impact on sharing the new meaning and possibilities for managing a given situation with fellow professional nurses. Therefore, study assumptions are that this newly developed model may provide experience with possible movements that can be used to involve family members in mental health care in future (Chinn & Kramer (2014).

7.3 JUSTIFICATION OF THE ORIGINAL CONTRIBUTION OF THE STUDY TO THE BODY OF KNOWLEDGE

Probabilities are that this is an original study that contribute to the body of knowledge hence the provision of quality mental health care services will also improve. The following provides evidence that this study is an original contribution to the body of knowledge; however, the extent to which empirically participants/respondents' perceptions about family involvement in caring for MHCUs long-term mental health institutions were described and explored.

This study also described and explored factors contributing to insufficient family involvement in caring for MHCUs in long-term mental health institutions. Unstructured in-depth interview from 21 families and FGDs were analysed using Tech's steps by Creswell (2009) whereas perceptions of nurses regarding the family involvement in caring for MHCUs in long-term mental health institutions were analysed using SPSS version 22.

Data analysis began concurrently and analysed independently following procedures of both qualitative and quantitative approach in order to merge the results. However, the researcher uses convergent analytic approach to merge the two data sets. This study found that the qualitative findings are related to quantitative findings to the extent that both answered the research questions.

In addition, MHCUs' behaviour and attitude towards families contribute to family members not visiting MHCUs while admitted in long-term mental health care. MHCUs feel rejected hence nurses perceive that insufficient family involvement hinders the provision of mental health care services. Furthermore, the discussion and interpretations of the findings were guided by Thornton's Model of WPC framework derived from theorists in the fields of nursing, physics, and systems analysis (Thornton, 2013).

The concept "*family involvement in caring for MHCUs*" was analysed using eight steps in the Walker and Avant (2013) method to clarify and distinguish the definition of the main concepts. Results drawn from analysis of concept revealed that "*family involvement in caring for MHCUs*" is an engagement and encourages family members to participate in the diagnosis, treatment and recovery process of their member with mental illness, with due regard for the rights of the person living with mental illness and for their confidentiality and privacy (Tambuyzer et al., 2014).

In addition, family involvement model is believed to enhance interaction between the MHCUs and their families; frequent visit by family members; MHCUs going home back to the hospital when discharged or granted LOA; MHCUs not absconding from their home when discharged or granted LOA;

treatment compliance, recovery of mental illness; and MHCUs being accepted by community members. This study's results were presented in MDT meetings, at the research conference and refined. However, the model was developed and described, directed by the results from concept analysis. The theoretical definition of "*family involvement in caring for MHCUs*" is unique and pivotal in the MHI and family context. The researcher adopted Dockoff et al. (1968) methods to develop a model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

Various authors also applied Dockoff et al. (1968) methods to develop their recent models such as Empirical development of a middle range theory of caring by Swanson (2012); A model for incorporation of the traditional healers into the national health care delivery system of South Africa by Pinkoane, Greeff and Koen, (2012); Woman-centred care in childbirth: A concept analysis (Part 1) by Maputle and Donavon (2013); and Authentic qualitative research and the quest for methodology rigour by Carnevale (2016). In addition, a model to promote family involvement was done in response to 6Cs of the NHS to improve the quality of the provision of the mental health care services.

7.4 CONCLUSION

This chapter discusses validation of the model by responding questions to describe critical reflection of the process for development of a model. Justification of the original contribution of the study to the body of knowledge was discussed. Chapter eight will focus on conclusion, limitations and recommendations of the study.

CHAPTER 8

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

The previous chapter discusses model validation against its rationale, purpose and objectives as outlined in chapter one and justification of the original contribution of the study to the body of knowledge towards family involvement in caring for MNCUs in long-term mental health institutions. This chapter focuses on conclusion, limitations and recommendations of the study.

8.2 CONCLUSION

The overarching purpose of the study existed to determine the factors contributing to insufficient effort in caring for MHCUs, perceptions of family members regarding the views of MHCUs on the involvement of family members as well as the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions. The empirical data congregated led to development of a model to promote family involvement in caring for MHCUs in long-term mental health institutions. Thornton's Model of Whole-Person Caring adapted to understand the interrelatedness of the mental, emotional, spiritual, physical and relational aspects of MHCUs that seek family involvement in caring for those in long-term mental health institutions. This process was attained through the following:

- Exploration and description of the perceptions of family members regarding their involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

- Determining factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- Exploration and description of the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province.
- Exploration and description of the perception of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- Concept analysis and developing a model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- Validation of the developed model and guidelines formulated for implementing “A model to promote family involvement in caring for MHCUs in long-term mental health institutions” that will be used to improve the quality of mental health services. Validation was conducted with subject professional nurses, advanced psychiatric nurses and operational managers to ensure that guidelines for implementation are suitable and relevant to the nursing practice status quo.

Objectives one to four were attained by utilisation of mixed method as one data source may be insufficient. Unstructured in-depth interviews were conducted with 21 family members of MHCUs and six FGDs methods were used to collect data from MHCUs admitted in long term mental health institutions in qualitative approach. Quantitative descriptive strategy was used in this study to collect data from 360 nurses working at Evuxakeni, Hayani and Thabamopo mental health hospitals. Data collection began concurrently, analysed independently and merged. Triangulation mixed method design was used to compare quantitative results with qualitative findings to cultivate a more complete understanding of phenomena and compare multiple levels within the system. This study found that the

qualitative findings are related to quantitative findings to the extent that both answered the research questions. A model was developed by utilisation of evidence obtained from data analysis in order to conduct concept analysis and develop “A model to promote family involvement in caring for MHCUs in long-term mental health institutions” and to formulate guidelines to operationalize the model.

8.2.1 Summary of chapters in this thesis

Table 8.1 Summary of chapters in this thesis

Chapter	Description
1	<p>An orientation to the study.</p> <p>It is an introductory chapter. It discusses the background, rationale, significance of the study, problem statement, purpose of the study, research questions, objectives, conceptual framework, definition of concepts, the outline of the dissertation, a brief description of research design, trustworthiness as well as ethical consideration.</p>
2	<p>Literature Review</p> <p>This chapter discusses the literature review related to the topic of family involvement in caring for MHCUs in long-term mental health institutions of Limpopo Province, South Africa. The literature review has been discussed under the following headings:</p> <ul style="list-style-type: none"> • History of mental illness • Factors contributing to insufficient family involvement in mental health care • Nurses’ role in mental health care • Promoting involvement of the family members in long-term mental health care • Perceptions of family members regarding mentally-ill patients • Views of MHCUs regarding the involvement of their family members in mental healthcare

3	<p>Research Methodology</p> <p>An overview of the methodology used in phase one and three are presented. This chapter designates the research design, population, sampling, data collection and data analysis of this study. Ethical considerations and measures to provide trustworthiness are also deliberated.</p>					
4	<p>Data Analysis, Interpretation and Discussion</p> <p>The findings of the study were analysed, interpreted and controlled through the literature.</p> <table border="1" data-bbox="393 682 1424 1459"> <tr> <td data-bbox="393 682 880 892"> <p>Themes reflecting the views of MHCUs regarding the involvement of their family members in mental health care, treatment and rehabilitation</p> </td> <td data-bbox="886 682 1424 892"> <p>Themes reflecting the perceptions of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation</p> </td> </tr> <tr> <td data-bbox="393 900 880 1459"> <ol style="list-style-type: none"> 1. Experiences of MHCUs related to the attitude of family members towards the provision of care to them 2. Observation made by MHCUs towards family members and hospital management 3. Knowledge of family members related to care of MHCUs 4. Challenges resulting from lack of support by family members </td> <td data-bbox="886 900 1424 1459"> <ol style="list-style-type: none"> 1. MHCUs families' views and experiences related to involvement in the care of a family member 2. Practices related to carrying for MHCUs at home by family members 3. Practices related to carrying for MHCUs at home by family members 4. Existing challenges in carrying for MHCUs by family members </td> </tr> </table> <p>Responses of nurses to describe their perceptions regarding the family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province revealed that there is poor interaction between family members and the MHCUs. In addition, MHCUs returned to the hospital before expected date when granted LOA. Data analysis conducted independently following procedures of both qualitative and quantitative approach in order to merge the results. Convergent analytic approach was used to merge the two data sets. This study found that the</p>		<p>Themes reflecting the views of MHCUs regarding the involvement of their family members in mental health care, treatment and rehabilitation</p>	<p>Themes reflecting the perceptions of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation</p>	<ol style="list-style-type: none"> 1. Experiences of MHCUs related to the attitude of family members towards the provision of care to them 2. Observation made by MHCUs towards family members and hospital management 3. Knowledge of family members related to care of MHCUs 4. Challenges resulting from lack of support by family members 	<ol style="list-style-type: none"> 1. MHCUs families' views and experiences related to involvement in the care of a family member 2. Practices related to carrying for MHCUs at home by family members 3. Practices related to carrying for MHCUs at home by family members 4. Existing challenges in carrying for MHCUs by family members
<p>Themes reflecting the views of MHCUs regarding the involvement of their family members in mental health care, treatment and rehabilitation</p>	<p>Themes reflecting the perceptions of MHCUs families regarding their involvement in mental health care, treatment and rehabilitation</p>					
<ol style="list-style-type: none"> 1. Experiences of MHCUs related to the attitude of family members towards the provision of care to them 2. Observation made by MHCUs towards family members and hospital management 3. Knowledge of family members related to care of MHCUs 4. Challenges resulting from lack of support by family members 	<ol style="list-style-type: none"> 1. MHCUs families' views and experiences related to involvement in the care of a family member 2. Practices related to carrying for MHCUs at home by family members 3. Practices related to carrying for MHCUs at home by family members 4. Existing challenges in carrying for MHCUs by family members 					

	<p>qualitative findings are related to quantitative findings to the extent that both answered the research questions.</p>
5	<p>Concept analysis</p> <p>This chapter discussed the concept analysis phase three utilised in this study. Concept analysis conducted adapting the eight steps in the Walker and Avant Method to clarify and distinguish the definition of the main concepts. The definition of the main concepts are as follows:</p> <ul style="list-style-type: none"> • selecting a concept • determining the purpose of analysis • identifying all the uses of the concept • determining the defining attributes • contrasting the model case • contrasting additional cases, borderline, related, contrary, invented and illegitimate cases • identifying antecedents and consequences • defining empirical references
6	<p>Model development</p> <p>This chapter discussed the model development and model validation phase three utilised of this study. This chapter also focuses on the justification and contribution to the body of knowledge. A model to promote family involvement was conceptualised using the six areas as described by Dickoff et al (1968) as follows:</p> <ul style="list-style-type: none"> • Agent: nurses and family members • Recipient: MHCUs • Context: mental health care institution and family • Dynamics: cultural beliefs, MHCA and Batho Pele principles • Procedure: <u>Phase 1:</u> Conducting situational analysis <u>Phase 2:</u> Developing collaborative strategies

	<p style="text-align: center;"><u>Phase 3: Implementing collaborative strategies</u></p> <ul style="list-style-type: none"> • Terminus: Families often visiting MHCUs <p style="padding-left: 40px;">Sufficient interaction between MHCUs and families</p> <p style="padding-left: 40px;">MHCUs accepted at home</p> <p style="padding-left: 40px;">Successful LOA</p> <p style="padding-left: 40px;">Treatment supervision when granted LOA or discharged</p>
7	<p>Model validation, justification of the original contribution to the body of knowledge. Model validation was conducted adopting Chinn and Kramer (1999) by posing the following questions:</p> <ul style="list-style-type: none"> • How clear is the model? • How simple is the model? • How general is the model? • How accessible is the model? • How important is the model? <p>Justification of the original contribution of the study to the body of knowledge was discussed. It could be possible that this is an original study that contributes to the body of knowledge hence the provision of quality mental health care services will also improve.</p>
8	<p>Conclusion. Limitations and Recommendations</p> <p>This chapter provides the conclusion, including strengths and limitations of the research findings. There are also recommendations with reference to the presented research, guidelines to operationalize the model and future research.</p>

8.3 LIMITATIONS

Approval from Thabamooopo and Hayani hospitals was delayed, and slowed down the progress of the study. Empirical data was limited at Thabamooopo hospital as the researcher was not granted permission to conduct FDGs from MHCUs. However, nursing personnel were interested in the research topic. The extensive distance between Mopani, Vhembe and Capricorn Districts during data collection also slowed down the progress of the study. During model validation, the model was presented to MDT members based on its structures representation of simplicity, exactitude, suitability and applicability. All MDT members were interested to validate the model. The researcher considered the target population which were nursing staff only.

8.4 RECOMMENDATIONS

Recommendations were formulated based on the findings and conclusion to ensure that a model to promote family involvement in caring for MHCUs is operationalized to improve provision of quality mental health care, treatment and rehabilitation. Recommendations were made related to nursing practice, mental health policies and further research.

8.4.1 Nursing practice

The researcher made recommendations based on themes and items for quantitative data related to nursing practice as illustrated in table 8.2.

Table 8.2. Recommendations related to nursing Practice

Qualitative data	Quantitative data	Recommendations
<p>Themes from MHCUs</p> <ol style="list-style-type: none"> Experiences of MHCUs related to the attitude of family members towards the provision of care to them Observation made by MHCUs towards family members and hospital management Knowledge of family members related to care of MHCUs Challenges resulting from lack of support by family members 	<p>Perceptions of nurses</p> <ul style="list-style-type: none"> -Poor interaction between MHCUS and families -MHCUs came back before expected date when granted LOA -MHCUs abscond from home back to the hospital when granted LOA -MHCUS not accepted at home when granted LOA or discharged -MHCUs came back before expected date when granted LOA -More cases referred to social workers -MHCUS not visited by family members -MHCUs not having Identity Documents -MHCUs buried as paupers when died and family tracing failed 	<ul style="list-style-type: none"> -MHCUs should be admitted in their local districts so that their families could be involved and able to visit their loved ones without traveling a long distance. -Maximum security wards should be built in all institutions providing mental health services to improve the quality of services and prevent MHCUs from admitted fare from their local hospitals -Developed model should be implemented in a health establishment providing mental health services. -Developed model should be included in continuous professional development programme to increase the knowledge and understanding of the importance of family involvement.
<p>Themes from family members</p> <ol style="list-style-type: none"> MHCUs families' views and experiences related to involvement in the care of a family member Practices related to carrying for MHCUs at home by family members Practices related to caring for MHCUs at home by family members Existing challenges in carrying for MHCUs by family members 	<ul style="list-style-type: none"> -More cases referred to social workers -MHCUS not visited by family members -MHCUs not having identity Documents -MHCUs buried as paupers when died and family tracing failed -MHCUS not accepted at home when granted LOA or discharged -MHCUs came back before expected date when granted LOA -MHCUs abscond from home back to the hospital during LOA -MHCUs came back before expected date when granted LOA 	<ul style="list-style-type: none"> -Discharge policy should be reviewed to include activities which the families should be notified of before the MHCU is discharged. -Admission policy should be reviewed to include activities of which the families should be notified immediately the mentally ill patient is declared to receive mental health care, treatment and rehabilitation.

8.4.2 Mental health policies

8.4.2.1 Admission policy

Admission policy should be reviewed to include activities of which the families should be notified immediately the mentally ill patient is declared to receive mental health care, treatment and rehabilitation. Activities should include:

- Family therapy to be conducted within seven days
- Family to visit the MHCU for interaction at least once per month
- Check-list for family visit to identify the frequency
- MHCU to be granted LOA when necessary
- Home visit to be conducted while the MHCU is on LOA
- Home visit to be conducted when family does not comply to determine issues that need immediate intervention

8.4.2.2 Family involvement policy

Family involvement policy should be developed to improve the quality of mental health care, treatment and rehabilitation. Cultural beliefs and values should be considered to minimise barriers when developing the policy. Policy makers should ensure that MDT members, hospital board and traditional leaders are involved to exercise values-clarification when developing the policy. In addition, family therapy guidelines should form part of the policy to address how families should be involved effectively

8.4.2.3 Discharge policy

Discharge policy should be reviewed to include activities which the families should be notified of before the MHCU is discharged. Activities should include:

- Family therapy to be conducted before the MHCU is discharged to prepare the family.
- Home visit to be conducted before the MHCU is discharged to determine family's readiness and issues that need immediate intervention.
- MHCU to be reviewed at outpatient department for six months.
- MHCU to be transferred to local clinic to continue with mental health care, treatment and rehabilitation,
- Follow-up to be done with the local clinic to promote treatment compliance.

8.4.3 Research

The following recommendations were made in relation to future research.

- Developed model should be piloted and evaluated to identify areas that will further improve the quality of mental health services.
- Experiences of participants towards implementation of the developed model should be assessed.
- Guidelines to implement developed model should be evaluated to determine the effectiveness of the model.

8.5 SUMMARY

This chapter discussed the conclusion, limitations and recommendations of the study. Conclusion of this study addresses how the purpose and objectives were reached. The summary of the chapters within this thesis was highlighted. This chapter also outlined the limitations and the recommendations based on the research results.

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ANEXURE A: QUESTIONNAIRE

NOTE TO PARTICIPANTS: Please answer the following questions based on your understanding of the statement. Make a cross (x) next to an option/statement that reflects your choice. Every answer is correct

Section A: Demographic data

Participants' details		F	%		F	%		F	%		F	%		F	%		F	%	
Years of service	<2			2-5			15-10			10-30			>30						
Rank	Enrolled Nursing Assistance			Enrolled Nurse			Registered nurse			Professional Nurse			Operational Managers				Nursing Service Managers		
Qualifications	Certificate			Diploma			Degree			Masters			Doctorate						
Age	20-25			25-35			35-45			45-55			>55						
Marital status	Single			Married			Divorced			Widowed									
Gender	Male						Female												

Section B: Data Descriptions

Questions				Agree		Disagree		Minor		Major		
1. Do you have challenges regarding involvement of the family members in mental health care?				F	%	F	%	F	%	F	%	
2. Are you concerned about the involvement of the family members												
3. How would you rate this concern												
4. Do this concern affects your provision of mental health care services												
5. Did you ever refer the case to the relevant health care provider												
6. What was the feed back		F	%		F	%		F	%		F	%
Family members' contact available, ready to be involved				Family members' contact available, not ready to be involved			Family members' contact not available			Family members' contact available, MHCU refuses to involve his family members		
7. MHCUs in your unit have family contact				All of them				Some of them				
8. MHCUs visited				Less than five MHCUs visited			Less than ten MHCUs visited			All MHCUs visited		
Only one MHCUs visited												
9. How can you rate family members' visit		F	%			F	%			F	%	
Often				Seldom				Never				
Good				Fair				Poor				
11. MHCUs' family members accessible where necessary				Agree		Disagree		Some of them				
12. How do you access the family members				Home visit				Telephonically				
13. How can you rate the family members' attitude during home visit		F	%			F	%			F	%	
Positive				Negative				Neutral				
14. MHCUs in your unit have birth certificates		All of them		Some of them		None						

15. MHCUs in your unit have Identity Documents	All of them			Some of them			None		
16. Your intervention regarding MHCUs Identity Document or birth certificate									
Case referred to social worker until MHCUs got Identity Document			Family members were involved and applied MHCUs Identity Document				You have accompanied the MHCUs to apply Identity Document		
17. MHCUs without Identity Document	Easily identified						Not easily identified		
18. How do you identify MHCUs without Identity Documents	MHCU have same date of birth						MHCU have no date of birth in their documents		
19. MHCUs without Identity Documents	Have same date of birth						Have no date of birth		
20. In case of medical illness and procedures, family members are involved									
21. Family members are involved in decision making									
22. In case death, family members who rejected the MHCU are notified. Case referred to social worker for family tracing							MHCUs is buried as a pauper without tracing family members		
23. How long tracing family members referred to be failed six month	F	%	One year	F	%		None	F	%
24. MHCU is being buried MHCUs in your unit are being buried as a pauper									
25. In case MHCU is buried as a pauper, did you ever visited by the family members whom their									
26. How would you rate this concern									
27. MHCUs when granted leave of absence (LOA) came back on expected date							Some of them		
28. MHCUs when granted LOA came back before expected date	None						Some of them		
29. MHCUs exceed LOA when granted							Some of them		
30. MHCUs when granted LOA abscond from home to the hospital	None						Some of them		
31. MHCUs are accepted at home when granted LOA or discharged									
32. How would you rate this concern									
33. MHCUs are happy when visited by their family members									
34. Other MHCUs are happy when fellow MHCUs visited by family members									

ANNEXURE B

QUESTION TO THE FAMILY MEMBERS

Explain briefly your perceptions regarding being involved in caring for a MHCU who has been admitted to a mental healthcare hospital.

QUESTION TO THE MHCUs

Discuss briefly your views regarding the involvement of your family members in your mental health care, treatment and rehabilitation.

ANNEXURE C: INFORMED CONSENT/PARTICIPANT'S AND INVESTIGATOR'S STATEMENT FORM

Dear Participant

My name is Nkhensani Florence Mabunda. I am a professional nurse and a researcher conducting a research project on the topic – A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province. I need your participation and feedback, as the aim is to develop a model to promote the involvement of the family members in long-term mental healthcare institutions in Limpopo Province, South Africa.

The objectives of the study are:

- To determine factors contributing to insufficient effort in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- To explore and describe the perceptions of family members regarding their involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.
- To explore and describe the views of MHCUs regarding the involvement of family members while admitted in long-term mental health institutions in Limpopo Province.
- To explore and describe the perceptions of nurses regarding family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.

You are requested to complete a questionnaire which will take 25 minutes of your time. Your anonymity is guaranteed, as neither your name nor the name of the nursing unit is required. All questionnaires and raw data will be destroyed after the compilation of the final report. Your participation is voluntary and you will receive no remuneration. However, your participation will be valuable for future MHCUs.

Data collected from this project will be disseminated through a research report and research articles in accredited nursing journals.

Yours truly

Mabunda N.F.

I _____ agree to participate in the research project on “A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province” and understand the conditions and the type of participation needed for this research project.

Participant’s Signature: Date:

ANNEXURE D: INFORMATION SHEET

Introduction and background

Good Day

My name is Nkhensani Florence Mabunda. I am a student at the University of Venda, conducting the study “A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province,” as partial fulfilment of the requirements of my Doctor of Philosophy degree in nursing. The main aim of this study is to develop a model to promote the involvement of the family members in long-term mental healthcare institutions in Limpopo Province, South Africa. I am inviting you to participate in the study. The interview will last for about 25 minutes. If you agree to take part, I will ask you a question in relation to involvement of the family members in caring for MHCUs in long-term mental health institutions in Limpopo Province. My role as a researcher is to listen and take notes on your point of view, and not to judge you. Feel free to answer any question, even to express your discomfort; you will not be penalised.

Confidentiality

The information that you provide will be used when transcribing the interviews and kept confidential. Your names will not be written down. All information you have provided will be used only for the purpose of the study and treated as private and confidential. The information provided will be combined and analysed according to common themes and categories and disseminated in the form of a report.

Consent

Ethical clearance had been obtained from the School of Health Sciences Higher Degree Committee, University of Venda Higher Degree Committee, and University of Venda Ethics Committee. Permission to conduct the study was requested from the Limpopo Provincial Department of Health, as well as the

Mental Health Hospital management. You are requested to sign an informed consent form that indicates your consent to participate in the study and to be recorded in the interview. If you are willing to consent, the researcher appreciate your participation and the information you will provide as a valuable source.

Benefits and risks of participation

Please note that participation is voluntary and there will be no direct benefits to anyone who participates. You are allowed to terminate/withdraw from participation in the study or if you feel that you do not want to answer some of the questions if they are violating your rights. Therefore, I really appreciate your participation.

Recording the interview

I would like to ask permission to audio record the interview because as it is not possible to write all information quickly. I might miss some of the valuable information you provided. It is necessary to understand that the digital voice data and notes will remain confidential and your name will not be disclosed. Recordings and digital data of the interview will not be listened to by any individual except the researcher and the co-coder for research purposes. The information provided will be analysed and organised and presented in the form of a report. The recordings and digital data files will be kept in a locked safe and destroyed two years after the publication of the research findings in accordance with the national requirements of voice recordings.

Contact details

I will be available to answer any questions or to offer clarity any time during this study. If you have any questions please contact the researcher.

Mabunda N.F.

Cell: 0730862036

ANNEXURE E: MODEL VALIDATION INSTRUMENT

NOTE TO PARTICIPANTS:

Please answer all questions based on your understanding of the statement.

Make a cross (x) next to an option/statement that reflects your choice and comment where possible.

Do not discuss your answer with anybody

Section A: Demographic data

Participants' details	Professional Nurse	Advanced Psychiatric Nurses	Operational Managers
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Data distribution			
	Agree	Disagree	Comments
1. Is the model clear?			
2. Does the model provide a clear understanding of how the model is going to be implemented?			
3. Does the model guide clear explanation/process on how family involvement should be promoted in mental health?			

4. Does the model present sufficient dynamics/underlying forces that affect the process of family involvement?			
5. Is there anything that you can add or remove?			
6. Is the process in the model consistent to the extent that it can be practically applied?			
7. Does the model clearly describe nurses' role in mental health care?			
8. Does the model display the need for in-service training?			
9. Is the model simple to understand?			
10. Does the model address the importance of family involvement in mental health care?			
11. Is the model accessible?			
12. Do you think this model is important?			
13. Does the model address the extent to which family involvement contributes to the improvement on the provision of quality mental health care, treatment and rehabilitation?			

**ANNEXURE F: ETHICAL CLEARANCE FROM UNIVERSITY OF VENDA
RESEARCH ETHICS COMMITTEE**

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Ms NF Mabunda

Student No:

11563647

PROJECT TITLE: **A model to promote family involvement in caring for mental health care users in the long-term mental health institutions of Limpopo Province.**

PROJECT NO: SHS/16/PDC/35/1611

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof ML Netshikweta	University of Venda	Promoter
Prof RT Lebeso	University of Venda	Co- Promoter
Dr LH Nemathaga	University of Venda	Co- Promoter
Ms NF Mabunda	University of Venda	Investigator - Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: November 2016

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

Name of the Chairperson of the Committee: Prof. G.E. Ekosse



University of Venda

PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060

"A quality driven financially sustainable, rural-based Comprehensive University"

**ANNEXURE G1: APPLICATION LETTER REQUESTING PERMISSION TO
CONDUCT RESEARCH TO LIMPOPO PROVINCE
DEPARTMENT OF HEALTH TO CONDUCT RESEARCH**

PO Box 6389

Giyani

0826

17/03/2015

The Director General

Department of Health and Social Development

Polokwane

0700

Ref: Application for Permission to Conduct Research

Dear Sir/Madam

I, the researcher, am currently pursuing a Doctor of Philosophy (PhD) degree at the University of Venda. I am hereby applying for permission to conduct a study at the mental health institutions of Limpopo Province. The title of the study is "A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province." Participants will be family members for mentally ill patients, MHCUs and nurses working at Evuxaken, Hayani and Thabomooopo Mental Health Hospitals of the Limpopo Province.

I look forward to your positive response in this regard.

Yours faithfully,

Miss N.F. Mabunda. Contact number: 0730862036

ANNEXURE G2: APPROVAL LETTER FROM LIMPOPO PROVINCE DEPARTMENT OF HEALTH TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650)

Ref:4/2/2

Mabunda NF
University of Venda
Private Bag X5050
Thohoyandou
0950

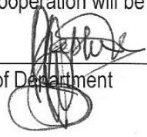
Greetings,

RE: A model to promote family involvement in caring for mental healthcare users in Long-Term mental health institutions of 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.
 - 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


Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa – *development is about people*

**ANNEXURE H1: APPLICATION LETTER REQUESTING PERMISSION TO
CONDUCT RESEARCH TO MOPANI, VHEMBE AND
CAPRICORN DISTRICTS TO CONDUCT RESEARCH**

PO Box 6389

Giyani

0826

17/03/2015

The DISTRICT EXECUTIVE MANAGER

Ref: Application for Permission to Conduct Research

Dear Sir/Madam

I, the researcher, am currently pursuing a Doctor of Philosophy (PhD) degree at the University of Venda. I am hereby applying for permission to conduct a study at the mental health institutions of Limpopo Province.

The title of the study is “A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.” Participants will be family members for mentally-ill patients, MHCUs and nurses working at Evuxaken, Hayani and Thabomoopo Mental Health Hospitals of the Limpopo Province.

I look forward to your positive response in this regard.

Yours faithfully,

Miss N.F. Mabunda. Contact number: 0730862036

ANNEXURE H2: APPROVAL LETTER FROM MOPANI DISTRICT TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA


DEPARTMENT OF HEALTH
MOPANI DISTRICT

Ref: S4/2/2
Enq: Mohatli IE
Tel: 015 811 6543

To **Ms Mabunda N.F**
UNIVERSITY OF VENDA
PRIVATE BAG x5050
THOHOYANDOU
0950

Re: PERMISSION TO CONDUCT RESEARCH IN MOPANI HEALTH FACILITIES: YOURSELF

1. The matter cited above bears reference
2. This serves to respond to the request submitted to research on the topic: "A model to promote family involvement in caring for mental healthcare users in long term mental health institutions of Limpopo Province, South Africa".
3. It is with pleasure to inform you about the decision to permit you to conduct research in the 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.


District Executive Manager
Date: 22/03/2017

ANNEXURE H3: APPROVAL LETTER FROM VHEMBE DISTRICT TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

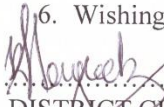
DEPARTMENT OF HEALTH VHEMBE DISTRICT

Ref: S5/6
Enq: Muvuri MME
Date: 06.July 2017

Dear Sir/ Madam ; MABUNDA N.F

PERMISSION TO CONDUCT RESEARCH “ A MODEL TO PROMOTE FAMILY INVOLVEMENT IN CARING FOR MHCUs IN LONG TERM MENTAL HEALTH INSTITUTIONS”

1. The above matter bears reference
2. Your letter received on the 06/07/2017 requesting for permission to conduct research in our facilities is hereby acknowledged
3. The District has no objection to your request.
4. Permission is therefore granted for the request to be conducted within Vhembe District.
5. You are however advised to make the necessary arrangements with the facilities concerned.
6. Wishing you success in your research in Vhembe health facilities .


.....
DISTRICT CHIEF DIRECTOR

07/07/2017
.....
DATE

Private Bag X5009 THOHOVANDOU 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

The heartland of Southern Africa – development is about people

ANNEXURE H4: APPROVAL LETTER FROM CAPRICORN DISTRICT TO CONDUCT RESEARCH



LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH – CAPRICORN DISTRICT

ENQ: Masenya Selaelo

DATE: 17 July 2017

TEL NO: 015 290 9268

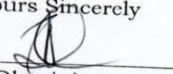
To: Mabunda N.F
University of Venda
Private Bag X5050
Thohoyandou
0950

SUBJECT: APPROVAL TO CONDUCT RESEARCH: YOURSELF.

Please be informed that the approval is granted for you to visit Thabamoopo Hospital and conduct your research.

Please ensure that you give them the outcome of this research.

Yours Sincerely


T Dlamini
ACTING DEM

18/07/17
DATE

**ANNEXURE I1: APPLICATION LETTER REQUESTING PERMISSION TO
EVUXAKEN, HAYANI AND THABAMOOPO HOSPITALS
TO CONDUCT RESEARCH**

PO Box 6389

Giyani

0826

17/03/2015

The CEO

Ref: Application for Permission to Conduct Research

Dear Sir/Madam

I, the researcher, am currently pursuing a Doctor of Philosophy (PhD) degree at the University of Venda. I am hereby applying for permission to conduct a study at the mental health institutions of Limpopo Province.

The title of the study is “A model to promote family involvement in caring for MHCUs in long-term mental health institutions in Limpopo Province.” Participants will be family members for mentally ill patients, MHCUs and nurses working at Evuxaken, Hayani and Thabomooopo Mental Health Hospitals of the Limpopo Province.

I look forward to your positive response in this regard.

Yours faithfully,

Miss N.F. Mabunda

Contact number: 0730862036

ANNEXURE 12: APPROVAL FROM EVUXAKEN HOSPITAL TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH EVUXAKENI HOSPITAL

Enquiries: S Chuma
Extension: 2017

12 January 2017

Ms NF Mabunda
P.O. Box 6389
Giyani
0826

Dear Madam

RE: APPLICATION FOR PERMISSION TO CONDUCT RESEARCH

1. Your above-mentioned request/application has reference.
2. It is with pleasure to inform you that permission has been granted for you to conduct the research study with the nursing personnel of Evuxakeni Hospital on "**A model to promote family involvement in caring for mental healthcare users in Long Term mental health institutions of Limpopo Province-South Africa**".
3. Note paragraph 2 of the approval letter from the Provincial Office dated the **14/12/2016** for compliance/adherence.
4. Also note that further arrangement should be made with the targeted nursing section in consultation with the Deputy Manager: Nursing Services.
5. Best wishes in your research.
6. Yours faithfully,


.....
CHIEF EXECUTIVE OFFICER

12/01/2017
.....
DATE

ANNEXURE I3: APPROVAL FROM HAYANI HOSPITAL TO CONDUCT RESEARCH

REF: S5/2/3
ENQUIRIES: Makakavhule T.
DATE: 01/02/2018

To: Ms Mabunda N.F

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH


1. The above matter refers:
2. We acknowledged receipt of your letter dated 17/03/2016.
3. Permission is hereby granted to conduct the study which will involve our nurses, Mental Health Care Users and their family members.
4. Kindly make sure that you contact Nursing Administration Office and arrange all the logistics before you come.
5. Hoping that you find this in order.


.....
CHIEF EXECUTIVE OFFICER

08/02/2018.....
DATE

ANNEXURE I4: APPROVAL FROM THABAMOOPO HOSPITAL TO CONDUCT RESEARCH

Confidential



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
THABAMOOPO HOSPITAL**

Reference: S5/3/1/2
Enquiries: Thoka M. E
Date: 07 March 2018

To whom it may concern.

1. Thabamooopo Hospital CEO hereby confirms that Miss N. F. Mabunda applied to conduct her research at this institution, which she conducted. In the title of her study, participants mentioned were also the nurses that are working at this hospital, hence the confirmation.
2. According to the permission letter signed on the 14/12/2016 by Head of Department (Department of Health, Limpopo Province), she was pursuing a Doctor of Philosophy (PHD) studies with University of Venda.
3. We hope that the results of the conducted research bring new knowledge in the Nursing Education for improvement of the care, treatment and rehabilitation of our mental health care users.

Kind Regards!

Name of CEO: THOKA ME Signature: [Signature] Date: 2018-03-07

THABAMOOPO HOSPITAL
LIMPOPO PROVINCE
RECORDS MANAGEMENT
2018-03-07
TEL: 015 932 5060
FAX: 015 632 5205
PRIVATE BAG 107, CHHENESEBORG 0485

ANNEXURE J: CODING CERTIFICATE FROM INDEPENDENT CODER

Qualitative data analysis

Doctor of Philosophy in Nursing Sciences

Mabunda Nkhesani Florence

THIS IS TO CERTIFY THAT:

Prof Tebogo Maria Mothiba has co-coded the following qualitative data:

Focus group discussions and interviews data

For the study:

**A MODEL TO PROMOTE FAMILY INVOLVEMENT IN CARING FOR
MENTAL HEALTH CARE USERS IN LONG-TERM MENTAL HEALTH
INSTITUTIONS OF LIMPOPO PROVINCE, SOUTH AFRICA**

I declare that the candidate and I have reached consensus on the major themes reflected by the data during a consensus discussion meeting. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Prof TM Mothiba



TM Mothiba (PhD)

ANNEXURE K1: INTERVIEW TRANSCRIPT FROM FAMILY MEMBERS

INTERVIEW TRANSCRIPT FROM FAMILY MEMBERS: TRANSLATED FROM XITSONGA TO ENGLISH ON PERCEPTIONS OF FAMILY MEMBERS REGARDING THEIR INVOLVEMENT IN CARING FOR MHCUs IN LONG-TERM MENTAL HEALTH INSTITUTIONS

Key: Researcher = R

Participant = P

R. Good day

P. Good day

R. How are you?

P. I am fine and how are you?

R. I am also fine

R. Thank you. Please explain briefly your perceptions regarding being involved in caring for your brother who is admitted in a long-term mental healthcare hospital.

P. To be involved in caring of my brother is very important. It help us to understand everything about mental illness. His mental illness affected the whole family. Our mother once asked for LOA. He was coping well at home until he get discharge. When he get his grant he started to be exhausted on credits, abuse dagga, when the creditors remind him about his credits, he started to be aggressive saying that he has mental illness. Why do the creditors allow the psych patient to credits? He is unmanageable at home. I believe that dagga interrupt treatment to work effectively.

R. Ok. You said your brother is unmanageable at home. Is there anything you want to add on what you said?

P. My brother is destructive at home (crying). I went to “*sangoma*” to try to get help about my brothers’ mental illness as he is no longer wanted by the community members. I took him there and paid R5000 of which I am owing another R7000, He did not complete the course at the “*sangoma*” because of his distractive behavior. He abuse dagga and alcohol. He broke church windows more than four houses within the community. He killed one cow of the famous funeral society. He wanted to throw a child in the toilet at his mothers’ sisters’ funeral. He threatened community children with a knife and also took groceries from the tuck-shop. He threatens everyone in the community. He don’t want to take treatment saying he is a traditional healer, he is dangerous to the community. I am afraid to take him when granted LOA. The community members even complained to the “*induna*”.

R. Ok. You said you are afraid to take him when granted LOA. Are you able to visit him since he was admitted?

P. No, I am not around, my concern is that there is no one at home who can visit or take care of him when the hospital give him chance to be at home. I’m working in Johannesburg of which it will be not easy to stay with him to follow him on taking treatment. Who is going to monitor him while I’m at work because some of treatment is taken during the day?

R. I understand. Thank you very much for your time and sharing your perceptions with me. I will contact you again if there is a need. I hope that it is fine.

P. Yes and thank you too.

R. Thanks

ANNEXURE K2: TRANSCRIPT FROM FDGs

FDGs TRANSCRIPT FROM MHCUs: TRANSLATED FROM XITSONGA TO ENGLISH ON THE VIEWS OF MHCUs REGARDING THE INVOLVEMENT OF FAMILY MEMBERS WHILE ADMITTED IN LONG-TERM MENTAL HEALTH INSTITUTIONS

R. Good morning everyone

P (all). Good morning

R. How are you?

P (all). We are fine and how are you?

R. I am also fine

R. Thank you. Explain briefly your views regarding the involvement of your family members in your mental health care, treatment and rehabilitation.

P1. I went for LOA last years, I was staying alone at home. My brother is working at Johannesburg. I was not taking my treatment thinking that I am ok for several days. There is no one at home to remind me to take treatment. I think that is why I relapsed and I ended being readmitted to the hospital. Since I've been taken for LOA last year they said they will take me for LOA. There's no house for me they want to build house for me since 2013. I've a talent I'm an artist, I feel stacked as am growing further. I even want to further my studies not depending on music. I am not progressing with my future. I accept that I relapsed but now I am stable and I think I can go home and open space for those who are aggressive as there's no enough space, we are overcrowded.

P2. I am staying in the hospital because of my parents, not because of mental illness. Doctors discharged me but my parents does not want me at home. They are not visiting me to prove that they want me. I will stay in the hospital until my son grow up to eighteen years. May be he will visit me and take me home. If I die I will be buries as a pauper.

R. Thank you. Remember, you have to explain your views without saying what others have said as you are not coming from the same family.

P3. Since 2013 I have never been visited until last year November. I think they are accepting me, I remember 2016 October at Bevhula. They promise to build a house for me, I think the follow ups through the hospital they will accept me. I also think that they have forget the bad things I did and that is why they want to build the house for me.

P4. I understand why they are not coming, they don't have money. I once went for LOA and brought back but since then, I've never went for LOA again. They have lied to me that I am going to register DG grant and being brought back to the hospital and I'm not sick. I am surprised other MHCU are granted LOA, I am running hospital tuck-shop of which I don't like. There's nothing wrong I did at home even if my wife visit me I have to run tuck-shop and when I come back I found them staying with my wife discussing my issues. I think they will pay for everything they are doing to me.

P5. They promised to come and visit me when I phone them they are not coming. They should not reject me they should accept that I am mentally ill they should accept and assist as to take treatment when we are in LOA they should monitor our treatment compliance. They present our problems to the social workers instead of assisting us to take treatment accordingly. They should be patient to us they should be patient, we are mentally ill.

R. Thank you. Is there anything you want to add or you forgot something related to your views regarding the involvement of your family members?

R. Okay, Thank you very much for your time and sharing your views with me. I will contact you again if there is a need. I hope that it is fine.

ANNEXURE L: EDITING CONFIRMATION



STEVENS EDITING AND PROOFREADING

~ EDITING ~ PROOFREADING ~ WRITING ~

BA: English; Industrial psychology (UNISA)

Sole Proprietor

Membership:

PEG (SA)

IPEd (WA)

7 April 201

THIS IS TO CERTIFY THAT:

I have language edited a thesis titled *A MODEL TO PROMOTE FAMILY INVOLVEMENT IN CARING FOR MENTAL HEALTH CARE USERS IN LONG-TERM MENTAL HEALTH INSTITUTIONS OF LIMPOPO PROVINCE, SOUTH AFRICA*, for Ms MABUNDA NKHENSANI FLORENCE, a Doctor of Philosophy student in Health studies at the University of Venda, South Africa. Email: nfnkhensy@gmail.com.

The scope of my editing comprised:

- Spelling
- Tense
- Vocabulary
- Punctuation
- Word usage
- Language and sentence structure
- Checking of referencing style

It was a pleasure working with Ms Mabunda who is very professional in her communications and presented a well-prepared paper for editing.

Her prompt payment further proves her integrity and is appreciated.

Yours faithfully,

Charlotte Stevens (Ms)

Stevens Editing and Proofreading

e: ajc.stevens@gmail.com

[Note: Signature withheld for security purposes.]