



**THE EXPERIENCES OF FAMILY MEMBERS REGARDING 72-HOURS
ASSESSMENT ADMISSION OF A MENTAL HEALTH CARE USER AT
SELECTED HOSPITAL IN VHEMBE DISTRICT OF LIMPOPO PROVINCE,
S.A**

BY

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DECLARATION

I, Mbedzi Takalani. Ellen, hereby declare that the dissertation titled **“Experiences of family members regarding 72-hour assessment admission of mental health care users at selected hospitals in Vhembe District, Limpopo Province”** for the degree of Masters in Advanced Nursing Sciences at the University of Venda, and has not been submitted to any other institution nor will it be submitted to any other institution for consideration. I also declare that the work contained in this dissertation is my own original contribution, and that the materials consulted have been duly acknowledged.

Student signature.....

Date.....

DEDICATION

To all the family members of the mental health care users specifically to those who took their valuable time to be part of this study, who had to look after their mentally ill relatives in the midst of all the challenges they encounter during the caregiving role.

This study is also dedicated to my husband Bethuel and my children Murangi, Orifha and Uaripfa for the sincere support throughout the research project.

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Thank the Almighty God for giving the strength to succeed. I can say to Him be the glory.

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ABSTRACT

Background: In South Africa the Mental Health Care Act No. 17 of 2002 direct district hospitals to render 72-hour assessment of the MHCU's. In Vhembe district 72- hour assessment is implemented in public general hospital.

Purpose: The study determined the experiences of family members regarding 72-hour assessment admission of MHCU's at selected hospital in Vhembe District.

Methodology: The research design was qualitative, exploratory, descriptive and contextual in nature. The study population consisted of the family members of the MHCU's admitted for 72-hour assessment. Purposive sampling was used to select 10 family members. This study used in-depth individual interviews to collect data until data saturation was reached and analysed using Tesch's steps. Ethical consideration and measures to ensure trustworthiness were given attention to throughout the study.

Results: Three themes emerged from analysed data which is negative experiences of family's members, family member's experience on coping mechanism and structural constraints.

Recommendations: This study recommends further research study on the development of a model to support the family members in their caregiving role. The study recommends further research study on the experiences of the health care professional regarding 72-hour assessment of a MHCU's

Key words: *experience, family member, mental health care user and 72-hour assessment.*

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LIST OF ABBREVIATIONS AND ACRONYMS

CTR	: Care Treatment and Rehabilitation
DoH	: Department of Health
ED	: Emergency Department
MHCA	: Mental Health Care Act
MHCP	: Mental Health Care Practitioner
MHCU	: Mental Health Care User
SAPS	: South African Police Services
WHO	: World Health Organization

LIST OF ANNEXURES

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

This study describes the qualitative enquiry into the lived experiences of family members with regard to 72-hour assessment of mental health care users at selected hospitals in the Vhembe District in the Limpopo Province. The content gives an overview of the introduction and background to the study, problem statement, purpose of the study, the research question, and the objectives of the study, literature and research methodology. Most developing countries and, indeed, many African countries, have been undertaking reforms of the mental health policies and strategies to improve access and equity for the community to mental health and psychiatric services.

This has been in conformity with a health policy philosophy which emphasizes decentralization of services to the lower administrative units such as districts, community care, as well as integrated delivery of health services within the lower health units. Uganda, one of the developing countries in Sub-Saharan Africa, has been implementing its Health Sector Strategic Plan in which mental health has been identified as a major priority. The guidelines from the World Health Organisation (WHO), (2008) the Alma Ata Declaration and the subsequent WHO recommendations, have provided the guiding philosophy for the implementation of decentralization process.

In South Africa, revision was made to the Mental Health Care Act NO 17 OF 2002 (MHCA) to ensure that the human right of mental health care users is protected, which is in line with the South African Constitution. Thus, following international trends, current South African legislation advocates for

a rehabilitative, community-based model of health care. This approach was meant to reduce the stigma attached to mental illness (Baumann, 2007; Moosa & Jeenah, 2008). Mentally ill patients had been previously confined to institutions which were far from their homes, generally inefficient and authoritarian, with impenetrable barriers to the outside world, had various rituals, and required huge expenditure.

Patients developed institutional neurosis characterised by symptoms such as apathy, lack of initiative, loss of interest and submissiveness. Lately institutions began to be replaced by the 'community' a concept that encourages the development of alternative services including psychiatric units in general hospital, community-based clinic, residential homes and day care centres (Moosa & Jeenah, 2008). South Africa set about reforming its outdated apartheid-era mental health legislation, and in 2004, the Mental Health Care Act NO 17 of 2002 was promulgated. This legislation was a major departure from the past legislature. Among other things, it enshrines the human rights of people with mental disorders, providing specific mechanisms for the protection and promotion of those rights, and broadens the range of practitioners and other stake holders, including mental health care users, who can contribute to improving the mental health status of South Africans.

The Act also improves access, makes primary health care the first contact of mental health care with the health system, and promotes the integration of mental health care into general health services and the development of community-based services (National Mental Health Strategic Plan, 2013-2020). The Mental Health Care Act NO. 17 of 2002 (MHCA) replaced the Mental Health Care Act NO. 18 of 1973 in South Africa in December 2004. The new Act serves to raise the issues and profile of mental health and support mental health care users (MHCUs). Some objectives of the Act are to ensure that appropriate care, treatment and rehabilitation (CTR) are provided at all levels of care of health care service, change from custodial approach to

the one that encourages community care, and to entrench the rights of the people with mental disabilities so that they are not discriminated against, stigmatised and abused. The act prescribed that the patients should be treated in the least restrictive environment and mental health is to be fully integrated into all levels of care.

The new Mental Health Care Act (MHCA) NO 17 of 2002 has designated all general hospitals to render 72-hour assessment of mental health care users who may be considered to require admission as involuntary patients' compulsory admission against the patient's will). The aim of assessment is to avoid unnecessary admission to a psychiatric ward, by excluding underlying medical conditions and providing treatment that can stabilize the mental health care user's mental condition such that the user may be discharged and sent home under the care of their relatives. In terms of the MHCA the 72-hour assessment refers to the time period for assessment of patient classified as involuntary MHCUs who refuses treatment, but potentially requiring such care, which will take place at a facility designated to render involuntary care.

Table 1.1 Health establishment for provision of 27-hour assessment in the Limpopo Province

District	No. of hospitals	Referral hospital
Capricorn	9	Thabamooopo, Mankweng
Sekhukhuni	7	Thabamooopo Mankweng
Waterberg	9	Thabamooopo, Mokopane
Mopani	8	Thabamooopo Evuxakeni
Vhembe	6	Siloam,Elim,Malamulele Donald Fraser

Adapted from the Psychiatric Department Polokwane Mankweng Hospital, University of Limpopo 2017

Freeman, (2011) points out that 72-hour assessment is expected to be conducted in district hospitals (primary care level). Although about 204

district hospitals country-wide are currently providing these required (involuntary) services, no facilities were created in which safe and adequate care can be ensured. While this would require a separate area in this district hospital, with dedicated psychiatric beds, no such facilities exist in most of the hospitals. Only 10 district hospitals nationally have an admission unit. A total number of 39 health establishments are providing 72-hour assessment in all five districts of the Limpopo Province in terms of section 34 of the MHCA NO 17 OF 2002 regulation 12.

In the past, individuals who display signs and symptoms of mental disorder were admitted to an acute psychiatric ward of the district hospital, and stayed there for a period of several weeks to a couple of months, until they had fully recovered from their mental condition. Almost all the patients admitted are labelled with a psychiatric diagnosis by first presentation, and carry the stigma attached to mental illness, together with the family members.

Currently, people with mental health problems are admitted first in the general setting with other patients who are suffering from medical illnesses. Diagnosing the individual as a psychiatric patient is suspended until investigations regarding possible contributory factors for the strange behaviours are done. Chapter Three of the Act deals with the rights and duties of the mental health care users (Moosa & Jeenah, 2010).

It has been noted internationally that the majority of MHCUs should be treated as voluntary patients. A minority will require admission and treatment without consent (involuntary). It has been estimated that worldwide 10-15% of MHCUs require involuntary admission. In some countries such as Portugal and Denmark less than 5% of all admission are involuntary. In South Africa the incidence is not known (Moosa & Jeenah, 2008).

The number of psychiatric emergencies presenting to the emergency department (ED) in the United States continues to rise. Evidence suggests that psychiatric ED care encounters can have less than optimal outcomes, and result in stress for providers (Harris, Baumann, Fagien, & Shathell, 2016). A 72-hour assessment unit is referred to psychiatric emergencies department in other international countries. The majority of mental health care users requires compulsory admission.

Moosa and Jeenah, (2010) report that the treatment of involuntary patients requires, among other things, an infrastructure designed for this service, 'psychiatric intensive care' capabilities, special staffing, training and supervision, ancillary services and funding. Aromaa, (2011) states that general nurses lack knowledge and skills needed for psychiatric patients. Such services are lacking at most regional hospitals in Gauteng, so the 72-hour assessments are conducted at regional hospitals and the MHCU is then referred to a specialised psychiatric hospital for further involuntary inpatient CTR. This accounts for the higher number of applications by specialised psychiatric hospitals, which are usually full. Currently, the regular 72-hour assessment is often conducted in an adequate locked room adjacent to the casualty section, or in an open-area, non-secured medical ward of the general hospitals, where safety of the mental health care user and mental health care practitioners (MHCP) is not guaranteed (Freeman, 2011). In other hospitals, a 72-hour assessment is conducted in closed acute mental health care units of the District or Regional Hospital.

Freeman, (2011) further highlights what is lacking in existing facilities, such as counseling rooms for psychiatry, and recommends having patient accommodation facilities located within communities. These may include facilities for both short-term stays and long-term stays, such as group homes, day care facilities, houses promoting independent living, as well as specialist psychiatrist facilities that could be small in size, and forensic facilities. Issues

which prompted lively debate were the human resource constraints, the nature and location of 72-hour observation facilities, the lack of resources and equipment to do the necessary assessments, and the need for more beds for mental health patients. It is apparent that mental health is not the top of ‘the illness agenda’ for government, because people are not dying from it.

Burns, (2008) reports that most institutions were experiencing problems regarding 72-hour observation which resulted in sub-optimal care. The MHCUs were highly sedated, making the prescribed assessment and observation difficult. Inadequate and poorly skilled health workers also worsened the situation. A study conducted by Ramlall, Chipps, and Mars (cited by Simpson and Chipps, 2012), confirmed that numerous challenges exist in South Africa in respect to the 72-hour assessment. In Kwazulu-Natal, sixty-three percent of the designated hospitals reported a lack of beds, staff and appropriate seclusion rooms to accommodate MHCUs. This definitely indicates that the assessment conducted on the user is compromised, even though the user period of assessment cannot be extended.

Mentally ill individuals with violent behaviours attack family members and people in the streets. According to the Mental Health Care Act No 17 of 2002, the family can only take the person to the state hospital for psychiatric assessment and observation for a period of 72 hours, but the problem is that a person can be kept there for only three days. The hospital often cannot send them to a psychiatric institution, because most of them are full. It takes six months to two years to get an open bed in these institutions (Smith, 2014).

Almost a decade earlier, Mavundla and Uys, (1997) concluded that in rural areas, medical and surgical wards admit psychiatric emergencies, when they have relapsed. However due to challenges of the referral system, it takes more than a week for users to be transferred to a psychiatric hospital for on-going care. This scenario leaves psychiatric and generalist nurses with the burden

of caring for increased number of users, causing overcrowding. There may be a possibility of mismanagement of the users which can negatively affect the assessment process.

The MHCA No. 17 of 2002 states that when 72-hour period of assessment has expired and the patient's condition has improved to a point at which they are considered not to be a danger to themselves or others, but still lacks capacity to consent to voluntary treatment, they can be discharged into the care of their family members. The intention of the act is to empower family members and help ensure that they actively participate in the ongoing care of the MHCUs.

A study conducted by Mabena, (2010) on evaluation of the involuntary 72-hour assessment at Gauteng general hospital, revealed that a large number of involuntary mental health care users are frequently readmitted in the unit as involuntary users. The number of involuntary admission users is very high, as compared with those in other countries. In support of the findings Janse van Rensburg, (2011) highlights that in the previous study the researchers observed that a number of users were re-admitted in the 72-hour unit in a 'Revolving door pattern' following a period of 72-hour assessment at Helen Joseph Hospital in Gauteng. Jankovic, Yeeles, Katsakou, Amos, Morris, Rose, Nicol, McCabe and Priebe, (2011) argue that compulsory admission of a close relative can be a complex and stressful experience for family caregivers. Frequent admission of an involuntary MHCU, who poses a danger to themselves and others, but still refuses to be admitted, is a challenge to the family caregivers. In most instances, the users are brought to the health establishment with assistance from South African Police Officers (SAPS) who are not always easily accessible to the community. Family members are more concerned about their safety and lack knowledge and skills in handling MHCUs.

Simpson and Chipps, (2012) found that only nine of possible 27 patients considered ready for discharge at a Gauteng facility were successfully placed in the community after one year. Some family members refused to accept their mentally ill relative because of their limited emotional and physical resources in the community that contributed to the family members being reluctant to take the user home. A study done in the United Kingdom related to the family caregivers experience of involuntary patient admission, reported that family members expressed relief as a response to the relative's admission and this was accompanied by feelings of guilt and worry. Family members experience difficulties in obtaining help from service providers prior to admission, and some thought that services responded to crises rather than prevented them.

They experienced increased burdens when services shifted responsibility of caring for their unwell relative to themselves. Confidentiality was a delicate issue with family caregivers wanting more information and a say in decisions when they were responsible for after care and being concerned about the confidentiality of information they provided to the services (Jankovic *et al*, 2011). There are further issues which raises a serious concern relating to the rights of families and community members when services to the mental health care users fail. Inadequate care at district hospitals put other health care users at risk (Simpson & Chipps, 2012). Lethoba, Netswera, Rankhumise (cited by Gule, 2013) confirmed the perception of the community at large by indicating that psychiatric patients are potentially dangerous. According to a study conducted around the experiences of general nurses working in medial wards designated to be a 72-hour assessment, Gule, (2013) found that a lack of skills, perceived danger and self-fulfilling prophecy, instils stress in patients, patient's families and nurses.

There is very little published data regarding the 72-hour assessment of involuntary mental health care users, and in particular the family member's experiences. This prompted the interest to conduct this study in order to 'hear'

the voice of the family members caring for the mental health care users regarding the 72-hour assessment that is done in medical wards of the selected Vhembe district hospitals

In the Vhembe District, 72-hour assessment commenced in 2011 in one of the regional hospitals. Currently, all district hospitals are rendering 72-hour assessment, either in medical wards of the general hospital, or in acute psychiatric units. Hence this study seeks to explore and describe the experiences of family members regarding the 72-hour assessment admission of mental health care users at selected hospitals in the Vhembe District in Limpopo.

1.2 PROBLEM STATEMENT

The researcher is an experienced mental health care nurse who has worked for 16 years in an acute psychiatric unit, and 4 years in a medical unit designated to render a 72-hour assessment. The researcher observed with concern that when family members are informed about the discharge of the mental health care user admitted in a 72-hour assessment unit, they display angry outbursts protesting against the discharge. Some family members demanded to see the responsible doctor who initiated the discharge, and threaten to lodge their complaints to the higher authority. While others give excuses, such as not having clothes for the MHCU or not having enough money for transport to take the user home.

Some family members promise to take the MHCU at a later stage due to some commitments. Some will request that the MHCU be considered for long term institutionalisation. Sometimes, MHCUs are discharged one day, and the following day they are readmitted for another 72-hour assessment. In other

instances, users are transported home by the hospital transport in the company of nursing staff.

1.3 THE PURPOSE OF THE STUDY

Burns and Grove, (2012) describe the research purpose of the study as a clear, concise statement of the specific goal or aims of the study that is generated from the research problem.

The purpose of this study was to determine the experiences of family members with regard to the 72-hour assessment admission of mental health care users at selected hospitals, in the Limpopo Province.

1.4 THE RESEARCH QUESTION

According to LoBiondo-Wood and Haber, (2014) a research question is a key preliminary step in the research process. The research questions (sometimes called the problem statement) present the idea that is to be examined in the study constitute the foundation of research study.

This study was guided by the following research question:

“What are the experiences of family members regarding the 72-hour assessment admission of mental health care users?”

1.5 THE OBJECTIVES OF THE STUDY

An objective is a concrete, measurable end towards which effort or ambition is directed. Research objectives are defined as clear, concise, declarative statements that are written in the present tense (Burns and Grove, 2012).

Similarly, Brink, (2016) defines objectives as goals to be achieved at the end of the end of the study.

The objectives of this study are to:

- explore the experiences of family members regarding the 72-hour assessment admission of mental health care users at selected hospitals.
- describe the experiences of family members regarding the 72-hour assessment admission of mental health care users at selected hospitals.

1.6 SIGNIFICANCE OF THE STUDY

A crucial factor in selecting a problem is its significance to nursing. Evidence from study should have potential to contribute meaningfully to nursing practice (Polit & Beck, 2012; Brink, 2012).

1.6.1 Family members

This study gave the family members an opportunity to share their lived experiences regarding the 72-hour assessment of MHCUs admitted at selected hospitals, as compared to the information that is given by the MHCUs themselves. This is in line with the Bato-Pele principle of consultation, which requires the consumers of health services to air their views about the existing public health services. Gaining insights into the experiences of family members who are caring for the MHCUs at home, assisted the researcher to make recommendations that will empower the family members with knowledge and skills that will assist them to manage mental health care users at home. On-going psycho-education will be implemented to update and improve the family member's supervision skill of the treatment programme of their ill relative. It is envisaged that the skilled acquired by the family

caregivers will reduce the rate of relapse so that the MHCUs will stay in the community for most of their days.

1.6.2 Policy makers

This study's recommendations could have an impact on policy, education and research in the area of mental health care. It is hoped that the findings will contribute in the amendment of future Mental Health Care Acts. The recommendations could assist policymakers when they do infrastructural assessment and planning prior to designating a facility to be a 72-hour assessment. Furthermore, the results of the study may influence decision making when the Department of Health (DoH) reviews its policy guideline on 72-hour assessment of the MHCU at district hospitals.

1.6.3 Nurses

Nurses allocated in the medical wards are expected to care for mentally ill individuals who do not possess knowledge and skills to take care of people with mental health problems. Academics responsible for curriculum development may be advised to include basic psychiatric nursing in all the nursing education programme in order to equip the nurses with the necessary knowledge and skills of managing MHCUs in general medical settings. The knowledge and skills acquired will allay the anxiety and fear from general nurses and hopefully a change of attitude towards mentally ill individuals, giving rise to quality mental health care service.

1.6.4 Body of knowledge

Finally, this research may provide information about the experiences of family members regarding a 72-hour assessment at selected hospitals in the Vhembe

District in the Limpopo Province, because no such information was found in South Africa at the time when this study was conducted. The research findings will add value to the existing body of knowledge and set a foundation for future research.

1.7 DEFINITION OF KEY CONCEPTS

1.7.1 Experience

Soanes and Stevenson, (2006) define experience as an accumulation of knowledge or skills that result from direct participation in events or activities known only to the person who has lived through it and often makes an impression on the person.

In this study the family members will share their lived experiences accumulated during admission of their relative in a medical ward which is designated to conduct 72-hour assessment.

1.7.2 Family members

Family members are living, ongoing entities, organized wholes with members in a continuous, interactive, patterned relationship with one another extending over time and space (Goldenberg & Goldenberg, 2008).

In this study, a family member is any person older than 18 years who lives with and is a caregiver of MHCU's admitted in medical ward designated to be a 72-hour assessment at selected hospitals in Vhembe District in Limpopo.

1.7.3 Mental Health Care User

According to the Mental Health Care Act No 17 of 2002, a mental health care user means a person receiving care, treatment, and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient and mentally ill prisoner where the person concerned is below the age of 18 years or incapable of taking decisions.

In this study, a mental health care user shall mean any person admitted involuntarily for time of period of 72 hours undergoing an assessment and observation while receiving care, treatment and rehabilitation in a general ward designated to render 72- hour assessment and observation.

1.7.4 72-hour assessment

According to Bauman, (2007) the 72-hour assessment refers to the involuntary care granted by the Head of the health establishment (HHE), whereby the MHCUs undergoes a continuous period of assessment and observation for 72 hours. The purpose of the 72-hour observation is to rule out medical cause for altered mental status (Edenvale Hospital Protocol, 2008).

In this study, the 72-hour assessment shall mean health care service provided to individuals who are admitted as involuntary users for observation in a medical ward designated to render 72-hour assessment before being committed to a psychiatric hospital.

1.8 ASSUMPTION UNDERLYING THE STUDY

The study was based on the conceptual framework of Roy's Theory of Adaptation believes in holism and innate capabilities, purpose and self-worth of human beings.

The theory guides the researcher to describe the experiences of family members of MHCUs admitted in the new environment which is a 72-hour assessment emerging from the MHCA No 17 of 2002. The conceptual framework makes use of assumption to guide the study.

1.8.1 Assumptions

An assumption implies the standards or criteria for assessing value or worth of both processes and the procedures of the discipline, as well as to the methods of knowledge development within a discipline (Chinn & Kramer, 1999). An assumption is also defined as a set of beliefs that constitutes the researcher's perception regarding the nature of reality of the world, as well as the researcher's perception of where he/she stands in the reality of the world (de Vos, Schurink, Strydom, & Delpport, 2011).

The researcher' point of departure was three paradigmatic dimensions: Meta-theoretical, theoretical and methodological assumptions.

1.8.2 Meta-theoretical assumption

The researcher believes that the family is the primary caregivers, fulfilling God's principle of taking care for each other. The family is the basic unit which strives to satisfy basic needs of human kind, constitutes a support system for the individuals living with mental illness, who suffer from the disease that impairs cognitive functioning. A family is far more than a collection of

individuals sharing a specific physical and psychological space. While families occur in a diversity of forms and complexities in today's rapidly changing society, and represent a multiplicity of cultural heritage, each may be considered a natural, sustained social entity with properties of its own.

The researcher believes that the impact of hospitalisation of family members on the near relatives needs to be taken into consideration. The family members are expected to adapt to the change forced upon them. Nursing staff will have a role to play in helping them to adapt to such changes. It is important to evaluate the family as a unit because of the assumption that the element, once combined, produce an entity a whole that is greater than sum of its parts.

1.8.3 Theoretical assumption

The theory is based on the scientific and philosophical assumptions. Roy's model sees the individual as a set of interrelated system (biological, psychological and social). The individual strives to maintain a balance between these systems and the outside world, but there is no absolute level of balance. Individuals strive to live within a unique band in which they can cope adequately. Roy's adaptation theory is relevant in this study because the assumptions focus on the person, his thinking process and the relationships with the environment and with God.

This study was based on the family members as individuals whose state of equilibrium is disturbed by admission of one of the family member for a 72-hour assessment. Previously individuals who display odd behaviours were admitted in an acute ward for stabilisation of their mental condition. The family members are expected to adjust to a 72-hour assessment admission which a new program provided in the mental health services. The study aimed to describe the experiences of family members regarding the 72-hour

assessment, which is a new mental health facility of which the service users are not familiar with.

The theory is based on four major concepts:

- Human as adaptive systems as both individuals and groups
- The environment
- Health
- The goal of nursing

These four concepts are described as follows:

1.8.4 Humans as adaptive systems

This area focuses on human both as individuals and as groups from the point of view for shaping nursing activities. Any of these may be considered a human system each of which is considered by a nurse as a holistic adaptive system (George, 2010). In this study, family members are human beings who will be interviewed as individuals to get their lived experiences of the 72-hour assessment of MHCUs admitted in the general hospital. The findings of the study will be used to equip the family members with the necessary skills of managing the MHCUs after discharge from in-patient mental health care. The person is an open, adaptive system who uses coping skills to deal with the stressors.

1.8.5 Environment

George, (2010) defines the environment the as "all conditions, circumstances and influences that surround and affect the development and behaviour of the person". George, (2010) describes stressors as stimuli and uses the term 'residual stimuli' to describe those psychosocial stressors whose influence on

the person is not clear. The study will explore the conditions within the family which contributed anger outburst and threats of protesting against the discharge of the MHCU from a brief hospitalisation of 72 hours instead of the long-term hospitalisation in acute mental wards. The experiences of family members will be explored deeply in order to identify the contributory factors leading to the dissatisfaction regarding the services rendered in a 72-hour facility.

1.8.6 Health

Originally, Roy wrote that health and illness are on a continuum with many different states or degrees possible. More recently, she states that health is the process of being and becoming an integrated and whole person. As viewed in this perspective, health can exist for a person with physical, emotional or other changes more than the existence of a condition or an illness.

The family members are seen as unhealthy because hospitalization of a MHCU has a negative impact on the whole family. If one member is affected by the illness the other is affected. Family members also get emotionally and psychologically disturbed meanwhile they are expected to adapt to the changes forced upon them.

1.8.7 The goal of nursing

Roy's goal for nursing (in George, 2010) is the promotion of adaptation in each of the four modes, thereby contributing to the person's health, quality of life and dying with dignity. These four modes are physiological, self-concept, role function and interdependence. Therefore, nursing is aimed at reducing the negative responses and promoting the positive ones. The goal of nursing is to, to identify the needs, concerns and fears of the family members related to

their experiences of the 72-hour assessment admission of the mental health care user and plan the interventions strategies to help the family members to adapt to the situation as a means of offering support to them.

1.8.8 Methodological assumption

Methodological assumptions are concerned with the nature and the structure of the science of research, and include the preferences and assumptions of the research. The methodological assumption which guided this study were in line with the functional approach, which implied that the research, should be functional and should contribute to the body of knowledge and improve the quality of life It was assumed that this study could produce data which provided an understanding of the experiences of family members with regard to 72-hour assessment and observation of the mental health care users admitted at the selected hospitals.

1.9 RESEARCH METHODOLOGY

Research methods involves the process of selecting the type of approach and design the researcher will apply with regard to the population, sampling, data collection and measurement to ensure compliance with the ethics and trustworthiness are clearly described. The study methods with be described in detail in Chapter 2.

1.10 RESEARCH DESIGN

According to de Vos *et al*, (2011) the research approach focuses on the end product, formulates a research problem as a point of departure, and focuses on the logic research. Research design according to Polit and Beck, (2012), is the overall plan for obtaining answers to the research question. In this study

the research approach used was qualitative, which is explorative, descriptive and contextual in nature (Burns & Grove, 2012).

1.10.1 Qualitative

Qualitative research according to Burns and Grove, (2012) seeks to describe and analyse culture and behaviour of humans and their groups from the point of view of the people being studied. In this study, qualitative design was used to allow family members to narrate the depth, richness and complexity inherent in their experiences of the 72-hour assessment admission of the mental health care users.

1.10.2 Exploratory

Exploratory research design typically occurs when a researcher examines a new interest or when the subject of study itself is relatively new and unstudied (Babbie, 2010). 72-hour assessment is a new mental health service in the market psychiatry hence the study intends to explore the family member's experiences regarding the assessment and observation of mental health care users admitted in a ward designated to render the assessment for the duration of 72 hours.

1.10.3 Descriptive

A descriptive study design is crafted to gain more information about characteristics within a particular field of study. The purpose of the descriptive study is to provide a picture of situation as they naturally happen. It is used to develop theory, identify problems with the current practice, makes judgement, or determine what others in similar situation are doing (Burns & Grove, 2012; Polit & Beck, 2012). In this study the family members

will be interviewed and while they answer, their non-verbal cues like facial expressions will be observed and recorded as field notes.

1.10.4 Contextual

De Vos *et al*, (2011) and Creswell, (2014) describe contextual research as an ideograph research, in that it is uniquely descriptive within the context of the individual setting. This study is contextual because the researcher tries as far as possible to study the people in their own natural setting in order to understand the dynamics of human meaning as fully as possible. Qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study.

The researchers do not bring individuals into the laboratory nor do they typically send instrument for individuals to complete. This study is contextual in nature because attention was given to the experiences of family members with regards to a 72-hour assessment at the Tshilidzini and Donald Fraser hospitals in the Vhembe District. Only the family members of the MHCU's admitted at the selected hospitals will be recruited, other family members of MHCU's admitted for 72-hour assessment will not be included in the study. The participant was interviewed at their home setting.

1.11 POPULATION

A population is the entire group of persons or objects that are of interest to the researcher, in other words, meets the criteria which the researcher is interested in studying (De Vos *et al*, 2011; Brink, 2012). The population in this study were all the family members of the mental health care users admitted at medical wards designated to provide 72-hour assessment at

selected hospitals. A total number of 10 family members were interviewed during the data collection process.

1.12 SAMPLING METHOD

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove, 2012). Brink, (2012) also defines sampling as the researcher's process of selecting the sample from a population in order to obtain information regarding phenomena in a way that represent the population of interest.

In this study, non-probability purposive sampling was used. The purposive sampling method is based on the judgement of the researcher regarding subjects or object that are typical or representative of the topic being studied or who are especially knowledgeable about the research question. Sampling occurred in two phases, namely, sampling of the hospital and sampling of the participants. Details of the sampling method will be discussed in Chapter 2.

1.13 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions, or hypotheses of study (Polit & Beck, 2012).

In this study, data collection involved preparation, the data collection instrument, and the role of myself as researcher. Data were collected by means of semi-structured interviews. These steps will be discussed in detail in the next chapter 2.

Effective communication skills were employed to facilitated interviews as described by Babbie and Mouton, (2010), and De Vos *et al*, (2012) when the authors pointed out that active interviewing is not only restricted to asking questions and recording answers, it also entails mutual attentiveness, monitoring and responsiveness. All effective communication skills will be discussed in details in Chapter 2.

1.14 DATA ANALYSIS

In this study, a data analysis guide developed by Tesch was used to analyse data. Tesch provides eight steps following Cresswell, (2014) that should be considered when analysing qualitative data. Details of the steps (one to eight) will be discussed in Chapter 2.

1.15 LITERATURE CONTROL

After data analysis, experiences of family members regarding the 72-hour assessment admission of mental health care users was explored and literature control was conducted. This will be discussed in Chapter 2.

1.16 STUDY SETTING

The study was conducted in the Vhembe District, which is located in the Limpopo Province. The Limpopo Province is divided into five districts: Vhembe, Mopani, Capricorn, Sekhukhune and Waterberg. The Limpopo Province is mostly rural except some part of the Capricorn District. Most people in the population are unemployed, resulting in low socio-economic status. Their literacy level is also low.

The Vhembe district has eight hospitals, one referral hospital, and six community hospitals (Donald Fraser, Mesina, Malamulele, Elim, Louis Trichardt and Siloam Hospital), one regional hospital which is Tshilidzini and one mental hospital which is Hayani health establishment. This study was conducted at the Tshilidzini and Donald Fraser hospitals.

1.17 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba, (1999) state that trustworthiness of a research study is important in evaluating its worth. Trustworthiness refers to the degree of confidence qualitative researchers have in their data assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck, 2012). These are described briefly below and details will be discussed in Chapter 2.

1.17.1 Credibility (Truth value)

Lincoln & Guba, (1999) indicate that truth value asks whether the researcher has established confidence in the truth of the findings from the participants and the context in which the study is undertaken.

1.17.2 Transferability (Applicability)

Applicability refers to the degree to which the findings can be applied to other contexts and settings or with other groups (Lincoln & Guba, 1999).

1.17.3 Dependability (Consistency)

Lincoln & Guba, (1999) reflect consistency of the data in research as important because it considers whether the findings would be consistent if the inquiry were to be replicated with the same subjects or similar context.

1.17.4 Confirmability (Neutrality)

Lincoln & Guba, (1999) refers to neutrality as the degree to which the findings are a function of the participants and conditions of the research and not of other biases, motivations and perspectives

1.18 ETHICAL CONSIDERATION

The researcher adhered to the following ethical principle during the study, the principle will be explained in full in Chapter 2

- Permission to conduct the study
- Informed consent
- Principle of non-maleficence
- Principle of justice
- Confidentiality
- Analysis and reporting
- Anonymity

1.19 OUTLINE OF THE DISSERTATION

The chapters of the dissertation are as follows:

Chapter one: Orientation to the study

Chapter two: Methodology

Chapter three: Discussion of findings

Chapter four: Conclusion, Limitation and recommendations

1.20 SUMMARY

Chapter one gave an overview of the study, which included introduction, problem statement, research question and objectives. Research methodology was discussed in summary. Measures to ensure trustworthiness and ethical issues were described. The next chapter gives a full description of the design and methodology of the study.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter of the study seeks to outline the research methods that were applied in order to carry out the study successfully. The previous chapter gave the highlights of the research methods. In this chapter a detailed discussion and justification of the research design will be described. This includes the description of the design of the study, setting of the study, population sample, data collection methods, data analysis and measures of ensuring trustworthiness and ethical considerations.

2.2 RESEARCH APPROACH

According to de Vos *et al*, (2011) the research design focuses on the end product, formulates a research problem as a point of departure, and focuses on the logic research. Research design, according to Polit and Beck, (2012), is the overall plan for obtaining answers to the research question. The research involves a qualitative design, which is explorative, descriptive and contextual in nature, in order to explore and describe the experiences of family members regarding the 72-hour assessment admission of the mental health care users.

2.2.1 Qualitative design

Qualitative research, according to Burns and Grove, (2012), seeks to describe and analyse culture and behaviour of humans and their groups from the point of view of the people being studied. Its emphasis is on providing a comprehensive or holistic understanding of social setting in which research

is being conducted. While de Vos *et al*, (2011) is of the opinion that without the holistic view, there is little value to qualitative research. The most possible relevant information is obtained to enable the researcher to draw a clear picture which is aimed at analysing the in-depth of the network of relationships within and amongst the various aspects relevant to the problem. Qualitative research focuses on understanding the phenomena as a whole, because whole is more than sum of its parts.

In this study, a qualitative design was used to explore and describe the depth, richness and complexity inherent in the lived experiences of the family members caring for the mental health care users who were admitted for 72-hours assessment.

The phenomenological approach was used to study and describe the essence of the lived human experiences, and the preconceived ideas were put aside. The qualitative approach was used because little is known about the phenomena under study, since a 72-hour assessment service in mental health was recently introduced in South Africa by the New Mental Health Care Act No 17 of 2002. The research design is suitable for the current study. Furthermore, the study used qualitative design to gain a richer understanding of how the implementation of the 72-hour assessment is viewed by the family members. The researcher tried as much as possible to put aside preconceived ideas.

2.2.2 Exploratory research

Exploratory research design typically occurs when a researcher examines a new interest topic or when the subject of study itself is relatively new and unstudied (Babbie & Mouton, 2010). It is mostly conducted when little information is available about the phenomenon and gives the researcher a

chance to explore more. The 72-hour assessment is a new mental health care service in the market of psychiatry, hence the study was intended to explore the family members' experiences regarding the assessment and observation of mental health care users admitted in a ward designated to render the assessment of MHCUs for the duration of 72 hours.

The researcher explored the experiences of family members of the mental health care health care users admitted for 72-hours assessment, and gained new understanding and discovered new ideas to the phenomenon that was investigated.

2.2.3 Descriptive research

Descriptive research design is crafted to gain more information about characteristics within a particular field of study. The purpose of the descriptive study was to provide a picture of the situation as it naturally happens. It is used to develop theory, identify problems with the current practice, make judgement, or determine what others in similar situations are doing (Burns & Grove, 2012; Polit & Beck, 2012).

In this study, the researcher selected the exploratory method to gain new insight, discover new ideas and increase knowledge about the experiences of family members regarding the 72-hour assessment of MHCUs who are admitted at selected hospitals. The researcher gave the family members of the mental health care users admitted for the 72-hour assessment an opportunity to describe in full, without any limit, their experiences with regards to the admission of their relative for 72 hours. The participants were interviewed in the Tshivenda language which enabled them to share their lived experiences freely.

2.2.4 Contextual design

De Vos *et al*, (2011), and Creswell, (2014) describe contextual design as an ideograph research, in that it is uniquely descriptive within the context of the individual setting. This study is contextual because the researcher tries try as far as possible to study the people in their own natural setting in order to understand the dynamics of human meaning as fully as possible. Qualitative researchers collect data in the field at the site where participants experience the issue or problem under study. The researchers do not bring individuals into the laboratory nor do they typically send an instrument for individuals to complete.

This study is contextual in nature because the researcher focused only the family members of the mental health care users who were admitted for 72-hours assessment, and left out those family members of the mental health care user who were not admitted for 72-hour assessment admission. Secondly, the study was contextual since the interviews were conducted at the homes of the family members.

2.3 RESEARCH SETTING

A research setting is the physical location and condition in which data collection will take place (Burns & Grove, 2012). The study was conducted at the two selected general hospitals in the Vhembe District in the Limpopo Province in South Africa. Vhembe is located in the Northern part of the Limpopo Province and shares borders with the Capricorn and Mopani District Municipalities in the eastern, and western direction respectively. The sharing of borders extends to Zimbabwe and Botswana in the North West and Mozambique in the South East through the Kruger National Park. The Limpopo River forms the border between the Vhembe district and its international neighbours.

It includes areas that were previously under the Venda and Gazankula Bantustans' administration and the Transvaal. It consists of four local municipalities, namely Musina, Mutale, Thulamela and Makhado. The Vhembe District has 8 hospitals: Tshilidzini, which is a regional hospital, Donald Fraser, Elim, Messina, Louis Trichardt, Siloam and Malamulele, which are community hospitals, and Hayani, which is a specialised mental hospital. The five general hospitals refer their patients to Tshilidzini hospital, which is a regional hospital for the Vhembe District. The two hospitals selected for the study are Tshilidzini and Donald Fraser Hospitals.

This study was conducted at Tshilidzini hospital which is a public general institution in the Vhembe District in the Limpopo Province that provides comprehensive health care services. The hospital is situated along the R524 Punda Maria Road, about 10km from the Thohoyandou Shopping Centre. It has 538 inpatient beds, 45 medical practitioners and 647 nurses. The psychiatric unit of Tshilidzini is designated as a 72-hour assessment and observation unit. The 72-hour assessment is conducted in two cubicles in the male and female medical wards, with 8 usable beds for males, and 4 beds for females. The unit provides in-patient, out-patient and consultation services. The 72-hour assessment unit started to operate in January 2011. An average of 64 mental health care users are admitted per month in the unit. The study took place in a natural setting which was not manipulated by the researcher.

Donald Fraser hospital is situated between the Vhufuli and Tshitereke villages in the Vhembe District, of the Limpopo Province. It is a general community hospital which has 266 usable beds and 349 approved beds. The hospital has 11 wards, including a mental health care acute ward. The map in Figure 3.2 portrays the four municipalities.

Vhembe District Municipality Map

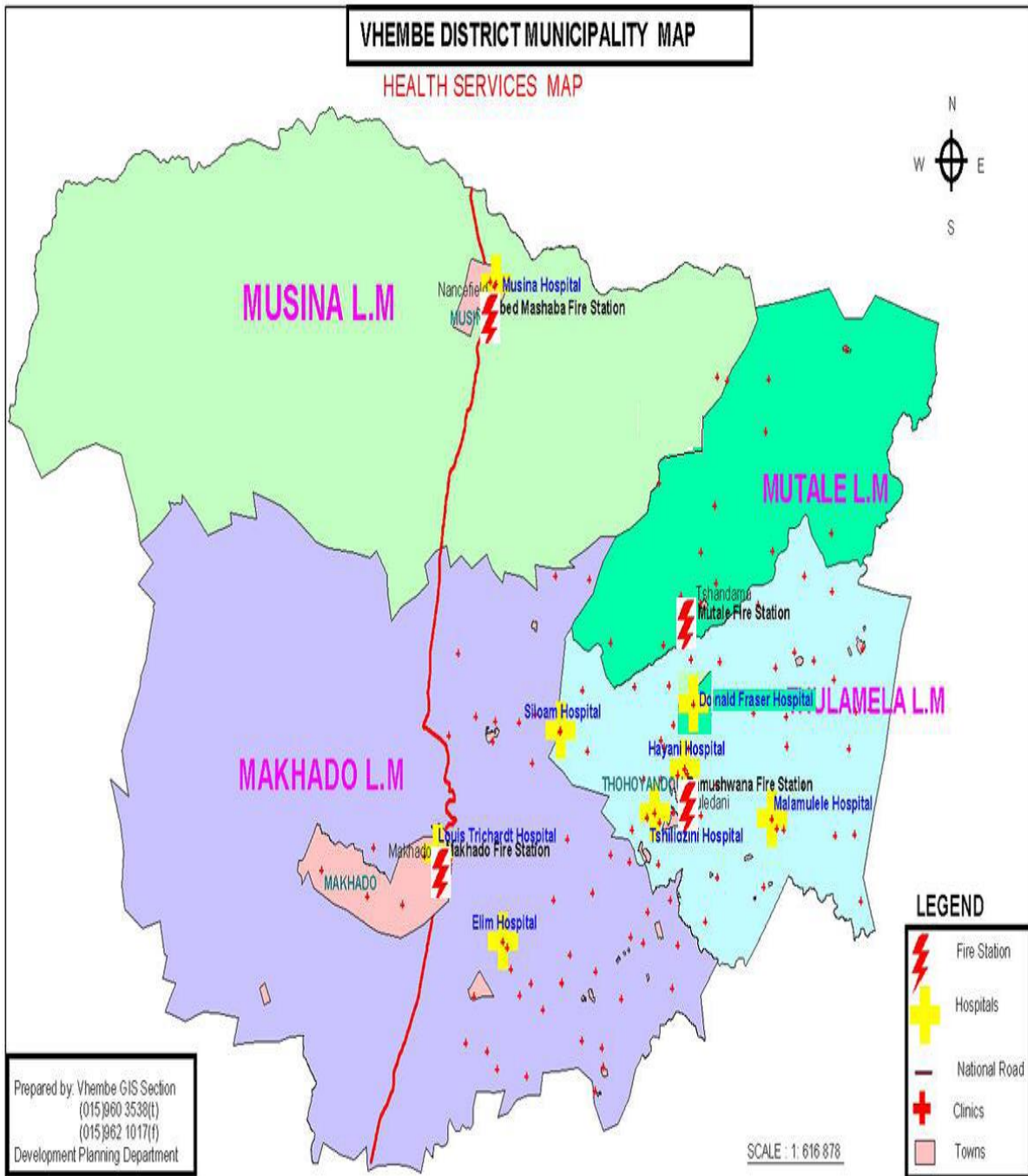


Figure 3.1: The district hospitals of Vhembe Municipality

2.4 POPULATION AND SAMPLING

2.4.1 Population

A population is the entire group of persons or objects that are of interest to the researcher. In other words, all of the group that meets the criteria which the researcher is interested in studying (de Vos *et al*, 2011; Brink, 2012). The population in this study were all the family members of the mental health care users that are admitted in the medical ward of the public hospital designated to provide 72-hour assessment in the Vhembe District in the Limpopo province. The family members of the patients were chosen because they are caring for a relative who had been admitted for the 72h-hour assessment. The family members were chosen to participate in the study because they are knowledgeable about the phenomena under study.

2.4.2 Sampling method

Sampling involves selecting a group of people, events, behaviours, or other elements with which to conduct a study (Burns & Grove, 2012). Brink, (2012) also defined sampling as the researcher's process of selecting the sample from a population in order to obtain information regarding phenomena in a way that represents the population of interest.

In this study, non-probability purposive sampling was used. The purposive sampling method is based on judgement of the researcher regarding subjects or objects that are relevant or representative of the topic being studied, or who have knowledge about the study topic. Family members of mental health care users who speaks Tshivenda who were found on the admission and visitors book were listed, and were sampled to become participants of the study.

Sampling occurred in two stages namely; sampling of the hospital and sampling of the participant.

2.4.3 Sampling of the hospitals

Two hospitals in the Vhembe district were purposefully selected for the study; these were the Tshilidzini and Donald Fraser hospitals. Both institutions admit mental health care users who are Venda speaking in large numbers. The reason for selecting these institutions is that both the hospitals are situated in the Vhembe District and are general hospitals with an observation room in a medical ward designated to conduct a 72-hour assessment.

2.4.5 Sampling the participants

A sample is part or a fraction of a whole, or subset of a larger set, selected by the researcher to participate in the study. A sample consists of selected group of elements or units from a defined population (Brink, 2012; Burns & Grove, 2012). The sample of the study was selected using non-probability sampling techniques, purposive sampling. All Venda speaking family members of the mental health care users who are admitted at the medical ward designated to render 72-hour assessment admission of the mental health care users were purposively sampled.

A convenient sampling refers to a situation where population elements are selected based on the fact that they are easily and conveniently available. Family members of mental health care users admitted in general wards at Tshilidzini and Donald Fraser hospitals designated to render a 72-hour assessment were purposefully and conveniently selected. In this study, only one family member who was readily available in the hospital during visiting times, was recruited to participate in the study. The selected hospitals have

three visiting times in a day which was targeted by the researcher for recruitment of participants. The researcher used the admission books and visitors book of the medical ward wherein the names and the contact number of the family members appeared. Those with incomplete contact numbers were not sampled.

The contact numbers of family members who were interested in participating in the study was kept for the purpose of making an appointment. Some family members were recruited in the ward as they were coming to visit their mental health care users. Those with mobile phone numbers were recruited telephonically to establish rapport with the family members which form part of initiating prolonged engagement. Other family members were recruited personally during the time they were visiting their relatives. The sample size consisted of 10 members, and were interviewed until data saturation occurred.

2.4.6 Sample size

The question of sample size is an equally important decision to sampling strategy in data collection process. One of guideline in qualitative research is not to study few site or individuals, but also to go deeper into the extensive detail of each site or individuals. The intent in qualitative research is not to generalize the information, but to elucidate the particular, the specific (Creswell, 2014).

In qualitative research the researcher does not know in advance exactly how many participants are required. Data is collected until saturation occurs, when no new information is obtained (Brink, 2012). The researcher sampled 20 family members of the mental health care users admitted at the selected

hospitals, 10 from each of the selected hospital. However only 10 family members were interviewed until data saturation occurred.

2.4.7 Inclusion criteria

The inclusion criteria specify the characteristic of the population that the researcher wants (Polit & Beck, 2012). In this study, the researcher selected only those participants who met certain specific criteria which are as follows:

- Family members of mental health care users admitted for the 72-hour assessment and observation.
- Family members who speak Venda
- Family members who are 18 years and older

2.5 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions, or hypothesis of the study (Burns & Grove, 2012). In this study, data collection involved preparation of data collection instrument, pre-testing the instrument and the role of the researcher. These are discussed as follows:

2.5.1 Preparation

Permission was sought from the University Higher Degree, the Department of Health in the Limpopo Province, the Vhembe district and selected hospitals of the district. The researcher the participants were contacted telephonically to

remind them about the interviews several times before the day of the actual interview. A plan was drawn up which included the following: reading of a departure question many a times to consider whether they might be confusing, leading or problematic in any way for the interviewee, preparation of the data recording system, practice on how to operate the recording device. A note book was prepared for writing biographical data. The participants were informed that they can make a call back message instead of them contacting the researcher using their own airtime, so that they are not inconvenienced by an additional expense.

Pretesting was done with the family members of the mental health care users admitted for 72-hours assessment and observation, who speak Venda and who are 18 years and older. The departure question appeared to be confusing to the participants, for example, after the researcher had posed the question, the participant asked another question instead of answering. This indicated that the question was problematic. For example, instead of saying '72 hours', the question could have said 'three days' admission'. At first the interview was not recorded due to technical problems. With repeated practice the researcher managed to operate the device with ease. Three recording devices were prepared for safety reasons, namely a voice recorder and two mobile cell phones. Data collected during pretesting was transcribed verbatim.

The researcher made an appointment with the caregivers telephonically before the interviews, visited the homes of the participants and clearly explained to them that they are the relevant sources of data for the study that is being conducted and that their participation in this study will give them an opportunity to share their experiences the admission of the mental health care users. The family members were given information according to the participant information sheet (see Annexure G). In the case of the participant who cannot read the information sheet, the researcher read it to them. The participants were given the consent form to sign after they were given an

opportunity to clarify the content of the consent form (see Annexure H) that they could read and sign before they could be interviewed. The researcher then made the appointment with the family members who gave consent to participate in the study for days and times that were convenient to them.

Family members were informed that their participation in the study is voluntary, there would be no payments for participation in the study. The researcher also informed the caregivers that they are allowed to withdraw their participation from the study at any stage, and that they would not be questioned about their reasons in doing so. All the family members were informed that the interviews would be recorded, participants were shown how to operate the voice recorder. It was also explained to them that if there is something they would like to talk about which they feel should not be recorded, they can stop the voice recorder until they wish to continue with the recordings.

2.5.2 Conducting the interviews

Data collection dates were arranged with the participant well in advance according to the participant's preference. Interviews with the participants from the selected hospitals were conducted in the homes. The researcher conducted the semi-structured interviews.

The researcher reoriented the participants to the purpose of the study before the commencement of the interview, as they had received the information sheet in advance, during the time of the first contact. The participants were given an opportunity to get clarification on issues which they are not sure of. Thereafter, the participants signed the information consent form (Annexure G). The researcher asked the participant to use the voice recorder during the interview, so that the interview can be recorded to save information. All the participant agreed to be recorded. During the interview the participant and the researcher had a chance to perceive, interact, reflect the observation, and

attach meaning to the lived experiences. The researcher tried to manage the data collection process by being aware of how much time was left, what was left out, and how to proceed with the interview so that the conversation was free flowing.

Each interview lasted between 30 and 45 minutes. Data saturation for this study was reached after ten (10) participant were interviewed. Data saturation occurs when no new emerging themes from participants (Cresswell, 2014).

2.5.3 Presentation of self

The researcher was dressed in smart casual clothes to look presentable, and did not wear a nurse's uniform to provide privacy for the participant with a natural hairstyle. The researcher did not wear make up to make myself simple. The issue of body language was taken into consideration as the researcher is a mental health nurse. The communication process involves verbal and non-verbal cues, which is used on daily basis.

The researcher arrived at the home setting of the participant on time so that the participant did not have to wait. The recording equipment was set up and checked, and the voice recorder and the cellphones were quickly checked to see if they are in good working condition while establishing rapport. The researcher established rapport which included an introduction, handshake, small talk for ice breaking, for example weather issues and expression of appreciation. An introduction to the study was given, which included the purpose of the study, the objectives and benefits for the participant, and information that the interview will last for 30 to 45 minutes. The participants were also assured as to confidentiality, the right to decline to answer any questions, and the right to end the interview upon request.

2.5.4 The questioning process

The researcher planned what to say and how to say it in a manner that would put the participant at ease by asking the right questions, prompting and probing appropriately, keeping it moving, and finally providing a summary by highlighting the important aspect discussed. The researcher avoided use sensitive questions in the beginning which might appear to be threatening. Open-ended questions were mostly asked which helped me to dig more below the surface, for example “tell me more, can you elaborate further”. The departure question was asked first to open up the interview.

2.5.5 Data collection instrument

The researcher conducted one-on-one in-depth semi-structured interviews with the family members as participants. Semi-structured interviews are neither fully fixed nor fully free, and are perhaps best seen as flexible. Interviews generally start with some scheduled questions, but pursue a more conversational style of interview that may see questions answered in an order more natural to the flow of the conversation. They may start with a few defined questions, but be ready to pursue any interesting topic that may develop. This was one-on-one talk between the researcher and the participants.

One-on-one semi-structured interviews were employed because the method gives the researcher and the participant more flexibility, and participants are able to give the full picture of the phenomenon. Family members of the mental health care users were interviewed using this method, as they were found at home. Only one family member who gave a verbal or written consent was interviewed, other family members who happened to be found at homes were not entertained, even when they seemed to be interested. The interviews were free-flowing with the structure limited to the focus of the research. The participants narrated their lived experiences regarding 72-hour assessment.

The interviews were conducted in Tshivenda, since the researcher is a Venda speaking person, which gave the family members an opportunity to narrate their experiences regarding the admission of the mental health care user in a 72-hour assessment unit without any limitation. The interviews were conducted at the homes of the family members who gave informed consent. A private room was prepared by the participants free from distractors. Each interview lasted 30 to 45 minutes. The interviews were directed by the following open-ended question as a point of departure, which was constructed with the promoters.

“What are your experiences regarding the 72-hour assessment admission of a mental health care user”

The departure question was followed by probing, which made it possible to get a better understanding of the family member’s experience regarding the 72-hour assessment. An audiotape was used as explained above, and data was later transcribed verbatim for analysis purposes. The researcher attempted to gracefully withdraw from the setting and most of the personal relationship that was established. The participants were informed about withdrawal of the researcher from the field to prevent separation anxiety that can result after a prolonged engagement. They were made aware of the follow-up visit. Contact numbers were given to the participants. The interviewees were thanked for their time and honouring the appointment.

2.5.6 Pre-testing

Pretesting is about verifying the ability of the research instrument to collect data and ensuring that the instruction of the instrument is clear Brink (2016). Prior to the actual data collection process, the researcher selected three family members from the Tshilidzini and Donald Fraser hospitals, and conducted an interview to check if the way the question was structured will be understood. The researcher realised after interviewing the first participant that the question was not so clear to the family members, because the responses of

the family members of were not relevant to the questions asked. The researcher then consulted with the research supervisors and phrased the question in a different way, and then interviewed the participant using the same question but phrased in a simpler way. The researcher then interviewed the other remaining family members, after that the improvements could be seen, then continued with the interviews. Data that was collected during pre-testing was not included in the findings of the study.

2.5.7 The role of the researcher

As the researcher, I was the main research instrument for data collection and carefully observed, interviewed recorded, analysed, and interpreted as faithfully as possible what participants said and showed through body language. The researcher commenced the interview session by establishment of rapport and trust where an attitude of unconditional acceptance was displayed, respect, empathy honesty, openness and modesty.

The researcher has a responsibility to fit into the ideal situation of the participant. This was achieved by the researcher's attempts to dress in smart-casual attire, instead of wearing a nurse's uniform which might imply a superior position. The researcher's presence should neither affect the participant's perception of the question nor the answer given. The researcher conducted herself as a neutral medium through which questions and answers are transmitted. The rationale of the idea was to allow the participants to talk freely, which resulted in a rich data.

As a researcher, had a major role in the recruitment of the participants and confirmation of the dates and time of conducting an interview. Information was given both verbally and in writing to the participants who met the criteria

before an informed consent was signed. The researcher was engaged in a one-on-one relationship during the interview sessions. The researcher as a data collection instrument used herself therapeutically in order to get detailed data regarding the lived experiences of the family members regarding the 72-hours assessment admission of a mental health care user. Data indicates that the family members were dissatisfied with the ward environment which was perceived to be too small. They said the ward does not allow free movement which indicates that the ward is not good to promote healing. Furthermore, the ward was said to be disorganized because the ward and inadequate to meet the demands.

Effective communication skills were applied described by Perko and Kreigh, (1988) as follows:

- **Listening:** The researcher applies her listening skills, paying attention throughout the interview process and study.
- **Probing:** Probing questions are asked, emanating from the participant's answers, to allow participants to give more clarity. The purpose of probing is to deepen the response to a question, to increase the richness of information being obtained during data collection. It is a technique to encourage the participant to give narrate more experiences about the phenomenon being studied.
- **Minimal verbal responding:** Minimal verbal responding by nodding the head, saying "mm", "Yes", "continue" to allow free flow of information and to encourage participants to talk. This makes participants feel more relaxed and more willing to talk about their experiences.

- **Clarifying:** The researcher seeks clarification on statements that they do not understand in order to avoid assumptions.
- **Reflecting:** The researcher reflects by repeating the statement as mentioned by the participant in a question form in order for the participant to expand more on the specified points. She reflects back to the participant in her own words to understand what is being said when the need arises.
- **Focusing:** The researcher gives participants full attention as they are deliberating about their own experiences in order to help them focus. This is demonstrated by the seating arrangement, where the researcher ensures that, where the interview is conducted, chairs are the same, with no table between the researcher and the participant. The researcher maintains a non-threatening environment throughout the interview to enable participants to relate their stories without fear. All interviews are conducted at the time that is convenient to participants. The interviews are conducted in a private, comfortable place, accessible to the participants in their consulting rooms, as agreed. The researcher is respectful towards the participants; all these keep participants focused on the interview.
- **Paraphrasing:** The researcher rephrases the participant's words in another form, but with the same meaning. This encourages the participant to give more information. Furthermore, she paraphrases the responses from the participants before asking the next question.
- **Validating:** The researcher the participants, and interprets their non-verbal communications, such as vocalization, facial expression and body gestures and transcribes them for analysis. In this study, all non-

verbal communication collected during interviews as field notes were transcribed and analysed to give collected data more meaning.

- **Using Silence:** The researcher uses silence by keeping quiet and all the deliberations to allow the participants to think and continue to talk at their own pace without interference. The researcher maintains eye contact, remaining silent; demonstrating to participants that she is there listening to them. The researcher listens actively and attentively to what the participants are saying both verbally and non-verbally. This involves perceiving another person's body movement, facial expressions and quality and tone of voice.
- **Establishing a trust relationship:** The researcher immerses herself in the participant's lifeworld in order to better understand their experiences regarding available support to re-integrate state patients. Mutual trust is ensured to gain cooperation of the interviewee, and also improve the quality of collected data. The researcher responds in a manner that shows that the interviewees are worthy of their disclosure and does not condemn or oppose the interviewees. Pleasant interpersonal relationships are maintained throughout the interviews.

2.6 DATA ANALYSIS

Data analysis is the organization of information in ways that give meaning and facilitate insight to examine a phenomenon from a variety of angles in order to understand more clearly as to what is being described by Creswell, (2014). Data collection and data analysis in qualitative research occurs simultaneously. Individual verbatim responses were transcribed from tape-recordings, and those done in Tshivenda were translated into English. Each

transcription was analysed separately and together with the supervisors for the discussion and final layout of the themes, categories and subcategories.

In this study, data was analysed using Tech's method of open coding. According to Tesch, (in Creswell, 2014) there are steps to consider when analysing data, which are described as follows:

Step one: Get a sense of the whole: The researcher plays the voice recorder listening to the interview several times to make sure that no information is missed. The researcher then transcribes the interviews. The researcher reads through all the transcripts carefully, to get a sense of the whole several times, to acquaint the researcher with data collected and jotting down some ideas which come to mind

Step two: The researcher picks the most interesting document and reads it though again, attempting to make sense of the document. The researcher makes notes of her thoughts and writes these down.

Step three: When the researcher has completed the task for several participants, a list is made for all the topics. Similar topics are clustered together to form columns. From these topics into columns, columns are arrayed as major topics, unique topics and leftovers, different colour pens are used to simplify the task.

Step four: The researcher goes back to the data and abbreviates the topics as codes and writes a code next to the appropriate segments of the text. Thereafter, the researcher tries to preliminary organise a scheme to see if new categories and codes emerge.

Step five: The researcher tries to find the most descriptive wording for the topics and turns them into categories or themes and sub-themes. The researcher tries to reduce the total list of categories by grouping topics that relate to each other and draws lines between the categories to show interrelationships.

Step six: A final decision is made on the abbreviation for each category and codes, and they are arranged alphabetically. This is done after going through the codes for several times, making sure that all codes are noted.

Step seven: Data material belonging to each other are assembled and a preliminary analysis is done. These make it easier for the researcher to come up with the themes and sub-themes, based on the grouping list.

Step eight: The researcher records existing data to ensure that no data missing.

2.7 LITERATURE CONTROL

After data analysis, experiences of family members regarding the 72-hour assessment admission of mental health care users was recorded. After all participants had been interviewed, books, scientific journals, dissertations, thesis and other documents were examined, as they contain the most recent information on the subjects. A computerized database like the internet was consulted. Information from these sources serves to enrich the research knowledge. Full details of the literature control will be will be discussed in chapter three.

2.8 MEASURES TO ENSURE TRUSTWORTHINESS.

To ensure trustworthiness of data the four criteria for developing trustworthiness suggested by Lincoln and Guba's model in de Vos *et al*, (2011) was followed; focusing on credibility; conformability, transferability and authenticity.

2.8.1 Credibility (Truth value)

Credibility is defined as truth-value which, will be obtained from discovery of human experiences as they are lived and perceived by the participants (Lincoln & Guba, 1985). In this study, credibility was achieved by ensuring that population is accurately identified and especially knowledgeable about the phenomenon being studied. Data was transcribed as the direct quotation from the participants. Furthermore, credibility was ensured through prolonged engagement, persisted observation and member checking.

- **Prolonged engagement**

In this study, prolonged engagement and persistent observation with participants allowed for deification of recurring patterns, themes, and values for the validation of perspectives. The researcher met the participants while preparing for the interviews in order to build trust. The researcher also met family members at home to present to them the interview transcript and the interpretation derived from the interview, in order to confirm the accuracy and credibility of the findings. The participants were interviewed to the point of saturation of data.

- **Member checking**

Member checking means that the researcher provides feedback to the study participants about emerging interpretations and obtains their realities (Polit

& Beck, 2012). In this study, member checking was done throughout the interview by deliberate probing. The preliminary findings of the researcher were discussed with the participants. After data analysis had been analysed, the researcher went back to the participants for final member checking to determine if what was transcribed was what they meant.

2.8.2 Transferability

Due to the uniqueness of human beings and their context, generalization is usually not possible. Lincoln and Guba, (1985) suggest that the term ‘transferability’ would be a more appropriate perspective as the criterion against which the applicability of qualitative data is assessed. In this study, transferability was ensured by densely describing the background information of the participants. The research context and setting was also described, so as to allow others to assess how transferable the findings are. The purposive sampling technique was used to select participant who fit the criteria described. The research design, setting of the study, target population, sampling procedure and findings of the study were documented so that it would be possible for another person to make a comparison if there is a need. A nominated sample will be fully described to allow adequate comparison with others samples.

2.8.3 Dependability (consistency)

Dependability relates to consistency and the replication of the degree to which data can change overtime and alteration made in the researcher’s decisions during the data analysis process Lincoln and Guba (in Krefting, 1991). The audio-taped information taken during interviews and raw data was kept transcript and reports for a dependability were audited. This documents are open to scrutiny by the supervisors and external reviewers (Polit & Beck, 2012).

Experts were used to validate the methodological process. Discussions with the promoters throughout the study were done to ensure dependability. After a certain period, data coded was checked again for accuracy against the recorded taped information

2.8.4 Confirmability (Neutrality)

Krefting, (1991) states that conformability refers to the degree to which the findings are a function solely of the participants and conditions of the research, and not of other biases, motivations and perspectives. The information which was recorded during the interviews was transcribed without making any changes. The researcher did not influence the responses of the family members. In the study, tape recordings were kept to enable conduction of an adequate trail and to determine if the conclusion, interpretation and recommendation can be traced to the sources.

In this study, conformability was ensured by playing back the tape-recorded interviews to participants to check if what they had said is what they meant. Furthermore, a researcher tried to be non-judgemental by avoiding making use of the word “Why” in the interview.

2.9 ETHICAL CONSIDERATIONS

According to Burns and Grove, (2012,) ethics refers to a branch of philosophy that deals with morality. It contains a set of propositions for the intellectual

analysis of morality and a means of striving for rational ends. Therefore, in research ethics ensures that the rights of participants are observed, protected and respected. In this study the researcher ensured that the following are observed.

2.9.1 Permission to conduct the study

The researcher requested Permission to conduct this study was requested from the following:

- The University of Venda Research Ethics Committee. A proposal was presented to the Higher Degree's Committee of the school of Health Sciences. An ethical clearance certificate and permission to conduct the study was given by the University of Venda through the Higher Degree's committee (see Annexure A)
- The Limpopo Province Department of Health Research Ethics committee (see Annexure B)
- The Vhembe District Department of Health (see Annexure C)
- The Chief Executive officers of Hospitals (see Annexure D and E)
- Participants' consent (see Annexure H)

- **Coercion**

According to Burns and Grove, (2012) a subject's right to self-determination can be violated through the use of coercion, covert data collection, and deception. Coercion occurs when, one person intentionally presents another with an overt threat of harm or the lure of excessive rewards to obtain their compliance. Some subjects are coerced to participate in research because they fear that they will suffer harm or discomfort if they do not participate. Information regarding the purpose and the objectives was explained and the method of data collection was clearly described. In this study, before data collection, the researcher provided all participants with consent letters, which

each one of them read, and opportunity was given to the participants who sought clarity. If they understood the content of the letter, they signed the consent form to indicate their interest to participate in the study.

Obtaining informed consent implied that all possible or adequate information on the goals of the investigation, the procedures followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well the credibility of the researcher, was rendered to potential subjects (De Vos *et al*, 2011; Burns & Grove, 2012). Information as to the aim and purpose of the study was explained, including information on how data will be collected and used. Written consent was sought from the participants.

In this study, the information letters and consent forms were given to the participants, emphasizing the voluntary nature of participation and the absence of punishment if they decided to withdraw from the project prior to completion. In addition to being provided with the name and contact information of a neutral third party to contact, should they feel coerced at any time during the process. Permission to use an audio tape recorder was obtained from the participants.

2.9.2 Right to privacy

Privacy is an individual's right to determine the time, extent, and general circumstances under which personal information will be shared with, or withheld from others. This information consists of one's attitude, beliefs, behaviours, opinions and records (Burns & Grove, 2012).

Participants were assured of protection from loss of dignity, friendships embarrassment, or shame, as described by Burns and Grove (2012). Questions were phrased in a polite manner and were not humiliating. Participant's names were not disclosed in the research report. Participants were made aware of the use of an audiotape during discussions. The participants were also shown the stop button on the audiotape so that they could press the button if they felt the information that they wanted to disclose should not be recorded. Real names of the participants were not used; instead codes were used to ensure privacy.

2.9.3 Confidentiality and anonymity

Confidentiality is the researcher's management of private information shared by a subject that it must not be shared with others people without the authorization of the subjects. In this study, confidentiality was ensured by limiting access to the data to persons directly responsible for the research, as claimed by Burns and Grove, (2012). The participant's names were not used during data gathering. The researcher ensured confidentiality throughout the study. The researcher also provided confidentiality from self and participants were humbly requested to adhere to confidentiality. Information which was provided by the family members during the interview was kept in a safe place, where other people who were not part of the study could not access it.

Anonymity prohibits the researcher from making available any information which can lead to the identification of the research participant (De Vos *et al*, 2011). The real names of the family members were not used during the study; instead, the researcher coded the participants, in order to prevent linking them with the data. Finally, anonymity was ensured by assigning codes to the research participants when analysing and reporting the findings.

2.9.4 Protection from discomfort and harm

The comfort of participants was ensured through selection of a suitable venue and making use of the convenient time for both myself as the researcher, and the participants. Streubert and Carpenter, (2011) explain that the principle of beneficence is rooted in the premise that any participant has the right to be protected from emotional and physical harm. The researcher built a relationship with the participants prior to data collection to ensure that they felt free to participate in the study, which, in turn, lead to a detailed data. The researcher avoided asking questions which could cause psychological and emotional harm to the participants. The researcher also ensured that family members did not spend their money on something they will not gain from; the family members were followed up at their homes.

2.10 SUMMARY

This chapter outlined the research methodology, data collection and analysis methods as well as the ethical considerations observed during the time the study was conducted. Chapter 4 will give detailed information of the results of the study. The discussion of the findings will be followed by the recommendations based on the findings of the study.

CHAPTER THREE

DISCUSSION OF THE RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter presents a detailed discussion of the findings and analysis of the data. It also presents the information of the participants who were part of the study. The chapter discusses the identified themes, categories and subcategories with the meanings as said by the participants. A literature control will be used in the discussion of the findings to aid in the contextualization of the study.

3.2. SAMPLE DESCRIPTION

The study sample consisted of family members of the mental health care users who are admitted for 72-hour assessment in the medical ward of the selected hospitals. Ten family members were interviewed; all were the females. The ages of the participants ranges from thirty-six years to fifty-nine years. Their relationships with the mental health care users were as follows: two of the participants were sisters of the mental health care user, while one was a sister-in-law, one of the participants was a cousin, and six participants were the mothers of the mental health care users. Two of the participants were working, while two were retired employees of the government, one was self-employed, and the other five the participants were not employed.

3.3 DISCUSSION OF FINDINGS

A qualitative study was conducted, and data was obtained through in-depth individual semi-structured interviews. The interviews were conducted at the homes of the participants in a private room to ensure minimum interruptions.

The information was recorded using a voice recorder and transcribed verbatim. To ensure anonymity and confidentiality of the participants, pseudonyms were used instead of real names. Individual verbatim responses were transcribed from the tape recordings, and then translated from Tshivenda into English. Each transcript was analyzed separately. One broad question was asked to all participants, and was followed by probing questions.

Data was analysed using eight steps of qualitative data analysis outlined by Cresswell, (2014). Three themes were identified from the analysed data, namely: poor infrastructure, negative experiences and family members' experiences of coping mechanisms.

3.3.1 Theme 1: Negative experiences of the family members

Table 3.2 indicates the theme, category and subcategory of negative experiences of the family experiences.

Table 3.1 Theme 1: Negative experiences of the family members

THEME	CATEGORY	SUBCATEGORY
1. Negative experiences of family members	Lack of knowledge	<ul style="list-style-type: none"> • Not having information about this ward. • Patients are mixed • Act as a receiving ward
	Lack of family involvement	<ul style="list-style-type: none"> • No contact with the doctor • Not informed when patient was transferred and discharged
	Financial difficulties	<ul style="list-style-type: none"> • Do not have money for transport
	Procedure of admission lengthy	<ul style="list-style-type: none"> • Asked same questions • Waiting for the doctor • Forms taking time
	Premature discharge	<ul style="list-style-type: none"> • Discharged today same day he is back • Readmitted shortly after being discharged

DISCUSSION

THEME 1: NEGATIVE EXPERIENCES OF FAMILY MEMBERS

During the interviews the participants indicated that they experienced negative feelings related to the 72-hour assessment admission of their relative. The following are the categories identified from the theme:

- Lack of knowledge
- Lack of family involvement
- Financial difficulties
- Procedure of admission lengthy
- Premature discharge

Lack of knowledge

During the interview sessions, most participants highlighted that they lack knowledge about the way the 72-hour assessment works and the context where the assessment is conducted. Three subcategory emerged from this category which are the following:

- Not having information about this ward
- Patients are mixed
- Were offered a temporal accommodation.

Not having information about the ward

Data analysed showed that the participants had different understanding of the 72-hour assessment unit. The meaning and the purpose of the 72-hour assessment of varies. Some participants showed

that the mental health providers did not explained well how the 72-hour assessment operates.

Another participant said: "... I was told that in this 72-hour assessment ward the mental health care user is admitted to make his mental condition to be better, to minimize the signs and symptoms of mental illness not stabilize him as such. Due to the fact that the acute psychiatric ward burnt down the patient are now admitted in the medical units. I noticed that this ward which provides a three days services is not good comparing it with the psychiatric ward. In this single room where you can get forty patient admitted..." P6 sister- in- law to the MHCU.

Another participant said "...The nurses explained that they had moved to the medical ward because the old psychiatric ward burnt down, as a result they were temporarily offered accommodation here. They further indicated the number of days the patient can be hospitalized." P5 sister to the MHCU.

Participant further said: *"It was not explained well, the purpose of the ward, anyhow they said the 72-hour assessment unit is being used because they do not have place to keep the mentally ill individuals because they are lacking space they can only accommodate my brother for three days thereafter the patient can be transferred to Siloam Hospital. At times the patient is admitted for more than three days, for a longer period in case they did not admit many users during that period".P5 sister to the MHCU.*

The findings of the study support the findings of Chorwe-Sungani, Namelo, Chiona and Nyirongo, (2015), who indicate that the family members need adequate information about mental illness, treatment, discharge and symptoms of relapse and being given hope about recovery so that they can fully participate in the care. They feel dissatisfied with nursing care of their mentally ill relative when they perceive that there is lack of information and

support from nurses. It can be relevant to say that nurses must continuously provide relevant information and support from nurses. Families need supportive interaction with nurses to manage their care giving burden, and care for their sick relative.

One of the responsibilities of the nurses in the clinical environment is to give information to the family members of the sick individual. The nurses teach the patients and the relatives about rights, treatment plan implemented to the MHCUs. Family members have the right to be informed about the service that is offered to them. Empowering the family members with knowledge and skill may assist the family members to manage the mentally ill effectively in the community setting (Uys and Middleton, 2010; Kneisl & Trigoboff, 2014).

In the hospital setting nurses are generally the only members of the multi-disciplinary team who spent more time with the mental health care users on a 24-hour basis (Townsend, 2012). The nurse is responsible to provide basic nursing care including giving health education to the mental health care users together with their family members. Information giving is crucial aspect in the participatory management of the patient in clinical setting. It relieves anxiety of both the caregivers and the users make them to feel in control of the situation.

Patients are mixed

Some participant mentioned that the ward is specifically meant to admit the mentally ill individuals, some failed to understand why the ward admits both physically and mentally ill person in one roof. The participants were emotionally affected when they see the bedridden patients who could help themselves compared to their mentally ill users who are not physically ill.

Another participant said “Sometimes when you visit your patient when you pass the first rooms of the ward you will find that there are other patients who are ill in their bodies, other have pass on, whereas other are being fed. Because some of us have a soft heart cannot tolerate seeing such patients who are seriously ill. Our users are not like that, you may not find them being asleep, are not like the others who are in the body ill who cannot even manage to themselves. The mentally ill patients can be able to sit and you can have a discussion with them.” P 4 mother to the MHCU.

One participant said “Another issue which you expressed as a concern you said at this hospital they are admitting the physically .ill patient who cannot do anything for themselves, those who cannot raise their head, others dancing and singing are mixed with those that are having mental problems” P2 mother to the MHCU.

Uys and Middleton, (2010) indicated that it is a well-known fact that mental illness is stigmatized by the community at large. Society regards people with mental illness as dangerous. They make people uncomfortable, act strange, and do not react to people in a predictable manner. This is part of the reason why many mentally ill person and their families are socially shunned, and why person with mental illness cannot find work, or housing, nor friends.

Consumers of mental health services complained about the stigma attached to mental illness and requested that something should be done to decrease the stigma. One of the measures is that they should be treated in general hospital, and not in separate mental hospitals. In the same way, they want to be able to go to the same primary health clinic that others people use, on the same days as others do, so that they do not stand out as different (Uys & Middleton, 2010). This may be presumed to have led to the development of 72- hour assessment which originated from Mental Health Care Act (MHCA) No. 17 of 2002.

Integration of mental health in general health setting entails that both the specialist mental health care nurse and generalist nurse will be expected to undertake roles for which have not been adequately trained, and hence they feel insecure. This may lead to loss of professional identity and job security. Further, despite the fact that one of the goals of integrating mental health care into PHC was to reduce stigma attached to mental illness, this laudable goal has not been achieved. It has been reported that, despite integration, nurses who are not psychiatrically trained opt to leave the task of attending to mentally ill patient entirely psychiatric nurses, who in turn fell stigmatized by other staff members South Africa Health Review, 2008).

Were offered a temporal accommodation

Data analysed from what the family members said indicated that few of the participants consider the 72-hour assessment to operate like a temporal mental health care facility, while waiting for further CTR at the mental health care units or hospital that provides a longer stay for the MHCUs. The ward was perceived to be like a holding place wherein the user will be awaiting for an empty bed at the health establishment that offers a more number of days which is mostly preferred.

Another participant said "...The nurses explained that they had moved to the medical ward because the old psychiatric ward burnt down, as a result they were temporarily offered accommodation here. They further indicated the number of days the patient can be hospitalized." P5 sister to the MHCU

Another participant said: *“My understanding of the observation ward is unit which act as a receiving mental health facility, which admits patients for a few days where the user can be discharge home if he is stable or transferred to another hospital for if the patient is not looking better. The ward is not organized; the space is too small not adequate to accommodate the mentally patients. Since the psychiatric ward burnt down it has been a long time the government should have built another ward...”*P8 sister to the MHCU.

The Mental Health Care Act NO.17 of 2002 makes provision for integration of mental health services into the general health environment. Section 34 of the act makes for provision of the involuntary and assisted mental health care user to first be admitted for 72 hours' observation at a local general hospital. The reason behind the assessment is to exclude medical causes for behavioural or psychiatric disturbances. Many MHCUs may especially those with acute trauma or substance abuse problems, can recover and be discharged within 72 hours or at least improve sufficiently to give consent for voluntary treatment. Increasing access to care and availability of local services thus reduces the need for premature or unnecessary transfers to psychiatric hospitals.

The study in Gauteng by Moosa and Jeenah, (2010) on the review of the application for involuntary admission also indicates that 72-hour assessment is conducted before involuntary CTR. Furthermore, treatment during 72-hour may result in an improvement in the capacity of the MHCU give consent for further treatment as a voluntary MHCU. The user who can show some improvements after three days of admission can be discharged home under the care of their family members to continue with CTR as an out-patient user.

- **Lack of family involvement**

Most of the participants indicated that they were not involved in the care of the patient during the time their loved ones were undergoing a 72-hour assessment and observation. The following were categories identified from the theme:

- No contact with the doctor
- Not informed when patient was transferred and discharged

No contact with doctor

Most of family members said they were excluded from participating in the care of their ill relative during the 72-hour assessment period. They said that they only met the medical doctor during admission of the MHCU. They were not invited to take part during ward rounds as responsible relatives. They lacked information about the transfer of the MHCU from one health establishment to another for further involuntary CTR. From what was described the participants they cited that they only met the doctor on admission of the mental health care user, and never had an opportunity to see the doctors who were treating their family member.

One participant said: *“No I never met the doctor in this ward ever since I started coming to this ward”*. P8 sister to the known user.

Another participant said *“Of course on admission we are informed that the patient will be transferred to another hospital if there is need, i.e. in case he does not get better within three days. The problem that we experience when the user is transferred to Siloam hospital is the distance which is inaccessible for us. Siloam hospital is too far we do not have money for transport.*

Furthermore, we are not informed when the patient is transferred to Siloam hospital...".P8 sister to the MHCU.

Similar findings were indicated by Eassom *et al*, (2014) who concluded that there is an abundance of both quantitative and qualitative studies into experiences of inpatient care reporting that families feel marginalised and distanced from the care planning process by the mental health care team. Common themes across international studies regarding family involvement in the care of hospitalised mental health care users indicate that families feel isolated, uninformed, lack a recognised role and are not listened to or taken seriously by the mental health care providers.

The findings of the study are similar to a study done in Malawi, by Chorwe-Sungani, Namelo, Chiona and Nyirongo, (2015), which provided valuable information about the views of families regarding nursing care of psychiatric patients. In their study, family members indicated that they are involved in the care of mentally patients who are admitted in the hospital although there is lack of effective cooperation between them and nurses. The lack of collaboration with nurses has made families receive inadequate information about the condition of their mentally ill relative. Therefore, it is imperative that family members get enough support from nurses and other health care professionals so that they can improve their caring skill.

Not informed when patient was transferred and discharged

They were not involved in the discharge planning or the transfer to another hospital. Furthermore, they were not given feedback about the investigations done on the patient. They were left outside the care of the patient. The patient was discharged without their knowledge while they are expected to take over

with the supervision of treatment programme after discharge from the hospital.

Another participant said: If the ward is full the patient is transferred to Siloam hospital, at times when the nurses are busy they forget to inform you about the transfer, you will learn about it when you visit the patient which is a problem to us". P5 sister to a MHCU.

Another participant said: "Of course on admission we are informed that the patient will be transferred to another hospital if there is need, i.e. in case he does not get better within three days. The problem that we experience when the user is transferred to Siloam hospital is the distance which is inaccessible for us. Siloam hospital is too far we do not have money for transport. Furthermore, we are not informed when the patient is transferred to Siloam hospital". P8 sister to a known user.

Uys and Middleton, (2010) further claim that service providers should promote the involvement of consumers in the process of decision-making in areas of service delivery, service planning and development, training and evaluation of service. Both patients and their families have a unique perspective on the care that is provided. They should be considered as partners of the health care professionals to improve health service delivery. Participatory management helps the consumers to feel that they own the service.

Another one said: "I was not informed about how the ward works but previously in the old psychiatric ward the nurses used to have a conversation with us during visiting times. They will be advising us on how we should manage the patient after discharge from the 72-hour assessment ward. Presently in this new ward they are not able to do that anymore. In the old ward, the nurses will sit down with us discussing issues like how he came to

the hospital as well as how do we see him now. We are able to explain that the patient is reserved he is not talkative. They must not keep him in the hospital because he is quiet that is to say even if he is quiet they need that it is his character”.P8 sister to a MHCU.

- **Financial difficulties**

Family members of the mental health care users who were admitted for assessment and observation of three days, were saddened and frustrated because the hospital where their loved ones was transferred to was not easily accessible. From the data analysed, only one subcategories were identified:

- **Do not have money for transport**

Analysed data showed that the all the family members of the mental health care users who were transferred to another hospital after the 72-hour assessment admission, indicated that they experienced financial constraints. The hospital is not accessible to the family members, and as such they are unable to visit the MHCU as expected.

Another participant said: “If the user is admitted at Tshilidzini it is easy to pay a relative a visit but Siloam is very far. It is difficult to visit the patient I ended up asking people who are working there to check on the brother. Another thing is that we do not have time to go there especially myself since I am at working”.P5 sister to a MHCU.

Another participant said: “Of course on admission we are informed that the patient will be transferred to another hospital if there is need, i.e. in case he does not get better within three days. The problem that we experience when

the patient is transferred to Siloam hospital is the distance which is inaccessible for us. Siloam hospital is too far we do not have money for transport. Furthermore, we are not informed when the patient is transferred to Siloam hospital". P8 sister to a MHCU.

The Mental Health Care Act No 17 of 2002 made provision for the 72-hour assessment admission of those individuals who may require such service. The Act further stipulates that the service should be nearer to the consumers, which means that the mental health service should be accessible to MHCU's and their families.

According to Burns, (2008), psychiatric services were also centralized in urban-based tertiary psychiatric institutions, far from the homes and communities of most patients. Mental illness in a rural village often meant transfer over great distances, and a lengthy stay far from home, family and a place of employment. During the apartheid era, there was little or no care in the community.

The above findings affirm the argument by Uys and Middleton, (2010), when they remarked that families looking after a family member with mental illness usually do this due emotional bonds between them, because they take it as their sole responsibility. They feel guilty and often just because they do not have a choice. Caregiving for a long period often leads to stress suffered by the so-called 'responsible relatives'. One of the sources of the burden for caring is financial hardships.

Most families of mentally ill patients report that caring for the ill member is not very important, largely underappreciated by the community at large, stigmatized and expensive life-long responsibility (Kneisl & Trigoboff, 2014). Similarly, a study conducted in Ghana by Masunga, (2016), revealed that

family members caring for the people with mental health problems experience financial constraints because most of them are not employed family members.

Analysed data showed that the all the family members of the mental health care users who were transferred to another hospital after the 72-hour assessment admission, indicated that they experienced financial constraints. The hospital is not accessible to the family members, and as such they are unable to visit the MHCU as expected.

- **Procedure of admission lengthy**

The results of the data analysis reveal that the participants experienced negative feelings on admission of the mental health care user, prior to commencement of the 72-hour assessment. The participant indicated that the process takes a long time. The following are the categories identified from the theme:

- Asked same questions
- Waiting for the doctor
- Forms taking time

Asked same questions

The majority of the participant with multiple admission expressed their concerned with regard to the information taken on admission. The participants felt frustrated since the process was time consuming yet they needed an emergency attention. Collateral history was experienced to be tiresome as they were asked same questions time and again. They felt that the old notes could be used in order to save their time.

Another participant said: *“The form also causes some delays of admission process, in that we are asked same questions every time for example, how many are you in your family? Is there any history of mental illness? It will good if this kind of information is kept in the file of the patient for future references”*. P8 sister to MHCU.

One of the participant responded: *“The forms were completed well only that the person who was supposed to sign the forms somehow who came late”*. P3 mother to the known user.

Assessment according to Townsend, (2012) is the process whereby the mental health care professionals interact with the patient, families, and the health care providers and collect the collateral information about the MHCU in order to diagnose the mental condition that the user is suffering from. Furthermore, to plan a comprehensive management of the MHCU during this 72-hour assessment.

The psychiatric examination consists of three parts: the psychiatric history, mental status examination and the patient’s physical condition. It is done during the initial contact with patient and family members. Family members who know the mental health care user better are the ones to be give the collateral information, for example, the parents can give more detailed about the mental health care users However there are other sources of information such as police friends, mental health personnel, neighbours and any other person can be a source of data (Kneisl & Trigoboff, 2014; Uys & Middleton, 2010).

Waiting for a doctor

The family members who took part in the study showed that they failed to get help in time when they had brought their loved ones in casualty department. The found that there was only one medical doctor who were overloaded with the long queues of the patient presenting with different conditions.

Another participant said: *“In causality you find that there is only one doctor who is attending all the patients there. It takes him a long time to see the patients...”* P8 sister to a MHCU.

One participant said: *“Sometimes there is an emergency situation whereby the doctors will rush to go and help the patient. We are expected to wait while the user is tied up. Mind you the patient can break the string used and run away, you holding him down is not an easy job, and it is very difficult I tell you!”*P8 sister to a MHCU.

One participant said *“...I will say it was not good because we waited for too long. At (name of the hospital) normally there is one doctor attending all patients. Another man who had brought his daughter who collapsed at school, stoop up and said he will take some steps or take his daughter to the special doctor because they are delaying...”*P 10 cousin of the MHCU.

Janse van Rensburg, (2007) also indicated that one of the primary reasons for the challenges in the implementation of the act is the fact that the act was not accompanied by required provision of the resources by the national or provincial government. No provision was made in respect to suitable human resource and physical facilities for this new mental health care services.

The implementation of the MHCA No 17 of 2002 at the primary, secondary, and tertiary levels of care has not been an easy task. Presently, 72-hour assessment of the MHCU is difficult to implement across the country, due to increase workload, inadequate resources and poor infrastructure. A study conducted in Kwazulu-Natal province indicates less improvement on the funds allocated for the mental health services. There are insufficient number of the mental health professionals who are designated to conduct the assessment (Ramlall, Chipps & Mars, 2010). The shortage of resources indicates that mental health care users may not have easy access to the care they deserve (Burns, 2010).

Uys and Middleton, (2010) in support of the findings indicates that current primary health care system is inadequate adding to the new demand of provision of the 72-hour assessment. The hospitals are understaffed all over South Africa. Family members of the mental health care users admitted for the purpose of 72-hour assessment experienced a problem of not getting service they needed during crisis due to lack of readily available health care professional who are legally mandated by the Mental Health Care Act No 17 of 2002 to admit patients who requires mental health evaluation. They indicated that there was no doctor in the casualty department and they had to wait.

Forms taking time

The majority of the participants from the data analysed indicated that the admission of the mental health care users took a long time. They experienced delays which were caused by mental health practitioners who are mandated to fill the legal forms, who were found not readily available at the casualty department. Completion of many forms also delayed the process by the doctor and the nurse. Admission was said to include history taking whereby the family members are asked a lot of questions.

Furthermore, only one doctor was helping them who firstly attended the emergency patient.

Another participant said: *“I do not have much to say about the forms except that they delayed the admission process”. P8 sister to a known user.P3 mother of the MHCU.*

Another participant said: On arrival to casualty and O.P.D after getting the file we are informed to wait for the nurse who will attend to us. They will say nurse “so and so will be with you”. Okay we shall wait until she comes to assists us. When she comes she will be asking question taking a history we are to explain the same story related to the family history. The process of admission is lengthy; you cannot do it in a short space of time. P6 sister –in –law of the user.

Another participant said: *“They reported that they are waiting for the night super so that they can come and sign the forms. We waited for too long until they ultimately came”. P3 mother to the MHCU.*

Mental health care users are treated according to the prescripts of the Mental Health Care Act No.17 of 2002, as amended which provides for the following: That the prescribed requirements need to be met, and such requirement means filling of forms according to the classification in the Mental Health Regulation). It provides for treatment, care, and rehabilitation of the mentally ill. It has set out different procedures to be followed in the admission of such person MHCA, (2002).

The admission procedure of mental health care user according to the Mental Health Care Act No 17 of 2002.

Form 04 is the application for assisted or involuntary care, treatment and rehabilitation which is to be completed by the person who is initiating the admission, preferably a family member who should have seen the user within seven days. The applicant must be above 18 years and the form is completed under oath. Form 5 which is a medical examination form, is completed by two mental health care practitioners, one of the should be a medical doctor and other one can be a nurse, social worker, psychologist, occupational therapist who is trained to deal with mental health problems. Such professionals must not be the person making the application.

The two mental health care practitioners are required to independently assess the user. The findings should then be submitted to the head of the health establishment indicating whether the whether the mental health care user must receive care treatment and rehabilitation as assisted or involuntary care user. Form 06 is a 72-hour assessment and findings form which is completed by the medical practitioner and the mental health care practitioner after the head of the health establishment has granted approval for application of involuntary care treatment and rehabilitation. Form 07 is a notice by head of health establishment on whether to provide assisted or involuntary inpatient care, treatment and rehabilitation. Form 11 is completed by the head of the heath establishment when transferring an involuntary mental health care user to a psychiatric hospital after the expiry of the 72-hours assessment admission.

3.1.1 Summary of applications procedures for Limpopo Province

Table 2.1 Assisted and involuntary care admission procedure

STEP 1	FORM 04 completed by next of kin or any nurse
STEP 2	FORM 05 completed by 2 MHCP's (including 1 doctor)
STEP 3	ALL FORMS submitted to clinical manager /senior casualty doctor
STEP 4	Clinical manager records decision on FORM 07 (copy to applicant)
STEP 5	For Involuntary treatment only 2 MHCPs give daily reports to clinical manager on Form 06 for 3 days
STEP 6	Clinical manager records decision on further involuntary treatment on FORM 8
STEP 7	All original documents forwarded to MHRB by clinical manager (by fax daily and post within 7 days All copies kept in user's medical file
STEP 8	FORM 11 to be filled if transfer to psychiatric hospital is necessary. All other forms to accompany MHCU on transfer

Limpopo Department of Health guidelines and Protocol for General Hospital regarding mental health services (2008).

The admission procedure of a person presenting with psychiatric symptoms differs from admission of general patients. The differences pertain to the specific Mental Health Care Act forms which are used to admit a mental health care user. The admission of general patient is not time consuming as such does not demand too much paperwork. The MHCA forms are completed by more than one mental health care practitioner legally mandated to process such admission in order to protect the right of mentally ill persons.

Another participant said: *“It delays the whole process of admission. When you go the ward where the patient is to be admitted sometimes you are being told that the causality staff did not bring some forms, obviously, you are forced to wait longer. One time we came back home very late around 02H00 in the morning when we arrived at the hospital at 20h00 the previous day. We were waiting for the doctor and also that in the ward some of the forms were not in order”.*P5 sister to the MHCU.

Another participant said: *“We arrived in the ward at around half past nine, when my son was taken to the ward it was around two or past one. It took a long time to leave causality to the ward”*. P3 mother to the MHCU

- **Premature discharge**

During the interviews, most of the participants said that the mental health care users who were admitted for 72-hour assessment were discharged too early, when they were not yet stable. From the data analysed, two subcategories emerged indicated as follows:

- Discharged today same day he is back
- Readmitted shortly after being discharged.

Discharged today same day he is back

Family members of the MHCUs with multiple admission in observation unit expressed their worries associated with frequent admission in the unit. They indicated that their loved ones are in and out of the hospital, were admitted several times within a short space of time to the extent of even after few hours they are readmitted. Some participants identified early discharge as one of the contributory factors of their relative re-admission in the 72-hour assessment mental health care facility

One participant said: *“...It is a painful experience when a user is discharged today after the three days’ admission then the same day he is readmitted in the evening with only few hours being outside the hospital premises. By the way to take the user to the hospital is struggle. When he is ill we do not sleep, he demands to have a wife and wife is perceived to be myself and my daughters. He becomes very aggressive and is very strong physically. When*

take him to the hospital I need to be helped but only to be disappointed when the user is discharged prematurely”. P6 sister- in- law to the MHCU.

Another participant said: “I am not satisfied about the way patients are cared for in the medical ward. The patients are discharged before they are mentally stable and you find that they are still ill. In the past mental health care users who were admitted in the psychiatric ward they will be discharges being all right not like now, patients may stay for three months without showing the signs and symptoms of recurrence of mental illness at home. P8 sister to the MHCU

The Mental Health Care Act No 17 of 2002 section 34 of the act makes provision for involuntary and assisted mental health care users to first be admitted for 72-hour observation at a local general hospital. The study conducted by Burns, (2008) on the implementation of the act revealed the main reasons for conducting 72- assessment and observation of a MHCU’s. Medical causes for the behavioral or psychiatric disturbances can be ruled out and a large number of the mental health care users, after receiving the treatment for three days may improve conditionally and be in a position to give consent for treatment as a voluntary user. Increasing access for care at a local area reduces the need for premature or unnecessary transfer to psychiatric hospital.

MHCUs are branded as being violent, unpredictable and sometimes perceived by the community as responsible for their-own illness (Frisch & Frisch, 2011). Uys and Middleton, (2010) claimed that Health care workers often have a negative attitudes towards toward psychiatric patients and their care, and this may make it difficult to obtain their cooperation with regards to adherence to the therapeutic interventions. The negative attitudes, discrimination and stigmatization by health workers, causes them to discharge the MHCU before they are well stabilized.

A similar study, conducted on the challenges in acute care of people with co-morbid mental illness, Giandinoto and Edward (2014) found that general health care providers working in medical, surgical and emergency psychiatric units lack knowledge in managing patients with mental illness and physical conditions. This knowledge gap and skill deficit leads to dissatisfaction and feelings of frustration when providing care to these patients. As a results the MHCUs receive sub-optimal level of care. These includes instances where MHCUs are so heavily sedated that proper assessment of their mental health state is compromised, or agitated and psychotic MHCUs are inadequately sedated , making containment difficult and resulting in unsafe conditions for patients and staff (Burns, 2008).

Similar to the findings of the study in which premature discharge was reported by the majority of the family members. They felt that their loved ones were discharged before they are mentally stable. They experience dissatisfaction with the condition of the mental health care user on discharge. They frequently express the idea that in the past when their users were admitted in the psychiatric ward they would be discharged in a stable condition. 72-hour assessment unit is treating them unfairly because when the ward is full the user is discharged moreover they were not even involved in the discharging planning. The 72-hour assessment unit was expected to operate like a mental health care unit.

Readmitted shortly after being discharged

The participant felt that their ill relatives are frequently admitted in the 72-hour assessment units. The MHCUS are not staying for a long time at home. They indicated that at times they are discharge same day and readmitted the same day.

*One participant said: ‘...During the recent admission, the user was taken to the Siloam hospital where he was admitted for two weeks. To my surprise the user was readmitted shortly after being discharged from the hospital. I wondered if the same medication was like the one which is given in the previous ward, or maybe they are changed...’.*P8 sister to the MHCU.

*Another participant said “The patients can stay for two to three weeks without being admitted, thereafter the patients can show some signs which indicates that the illness is recurring (vhu khou vuwa) which leads to readmission. The patients were admitted more than three times in this psychiatric ward...”*P4 mother to the MHCUs

A study conducted in Gauteng in psychiatric unit designated as 72-hour assessment unit by Van Rensburg and Van Rensburg, (2011) on tracking the progress of in-patient MHCUs after discharge showed that a number of the users were re-admitted to the mental health care units in a “revolving door pattern” following 72 a period of 72-hour assessment, most users were referred to mental wards as involuntary MHCUs.

Virtually all severe and persistent disorders will involve some kind of relapse at some time, however more than one or two admissions in 12 months exceed a norm. Client-based factors that contributes to recidivism includes substance abuse, which may be the best predictor of readmission. Repeated admission through emergency and acute care has been associated with some form of personality disorder. However, many young clients with Schizophrenia and bipolar mood disorder abuse drugs and alcohol to deal with boredom and medication side effects, and to self-medicate or treat symptoms in what they perceived to be a “normal way” (Kneils & Trigoboff, 2014).

A study by Kotze, Van Delft and Ross (2010) reviewed the needs of outpatients with Schizophrenia. Both the patients and family caregivers needed help in managing the illness and lives after discharge from brief hospitalization, and they identified the need for psychosocial and after-care programme such as support groups. Caregivers were found to be a

vulnerable group with 92% of them indicating that their health had been affected (Kotze *et al*, 2010).

Conclusion

Data analysed revealed that the family members had negative experiences about the 72-hour assessment admission of the mental health care use. The negative experiences were a lack of knowledge regarding the 72-hour assessment mental health service, a lack of being involved in the care of the relative, financial difficulties experienced when their loved ones were transferred to another hospital which is not accessible, a lengthy admission procedure which was associated with shortage of human resource resulted in the family members leaving the hospital very late, and premature discharge.

3.3.2 Theme 2: Family members' coping mechanisms

Table 3.2. Indicates the theme, category and subcategory of family members' coping mechanisms.

Table 3.2 Theme 2: Family members' coping mechanisms

THEME	CATEGORY	SUB-CATEGORY
2. Family member's experiences on coping mechanism	Emotional discharge	<ul style="list-style-type: none"> • Worry about the future • Afraid of the patient • police no longer assist

Discussion of findings

THEME 2: FAMILY MEMBER'S EXPERIENCE OF COPING MECHANISMS

This theme emerged from data that reflected that the admission of the sick relative of the participant made them experience different feelings. Only one subcategory emerged from the data analysed which is the following is:

Emotional discharge

During the interviews, family members said they were more concerned about the condition of their loved ones as the caregivers. They expressed different emotions related to the negative emotional feelings they experienced when they are taking care of the MHUC's. The following were the categories identified:

- Worry about future
- Afraid of the patient
- Police no longer assist

Worry about future

The family members of MHCUs expressed their consent as the mothers to the users who were admitted for 72-hour assessment admission for the future of their children. They cited that they are more worried about the medication which can trigger some side effects.

One participant said "The future of my son, I am concern about it as to what will happen about his future".P3 mother to the MHCU.

One participant said “...Eish at first I felt so bad since it was the first time and did not know what was happening. Obviously anyone can feel uncomfortable. The situation was making to feel as if I am mad (u tangana thoho). I was so worried thinking that my child is suffering from mental illness, what will happen to her future, is he going to be better and continue with her studies. The pills which they are giving her will make her weak and if so how is she going to cope with her school work...”P2 mother of the MHCU.

One of the participant responded: “If I happen not to live long life my daughters will be scattered all over the whole world. No one can tolerate this behavior. When you are called a mother, you need to face it. (Ndi ngoho mikovhe ya tshilidzi) yo fhambana God’s grace differs. In the bible somebody asked a question like “who has sinned for the baby to be born being blind” the answer was no one has sinned, this made feel at ease, I told myself lets’ God will be done...”. P 4 Mother to the MHCU.

One of the emotional responses experienced by the families with members with serious mental illness, identified by Stuart, (2009) is grief. It relates to the loss of the future that the family members may have expected from the mentally ill member. Anger may be directed at the patient, but may be directed towards other family members and health care providers or the entire health care system.

Afraid of the patient

The family also indicated that the experience emotional pains which is associated with the aggressive behaviours displayed by the patients during the time is showing the signs and symptoms of relapse from their mental condition. They live in constant fear that the MHCU may cause harm to themselves or other family inmates.

P: It is somehow makes our lives so difficult especially as mothers who are not staying with the husband in the house who can be there in times like this when the patient does not understand anything and wanting to run away. Really this is too much and frustrating as a mother who is expected to take care of the son P3 mother of the MHCU.

P: When my son is ill at home there is his sister I am afraid to leave my daughter alone, I do want stay with my son but when he is not looking well I am afraid of him I feel my daughter is not safe because I just think he can become aggressive and starts to fight her ...” P3 mother of the MHCU.

Another participant said:”...The situation made my mother to become very scared when I reached there she told me the patient had locked himself in the house, one of his kids were there the other one was not there in the house. The child who was not around during the time we were going to the police station. So when came back she entered the house then he commanded her to sit down then she sat down. We asked her whether she cannot see that the situation we are faced with is very bad. We were scared that he can injure his daughter who was inside the house, if she fails to do what he is telling her ...” P5 sister to the MHCU.

Similar findings were highlighted in the study done in Malawi by Chorwe-Sungani et al, (2015) on the experiences of family members suffering when living with a relative who has mental health problems; their psychological wellbeing worsens alongside that of their sick family member. Mental illness of a family member can negatively influence the emotions of the whole family and other family members may develop their own health problems such as distress, sense of burden sadness and guilt. They carry a huge burden of taking care of their ill relative. Sometimes the family members feel that they are blamed for the illness of their mentally ill relative. It is a fact that family members sometimes fail to deal with their own individual or family needs because they focus on their sick relative. The burden to care is borne in the

minds of the African people which stems from the culture of growing in extended families. Most of the caregivers are found to be women and young girls.

Matsoso, (2012) argued that not all mentally ill patients share these characteristics of insight and good judgment. When such a person refuses treatment, it may cause significant distress and potential danger for the family, community and the patient. Historically, societies have determined that they may be treated involuntarily in institutions as a way of protecting them and the society around them.

Fear and powerlessness are often experienced by family when they realize that they are dealing with a chronic condition that is lifelong. The majority of the people believe that once the patient is admitted for mental health intervention, the person should be completely cured. When their expectation fails, they feel powerless and frustrated. The understanding can result in fear about the future of the mentally ill family member. Some family members feared that the ill relative can become aggressive and attack them.

Police no longer assists

The lack of assistance by police officers (SAPS) was a concern of the majority of participants. During the time when their family member is displaying dangerous behaviors that puts the patient or other people at risk of harm, the family members were frustrated when they could not get help from the police officers. They felt helpless as women when they are expected to apprehend a male MHCU.

The participant said: *“...Previously we were using the police officers provided assistance but now they do not want to hear anything. We finding having to deal with this situation alone, we are to use our car instead. When we arrive there, we are to retrieve the file of the user. The patient cannot be taken to the ward without being given an injection. The security is called to come and assists when they give him injection P 6 sister- in- law of the MHCU.*

Another participant said: “...Sometimes I find myself asking God as to how many days did God spared my life to continue looking for the users. Some of my relatives confessed that should I die they cannot manage to look after the users. No one accepts them, people claim that they are pretending to be affected mentally. I am pleading that the Almighty God can give more years to live for these people who are mentally ill...” P4 Mother of the MHCU.

Another participant said: “What I do not like about the police officers is when they respond to the call when someone is injured but if you call them to say the user has started to be aggressive, they will not respond to the call. They do not believe it will ask us what he did. Like I am saying he is not always dangerous but at times he is a danger to himself and other people around him. The police will ask you did he injured someone or killed a person...” P8 sister of MHCU.

The Mental Health Care Act no. 17 of 2002, section 40, stipulates that if a member of SAPS has a reason to believe, from personal observation or from information obtained from a mental health care practitioner, that a person due to his or her mental illness or severe or profound intellectual disability is likely to inflict serious harm to himself or others, the member of SAPS must apprehend the person and cause that person to be detained at an appropriate health establishment for assessment and observation of the mental health status of that person for brief period.

The treating MHCPs must ensure that the health practitioners and other MHCUs are always safe when managing a violent patient. A rapid escape route

must available during the time when the user is unmanageable. The security personnel must also be there in the unit and patients should be disarmed prior to commencement of the assessment if a person due to mental disturbance, severe or profound intellectual disability is likely to inflict serious harm to himself or others (Matsoso, 2012)

Most of the participants were concerned about the future of the mentally ill relatives. The mothers as responsible caregivers felt saddened by the condition of the MHCUs. They were concerned about the future caregiver when they die.

A study by Ramlall *et al*, (2010) confirmed that many problems existed in respect of 72-hour observation in Kwazulu-Natal. Sixty-three percent of designated reported that they did not have adequate facilities to provide the service as required by the Mental Health Care Act No 17 of 2002. The health establishment lacked beds, staff, and appropriate seclusion rooms to accommodate the mental health care user who are in need of the service.

One of the participant said: "...feel disappointed and overwhelmed because when a person they have relapsed it demands my time. I have to take them to the hospital, no one will assist me nor visits the patients when they are hospitalized. I am expected to pay them a visit alone. One day I thought of retiring since I have already reached 60 years of age so that I may get rest. I changed my mind when I realized that I will be facing this situation alone, it means I will collapse and die. It means I will be witnessing this drama every day as it is done in front of my eyes. When they see me, they start to behave in a strange way. Yes, they make me feel depressed, I get emotionally affected as a person..."P 4 mother to the MHCU.

The data analysed revealed that the family members are saddened, frustrated, and angry and worried when one of the family members is admitted for the 72-hour assessment ward. The family experienced the burden of caring for the ill relative who is suffering from a chronic stigmatized condition.

Conclusion

Emotional discharging of the unwanted feelings was described by the family as a weapon that assist them to cope with caring burden of the mental health care user. The participants mentioned that they use different ways to cope with the psychological distress they encounter while caring for the users. They were more worried about the future of their loved one and concerned about who will take care of their sick relative should they die as mothers. They also raised a concern of lack of support from SAPS who are longer assisting them to take the user to the hospital.

3.3.3 Theme 3: Structural constraints

Table 3.3 indicates themes, category and subcategory of structural constraints experienced.

Table 3.3 Theme 3: Structural constraints

THEMES	CATEGORY	SUBCATEGORY
1. Structural constraints	Lack of suitable infrastructure	<ul style="list-style-type: none"> There is no space patients sleeping on the floor.

Discussion of finding

THEME 1: STRUCTURAL CONSTRAINS

The analysed data showed that participants encounter different experiences while caring for a mental health care users admitted for 72-hour assessment. This theme emerged from data that reflected that the family members showed that the environment where assessment is done is perceived as non-conducive. Only one category emerged from the analysed data, which is unsuitable infrastructure

Lack of suitable infrastructure

The responses of the participants who were interviewed revealed that the medical ward where the 72-hour assessment takes place is not adequate to accommodate the mental health care users in need of hospitalization. Only one subcategory emerged from a theme:

There are no space patients sleeping on the floor.

The participant said: “...Like *providing a spacious ward that will be able to accommodate the users. They management keep on saying they will built a ward. The nurses do not have a nurse’s station they are sharing same room with the patients. You often find when they are busy eating, another user is destroying property, another one is playing with water because the water basin is there. That environment is stressful; something must be done. Indeed, you can see that that ward was met to be used for a short while*”. P5 sister to the MHCU.

Another participant said: "...My understanding of the observation ward is unit which act as a receiving mental health facility, which admits patients for a few days where the user can be discharge home if he is stable or transferred to another hospital for if the patient is not looking better. The ward is not organized; the space is too small not adequate to accommodate the mentally patients. Since the psychiatric ward burnt down it has been a long time the government should have built another ward. Sometimes the patient was admitted at Donald Fraser and Hayani hospital when there was no space available at Siloam hospital". P8 sister to the MHCU.

Another participant explained:"...I noticed that the ward is too small really I just wondered in case they can admit more people with mental disturbance. I think there will be a serious problem of space. The ward has only four beds and that sound to be insufficient. Yesterday some patients were sleeping on the floor". P9 sister to the MHCU.

Participant further said: "...At least the two hospitals are not that far they are nearer to us and we found that the same nursing staff from the acute psychiatric ward were working there. This made us to feel more comfortable knowing that the patient is familiar with the nurses and the nurses know the patient well. The worst painful thing is when there is no empty bed the patient is discharged home irrespective of the condition which may not be good as we observed..." P9 sister of the MHCU.

Another participant said: "...But the ward is too small, the nurses eat there, while on other side the patients are doing this and that. At another corner, another nurse will be busy writing at the same time the doctor is also seated busy seeing the patient with a social worker and nurses packed in that very small room. Yama! You can see that the environment is not well organized

but still the nurses do their best despite that environment...” P5 sister to the MHCU.

Deinstitutionalization has led to the reduction in number of beds in custodial facilities, but an overall evaluation of its consequences is disheartening. Many patients were transferred to the alternative forms of custodial care (including home care and sheltered employment). Patients with a diagnosis of Schizophrenia are reported to account for 15-45 percent of homeless Americans (Sadock & Sadock, 2007).

The focus of care has shifted dramatically since the mid-1950 from long-term hospital base care to acute hospital care and community-based services. Deinstitutionalization has led to the reduction in number of beds in custodial facilities, but an overall evaluation of its consequences is disheartening. Many patients have transferred to the alternative forms of custodial care (including home care and sheltered employment). Patient with a diagnosis of Schizophrenia are reported to account for 15-45 percent of homeless Americans (Sadock & Sadock, 2007; Eassom, Glaceo, Dirik, & Priebe, 2014).

A study by Ramlall et al, (2010) confirmed that many problems existed in respect of 72-hour observation in Kwazulu-Natal. Sixty-three percent of designated reported that they did not have adequate facilities to provide the service as required by the Mental Health Care Act No 17 of 2002. The health establishment lacked beds, staff, and appropriate seclusion rooms to accommodate the mental health care user who are in need of the service

The findings concur with those of Zun, (2012) who indicates that most Emergency Department directors (89%) mentioned that many psychiatric patients are transferred due to unavailability of beds in their hospitals, and 23% of the Emergency Department directors said they have no community

psychiatric resources. 72% stated that psychiatric patient requires more nursing time and other resources in the Emergency Department than non-psychiatric patients and 85% verbalized that the waiting time would improve if better mental health services can be put in place.

Data indicates that the family members were dissatisfied with the ward environment which was perceived to be too small. They said the ward does not allow free movement which indicates that the ward is not good to promote healing. Furthermore, the ward was said to be disorganized because the ward and inadequate to meet the demands.

Conclusion

The mental health care units that are providing 72-hour assessment admission are faced with a challenge of lack of physical facilities. The unit have limited space, lacked privacy, shortage of beds and lack of security. The environment is non-conducive for nursing the individuals with mental health problems who are at risk by nature of their condition. This led to the care of the mental health care users being compromised. Even the nurses were perceived to be negatively affected by this situation which places them and the users at risk.

The majority of the participants who took part in the study regarded lack of suitable infrastructure as a factor that is limiting the provision of quality mental health care. The implementation of the Mental Health Care Act No 17 of 2002 concerning the establishment of 72-hour assessment mental health service in public hospital possess a challenge since the general ward had to improvise some cubicle to cater for the mental health care users

3.4 SUMMARY

This chapter presented the data analysis from the experiences of family members regarding admission of mental health care users and discussion of the findings of the data presented. Three themes emerged. The findings were supported by transcribed data and relevant literature.

CHAPTER FOUR

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This preceding chapter concludes the study about the experiences of family members regarding 72-hour assessment admission of mental health care users. The chapter includes research limitation, summary and interpretation of the research findings as well as the recommendations and further research.

4.2 EVALUATION OF THE STUDY

The evaluation of this study is based on the purpose and the objectives as set in chapter 1

4.2.1 The purpose of the study was to determine the experiences of family members regarding 72-hour assessment admission of mental health care users at the selected hospitals in Vhembe district. The purpose of the study was achieved through in-depth individual interviews with the participants.

The objectives of the study were to:

- explore the experiences of family members regarding 72-hour assessment admission of mental health care user at the selected hospital of Vhembe district.
- describe the experiences of family members regarding 72-hour assessment admission of mental health care user at the selected hospital in Vhembe district.

The objective of the study was attained as the experiences of family members were explored and described during the in- depth interview.

4.3 CONCLUSION

The findings of the study revealed the experiences of the family members regarding 72-hour assessment admission. Three themes were identified during the analysis of data.

4.3.1 Theme 1: Negative experiences of the family members

- **Lack of knowledge**

Family members interviewed lacked sufficient knowledge about the 72-hours assessment of the mental health care users. Some participant indicated that they did not know what the assessment entails while other participants reported that they were told that the ward admits patients for three days and if patient's condition improves the person can be discharged and be under the care of the family members. The observation ward was viewed as the unit that is specifically meant for the mental disturbed patients. The participant who had a relative admitted at Tshilidzini hospital showed misunderstanding of the 72-hour assessment unit as the replacement of the burnt ward. This led to the participant to constantly comparing the unit with the non-existence acute mental health care ward. They participants indicated could not understand when the psychotic patients were mixed with those that are not actively psychotic.

- **Lack of family involvement**

The family members who participated in the study indicated that they were not involved in the treatment programme of their relative during the time when their loved ones were admitted for 72-hour assessment. Data analysed revealed that the family members were excluded from taking part in the care of their patients. The movement of the mental health care user after 72-hour assessment was not communicated with them. When the user was discharged they were not informed, this left the family members frustrated when they found the user at the gate accompanied by the nurses and the emergency personnel. Furthermore, the family members were also not informed when the mental health care users were transferred to another hospital. They cited that they only had contact with the medical doctor the day the mental health care user was admitted.

- **Financial difficulties**

Family members of the mental health care users admitted for assessment and observation of three days were saddened and frustrated because the hospital where their loved ones was transferred to was inaccessible to them. The participant indicated that when the patient is transferred to another hospital they find it difficult to pay the patient a visit because the hospital is too far. The hospital where the patient is transferred to for further care, treatment and rehabilitation is 30 km away from the hospital where 72-hour assessment was done. The participant in this study were vocal about the challenge of lack of money for transport.

The challenge of inaccessibility of the transferal hospital minimize the nurse-family relationship hence the mental health care user is discharge without the knowledge of their relatives. It was indicated by some participant that

users are escorted home after discharge by the nurses and the emergency practitioners. They get surprised when they see the patient at the gate discharged from the hospital which compromises the care rendered to the users.

- **Procedure of admission**

The procedure of admission of the mental health care user before 72-hour assessment is commenced was another factor which led to the delays of the admission process. The delay was associated with collateral history taking where the relative was asked many questions and some of questions were repeated. The participants were frustrated by waiting for the health professional who were not readily available at their working station casualty department of the selected hospitals. The participant were aware that only one doctor is allocated in casualty department, who is also seeing the general patients. The doctor preferred to start with the patient who needed emergency care. Furthermore, completion of mental health care act forms also caused some delays since they the forms are completed by two mental health care practitioners. An average of six hours was spending in the casualty department. This scenario left the family members experiencing a problem of transport to take them home in case they had finished consulting the mental health care user during late hours.

- **Premature discharge**

Data analysed revealed that the family members highlighted that their loved ones who were undergoing the 72-hour assessment were discharged from the hospital before they were mentally stable. Early discharge of the mental health care user was the cry of the participants. They indicated that the user was discharged today same day the user is taken back to the hospital. They

questioned the criteria which was used to discharge the user when the condition is not satisfactory. They felt that the patient should have been allowed to stay for more days to ensure that complete recovery is reached. The health care professionals were blamed for not involving the family members in the discharging plan, they felt that if they were present during ward round may be the user would be given kept for more days.

4.3.2 Family member's experiences on coping mechanism

- **Emotional discharged**

Family member's experience of negative feelings such as pain, anger, depression and frustration as they care for their loved ones who are admitted in the 72-hour assessment unit in the selected general hospital of Vhembe district. The family members were concerned about the future of their relatives and worried about the individual who will take care of the MHCU should they die, experienced fear associated with challenging behavior displayed by the patient during the period of relapse. The participant was concerned about stigma which is attached to mental illness.

Majority of the participant experienced sadness, pain, and frustration when their ill relatives display challenging behaviors before they are admitted for observation. The family members were worried and afraid of the mental health care user when the user tend to be aggressive during the acute episode of the illness. The participant felt that the inmates are not safe because they cannot manage to control the user during the relapse episodes. All the participants were females who felt that they are weaker vessels when it met managing the mentally ill patients

As data collection continued family members had varied experience regarding the support they received from the SAPS. A limited number of the participant reported that when they were in crises police officers helped them to take their ill relative to the hospital. On the other hand, majority of the participant were frustrated when they could not get any assistance from the law enforcement officers who openly informed them that they no longer offer any assistance. The family members on their own find it challenging to apprehend a person who lacks capacity to give consent to seek for health intervention. Previously the family members were assisted now they felt very disappointed and they do not know what to do when they have a crisis.

4.3.3 Structural constraints

The participant expressed their dissatisfaction with regard to the environment where the 72-hour assessment is conducted. The unit was observed to be disorganized which ideally is not right for provision of quality health care. The participant found that some of the patients were sleeping on the floor which caused by a limited space coupled with shortage of beds. This contributes to the discharge of the mental health care users before they are mentally stable. The unit does provide freedom of movement for the staff, patients and also family members.

In this study the participant voiced out their concern of lacking space which contributes to lack of privacy to the patient. Some family members were frustrated when the environment denied them an opportunity to sit and discuss private with their relatives. Psychiatric interviews were conducted in the presence of other patient which means the patient's right for privacy was violated. Data analysed further revealed that 72-hour assessment unit failed to provide adequate security for the mental health care users because the patient who are aggressive were mixed with those who are aggressive.

4.4 LIMITATION OF THE STUDY

The sample of the study consisted of female family members because they were conveniently found in the ward during the study.

The context where 72-hour assessment is practiced is not the same in the selected hospital. In one of the hospital the 72-hour assessment patients are admitted in separate cubicle whereas in another hospital the patients are mixed with the other patients.

4.5 RECOMMENDATIONS.

Based on the findings of the study, the following recommendations were made:

This study recommends further research study on the development of a model to support the family members in their caregiving role

The study recommends further research study on the experiences of the health care professional regarding 72-hour assessment of a MHCU's

4.7 CONCLUSION

In this chapter, the conclusion of the study highlighted how the objectives were attained through descriptive phenomenological research design. The following topics of the study were outlined: conclusion, limitations and recommendations of the study.

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ANNEXURE A

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Mrs TE Mbedzi

Student No:

11624760

PROJECT TITLE: The experiences of family members regarding 72-hour assessment admission of mental health care users at selected hospitals in Vhembe District in Limpopo Province.

PROJECT NO: SHS/17/PDC/97/1603

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS


NAME	INSTITUTION & DEPARTMENT	ROLE
Dr M. Ndlovu	University of Venda	Supervisor
Mrs AP. Mbedzi	University of Venda	Co-Supervisor
Mrs TE Mbedzi	University of Venda	Investigator - Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: March 2017

Decision by Ethical Clearance Committee: **Granted**

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. G.E. Skosana

<p>UNIVERSITY OF VENDA DIRECTOR RESEARCH AND INNOVATION 2017-03-22 Private Bag X5050 Tlokoeng, 0950</p>



University of Venda

PRIVATE BAG X5050, TLOKOENG, VUHI, VHEMBE PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8900/8115 FAX (015) 952 5067

"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE B



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stas M.L. (015 293 6169)

Ref:4/2/2

Mbedzi TE
University of Venda

Greetings,

RE: The experiences of family members regarding 72-hour assessment admission of mental health care users at selected hospitals in Vhembe District in Limpopo Province.

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

12/06/2017
Date

18 College Street, Polokwane, 0700, Private Bag 48002, POLOKWANE, 0700
Tel: (015) 293 8060; Fax: (015) 293 8211/25 Website: <http://www.limpopo.gov.za>

ANNEXURE C



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
VHEMBE DISTRICT**

Ref: S5/G
Enq: Muvazi MME
Date: 14 June 2017

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH: WREDZI TE.

1. The above matter bears reference
2. Your letter received on the 14/06/2017 requesting for permission to conduct research in our institutions 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 studies

[Signature]
DISTRICT CHIEF DIRECTOR

[Signature]
DATE

Private Bag 25009 THOHOMANDOU 0950
Old Parliamentary Building Tel (015) 962 1000 (Hon's) (015) 962 4954 (Facial Des) Fax (015) 962 2274/4623
Old Peace Embassy Building Tel (025) 962 1448, (015) 962 1452, (015) 962 1746, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227



ANNEXURE D

TSHILIDZINI HOSPITAL ETHICS COMMITTEE

Memorandum of understanding

Tshilidzini Hospital Ethics Committee with at their meeting resolved to sign a Memorandum of Understanding after the two parties have agreed on the following information:

1. Reasons for making a research at Tshilidzini hospital.
.....
2. What will be the benefit of the entire hospital community out of your findings?
.....
3. Who to meet in conducting your research.
.....
4. What do you do with your findings?
.....
5. We will require the hard copy of your research.
.....
6. We do not anticipate any information to be divulged to all types of media without the knowledge of the Ethics Committee and Hospital Board.
7. Memorandum of understanding should be signed by both parties.

Signed by:

.....
Date:

.....
Researcher

ANNEXURE E



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
DONALD FRASER HOSPITAL**

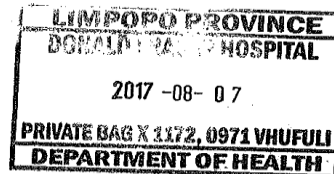
Ref: 4/2/2
Enquiries: Mphephu VF
Tell no. 072 1880 436
Ext. 9364
07/08/2017

TO: MRS Mbedzi T.E
University of Venda
Private Bag x505
Thohoyandou
0950

RE: Permission to access patients records on Research study about experiences of family members regarding 72-hour assessment admission of mental health care user at selected hospitals of Vhembe District in Limpopo Province .

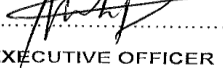
The above matter refers.

Permission to access patients records is hereby granted.



Hoping you will find this in order

Note that this permission is for Donald Fraser Hospital only.

SIGNED:  Date: 07/08/2017
CHIEF EXECUTIVE OFFICER

Private bag X1172, Vhufuli 0971
Tel: 015 963 1778/9, 015 1783 1791/2 • Fax: 015 963 1773, 015 963 1796
Cell: 083 248 0184

ANNEXURE F

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Freelance Editorial Services

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To whom it may concern.

I hereby confirm that I edited

T. E Mbedzi's

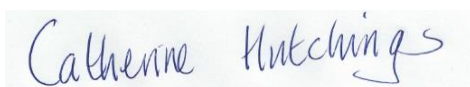
MCur thesis,

Title:

**THE EXPERIENCES OF FAMILY MEMBERS REGARDING THE 72-HOURS
ASSESSMENT ADMISSION OF A MENTAL HEALTH CARE USERS**

in February 2018.

I wish this student well in their endeavours.



Catherine Hutchings

ANNEXURE G

INFORMATION SHEET

Dear participant

REQUEST FOR CONSENT FROM PARTICIPANTS

I am a professional nurse at Tshilidzini Hospital and a master's student at the University of Venda, School of Health. I am presently engaged in a research study entitled 'The experiences of family members regarding a 72-hour assessment admission at selected hospitals in Vhembe District in Limpopo Province.

This study is to be conducted at Tshilidzini and Donald Fraser Hospital under the supervision of Dr M Maluleke and Prof. V.O Netshandama.

The purpose of the study is to explore and describe the experiences of family members regarding 72-hour assessment at Tshilidzini Hospital in Vhembe District in Limpopo Province.

To achieve this purpose, I need to interview family members who are caring for the mental health users who are admitted at Tshilidzini and Donald Fraser Hospitals in a 72-hour Individual interview as a method of data collection will be used explore and describe the experiences of family members with regard to a 72-hour assessment unit at Tshilidzini and Donald Fraser Hospital in Vhembe District in Limpopo Province.

The interview will be audio taped, transcribed verbatim and verified with you and the independent expert. The taped information will be erased on completion of transcribing the tapes to ensure confidentiality. Your anonymity will be safeguarded by omitting the use of names. The information related to the discussions will only be accessible to me and the promoters. No data will be linked to your name.

I invite you to participate in the study. You are of course under no obligation to participate in the study, but if you do so, you have the right to withdraw at any stage of the research.

For any information on your participation, contact the researcher on the following numbers: 0839876045 /0722114780

Thank you-----

Mrs T.E MBEDZI

ANNEXURE H

CONSENT FORM

I ----- Voluntarily participate in the study on the experiences of family members regarding a 72-hour assessment admission at selected Hospitals in Vhembe District in Limpopo. I understand that that my participation is voluntary and that I may withdraw at any time.

SIGNATURE

DATE

ANNEXURE I

PARTICIPANT NUMBER 6

P= PARTICIPANT R= RESEARCHER

P: Good evening

R: Good evening

P: How are you?

R: I am fine and how are you?

R: Like I said when I phoned you day before yesterday that I will come today, here I am now. My name is Vho Mbedzi. I am a student of the University of Venda. When you see me today, I came since we agreed that we shall meet each other so that we can have the interview.

P: Mmm!

R: I hope you can still remember that signed a consent form.

P: Yes I can remember that I have completed a form that time

R: To give the permission so that I can interview you. At least today I was possible for me to come

P: Mmm

R: What we are going to discuss pertains to your experiences as you had a child who was admitted in the ward which provides a three days assessment.

P: Mmm

R: What I can say as a way of reminding you that whatever we are going to discuss is between the two of us and also my supervisor who are assisting in the research project. All what we are going to discuss will be treated confidentially.

P: Mmm

R: Secondly your participation in this study is voluntary, you are however not coerced to take part.

P: Mmm

R: Even now if you feel you do not want to continue with the interview, you are free to do so, will not be punished are found guilty anyway or perceived to be somehow. I do not know are you allowing me to continue with the interview.

P: *Yes, you can proceed*

R: I am asking for permission to record the interview so that I capture the information we are going to discuss. Is that okay with you?

P: *It is fine*

R: I will be using a cellphone and a voice recorder, while the interview process is on if you may feel that there is something that is sensitive which you may not want to be recorded. There is a stop button which you can press. This is the button the researcher showing the participant the stop button.

P: *okay I can see it*

R: Today the weather is so good last week it was very hot

P: *No it is no longer hot*

R: Now it is no longer so hot this week the weather is fine it means the rain we had has done a good job

P: *It helped you see! Even the vegetables are grown*

R: Even delele (vegetable) will also grow not long we shall be eating green vegetables. Rain is a medicine for our crops.

P: *Just look this place is green and cool*

R: IT is greener and the whole country looks beautiful

P: *Mmm*

R: Really we burnt a lot the past days it was very hot but thank God for the rain. To ensure confidentiality as I told you earlier on, I am not going to call you by your name. I will just say Vhone (you in a way of respecting an older person) for the sake of ensuring confidentiality.

R: These days if a person is showing strange or rather unacceptable behaviours in the community or at home. The affected individual is taken to the hospital and admitted in the ward which provides an assessment for three days wherein the person will be exposed to this assessment by mental health practitioners in order to rule out medical or surgical causes that may have contributed to the behavioural changes. After three days the person can be discharged or be transferred to another hospital for further treatment.

R: At Tshilidzini hospital there is a ward located in the medical unit which is designated to render a 72-hour assessment and observation of persons who displays the signs and symptoms of mental illness. The ward admits the patients for a period of three only. After three days the patient is transferred to another hospital for further management or be discharged home if the user is showing some improvement which resulted from the outcome of the daily assessment done the mental health care practitioner. As a family member of the mental health care user “What is your experiences regarding the 72-hour assessment admission of the mental health care user?

P: That ward to tell the honest truth it is not good, we are not comfortable with the unit because if the patient is discharged it stand as it is, you cannot appeal to oppose discharge. When you compare it the old acute mental ward it differs completely in that the user can stay in the ward for more days. Upon assessment of the patient you can definitely see that there are remarkable changes the condition has improved. This is evidence by the user’s communication with the other people well and the face will be looking bright, no longer frowning like before admission.

R: Mmm! Tell me more about that.

P: Even the health care providers are also troubled by the situation of the 72-hour assessment ward because you will find other patients sleeping on the floor. It is difficult contain the users, whom you find them roaming around aimlessly. If you had left the patient with some belongings like a bath towel you would get it. Another user may take and claim that it belongs to him. According

to me really the ward is a disastrous it is totally disorganized. This makes the nursing personnel also to get frustrated. The ward is too small.

P: Sometimes when you may think that you are much better as compared to other who are having the elderly mental health care user in this disorganized ward admitted with the user who are aggressive and who are more powerful who overpowers the caregivers and nursing personnel. The mental health care users are discharged from the observation ward when they are not yet well, in that instances the user is discharged today same day in the evening he is taken back to the to the hospital. This practice we are not comfortable with surely the unit does not handles us well.

R: Mmm! I wonder what makes you to say that.

P: Mental health care users are discharged when they are not yet mentally well when comparing with the time they used to be hospitalized in the psychiatric ward of the hospital. The nurses are quiet, but they are also not happy with the situation is just that do not know where to raise their complaints.

R: Mmm

P: Sometimes we consulted the social workers to asking for help, they showed us the files indicating that they are willing to assist the family members by making the recommendations for long-term placement at Hayani hospital (Psychiatric hospital) but was in vain. When they enquire about the matter they are informed that at Hayani hospital there is no vacant bed.

R: Right now I hear you stating that the nurses are not comfortable with set-up of the 72-hour assessment unit what do you mean?

P: I am saying because there is no adequate space in that ward. You get the patient sleeping on the floor, some are disruptive and difficult to manage in that small area though there are security officers who are guarding them. The patients are going up and down, security officer will be following them even at the bathroom.

R: Tell me about it

P: The ward is not in order even if you get emotionally distressed by this condition you cannot blame the nurses because you can see that the nurses are working very hard despite the ward environment is not at all. We are experiencing a challenge and feel overwhelmed by this ward.

R: When you say the nurses are working hard can you elaborate on that?

P: The nurse are checking the patient during bathing during mealtimes. They also see to it the patients are given medication. They do try to control the unacceptable behavior displayed by the users. I will honestly say with confidence that the nurses are working to the best of their ability, but the ward is not in order. In the acute mental ward they were enough bed allocate for the users such as bed number A, B, C but in the in this new ward is not like that because there is no bed specifically allocated for those patient suffering from mental illness instead the other patients are sleeping on the floor.

R: When you say that there is no space do the nurses perhaps have a nurse's station?

P: No! No! There no office for the nursing staff because 72-hour assessment is done in one cubicle of medical ward, which also accommodate the patients in one single room, which is an office and a ward, it is because the psychiatric ward staff were borrowed this ward to use it until a new ward will be build

R: What information was given regarding the orientation about the ward?

P: I was told that in this 72-hour assessment ward the mental health care user is admitted to make his mental condition to be better, to minimize the signs and symptoms of mental illness not stabilize him as such. Due to the fact that the acute psychiatric ward burnt down the patient are now admitted in the medical units. I noticed that this ward which provides a three days services is not good comparing it with the psychiatric ward. In this single room where you can get forty patient admitted.

R: Mmm this sound difficult I can see. When you arrived in the ward on admission of the mental health care user how did the nurses welcome you?

P: I did not experience problem with the nurses, the nurses welcomed me warmly I must say however the environment of the ward is chaotic. The users are unmanageable will be roaming around that packed space.

R: Mmm, they need more space like you are saying

P: Sometimes they are handcuffed on bed in order to restrain them whereas in the old psychiatric ward the user whom they fail to contain him will be kept in a single room in a single room where you will see him as visitors through the hole. My patient was once admitted at Westkoppies usually when he has relapsed he need to be secluded because he is very aggressive. Bringing him to the health establishment is a difficult because he will be threatening to fights people.

R: Mmm!

P: I also observed other patients were tied up with the bed rails, the users will be pulling away the bed. In the past when the psychiatric patient were admitted in the psychiatric ward the patients were classified according to the level of their illness, those who are still very ill are separated from those who are better. Those who are very ill will be placed in a small room which is locked so that he does not trouble the other patients and the nurses. However I do not shift the blame to the nurses it is only that the work is too much for them, it is very challenging.

R: Were you greeted when you arrived in the ward?

P: Yes they greeted us all the time, asking some questions like where do we come from, how we are related to the patient. We feel good about it (Vha ri fara zwavhudi).

R: Who usually brings the patient to the hospital?

P: We used to accompany him with my husband (the younger brother to the user). At times the police officers do assist us but these days they are no longer willing to help us they informed us that we should ask the emergency staff to accompany the patient to the hospital.

R: Mmm

P: Emergency personnel too will say it is not their responsibility. As family members we are expected to shoulder that responsibility we have tie the patient which is also not an easy task because it demands manpower using the family car. We normally manage but after a long struggle like a repeatedly said it is not so easy.

R: How does that make you feel as caregivers?

P: Previously we were using the police officers provided assistance but now they do not want to hear anything. We finding having to deal with this situation alone, we are to use our car instead. When we arrive there we are to retrieve the file of the user. The patient cannot be taken to the ward without being given an injection. The security is called to come and assists the clinician to sedate the user. At casualty or outpatient department (O.P.D) we are assigned a specific nurse who take care of us. I think the nurse has acquired knowledge about management of the mentally ill individuals.

R: Mmm! Can you share your experiences with regard to the admission procedure step by step?

P: On arrival to casualty and O.P.D after getting the file we are informed to wait for the nurse who will attend to us. They will say nurse “so and so will be with you”. Okay we shall wait until she comes to assists us. When she comes she will be asking question taking a history we are to explain the same story related to the family history. The process of admission is lengthy; you cannot do it in a short space of time.

R: Mmm

P: The nurse will remain there with you and the security officers will have been called will be standing there. The user is given the injection to calm him then we is asleep we are escorted to the ward on a stretcher.

R: Are the vital signs taken from the patient?

P: Actually the vital signs are not taken at casualty they are done in the ward

R: To what extent were you informed about the law that govern the mental health care users in South Africa?

P: No! Never were we not told.

R: Were you at certain stage given an opportunity to meet the ward doctor?

P: No I never met a doctor in most instances when I visit the ward I am emotionally driven I get so frustrated when I see that situation. I usually verbalize my concern to the nursing staff. I confront the nurses at times I fail to control my emotions whereby I become verbally aggressive due to the frustration I am going through when a patient is discharged when he is not well.

R: Mmm!

P: It is a painful experience when a user is discharged today after the three days' admission then the same day he is readmitted in the evening with only few hours being outside the hospital premises. By the way to take the psychiatric patient to the hospital is a struggle. When he is ill we do not sleep, he demands to have a wife and wife is perceived to be myself and my daughters. He becomes very aggressive and is very strong physically. When take him to the hospital I need to be helped but only to be disappointed when the patient is discharged while he is not yet fine

R: When the user was discharged from how was he?

P: There was no improvement according to my experience when the user is mentally stable I will notice it at a glance when I enter the ward he will be smiling looking happy and with a charming face. I could see that indeed he is okay even myself I can discharge him when he is in that condition. He can sit down with me and have a good conversation there.

R: when the user was admitted to how were involved in the treatment programme of the user as family members?

P: We are not part of the treatment programme. The user is given medication and assisted with basic needs we are told that the user seemed to have improved and now he is fit to be discharged without our recommendations.

R: Still looking the same conditionally is that what you are trying to tell me now?

P: Yes, when you indicate to the nurses that the patient is not fine they tell us if he displays odd behaviours again we should bring the user back. We must bring him back again, bring him back, back again. We are also advised to take the patient to Siloam hospital where he can stay for a longer time which makes to get very upset.

R: What makes you to get disturbed?

P: At Siloam hospital the user is discharged when he they do not consider contacting you to inform you that the patient is discharged you are surprised when you find the patient at the gate of the house. You can see that he is not stable because he will be displaying aggressive behaviours to the nurses who escorted him at that time. I get crossed when they bring the user home without informing us as caregivers.

R: What happens when the user is showing the signs and symptoms of relapse before he is taken to the hospital?

P: When he is ill the user does urinate in the chamber that he uses at night will pour that urine on the vegetable saying he is watering the garden sometimes pouring it in the mugs believes is the medicine . He does not sleep or will wake up very early in the morning at 03h00 and start to roam around the street. He will be dancing and holding his legs up may be because he is demonstrating what they do at church.

R: Mmm!

P: He also sings at night at the top of his voice even during early hours of the morning. At times the user he will switch of the T.V and smear faces everywhere. When we clean the house he can decide to stamp the clean area. He is easily irritated sometimes beat children for no apparent reason. He uses a separate three roomed house. We bought him a bed but refuses to use it because he does not have a wife took the bed to another. If you wash his clothes he will through it away.

R: Mmm! How do you deal with this situation?

P: We were told that we should report him to SAPS who will open a case against him if we want him to be admitted at Hayani hospital. The health care professional think that we do not want stay with him at home. Sometimes he broke other people property. At home he also attempted to smash the mirror. He goes around surrounded by many dogs feeding them that does not belong to him. He makes the house very disorganized. There is no peace in the house because of the disruptive behaviours he displays when he is not well. The worse thing he sometimes verbalized that he will kill people. He sometimes says the food is poisoned.

R: That's sound very scaring

P: He loved me because I am a woman but he does love my children he does not want to eat the food served by them. Sometimes I had to force myself in order to give the food. There are times when he appears to be weak due to the side effects of medication.

R: When the mental health care user was admitted at Siloam how was your experience.

P: If I happen to visit the hospital I would raise my concern that they are not treating us well when they discharge the user we are not informed, only to find that no one is interested to listen to me as such. I feel that I am talking to myself. I was pleading that they should keep the patient for a reasonable period so that he can be better and go home being mentally stable.

R: How do you take care of him after discharge from a 72-hour assessment ward?

P: We are giving the medication in the morning and evening. My husband used to give the whole packet of his tablets and keep it himself. I understand why he is doing that because he did not get counselling from the nurses. When supervising treatment of the mental health care user you need to give him the tablets and stand there, so that he does not put it under his tongue. It not right

to give the user the packet of his medication because he may not take the treatment. He is always complaining that the tablet makes him feel tired.

R: Mmm, and what else

P: He is also receiving injectable which is administered on monthly basis. I am not sure about the indication for the injection. In addition, we are also giving him some tablet from the pharmacy which are very expensive. We actually do not mind about the price since we find the tablets to be very useful.

R: In which way are they so useful?

P: The tablets help him a lots he gets morning and one at night. Those tablets are helping the user to be contained so that he can stop roaming around the house.

R: When he is admitted how many days does he spend in the 72-hour assessment ward?

P: Three days and not more than that only if he was admitted during the weekends the days he spent in the ward can be more by one day. At least at Siloam he can spent two to four weeks.

R: How does the observation ward differs from acute mental health care unit

P: Psychiatric ward provides quality care to the users, I can allocate 100%. This ward which admits users for a short time I have never come across it in my life. Instead of doing good to people it is causing harm. It means you are killing people by admitting them in this ward. We are not getting any help there. The psychiatric patient is found lingering out there in the community because there are not getting proper treatment they deserve. This ward is Burundi

R: What do you mean when you say the observation ward resemble Burundi

P: When I look at the ward environment, the nursing staff and the patients I find that the place is not good at all for the nurses and the patients admitted there. We cannot put a blame on the staff members because they are also not comfortable. Even the visitors find it difficult to cope but arina ndamulelo

R: When you visit the user did you get a chance to sit with the nurses in private place

P: No you cannot get, there is no such an opportunity. When a user is admitted we have to sit outside in the passage while the user is changed clothes of the medical ward. There is privacy since there are no offices.

R: How does this make you feel?

P: This is horrible that's where you could see that the government is does not care for the people. All the patient who presenting with the symptoms of mental illness are suffering. After completion of 72-hours assessment they are discharged in the community. The patients are very aggressive when they are in the community because some are abusing drugs.

R: In the ward what did you observe as the treatment for the user?

P: I observed that he is supervised during bathing, mealtimes and is given medication.

R: According to your knowledge what is the purpose of the 72-hour assessment ward?

P: I do not have information about that all that I know is that the ward admits the mental health care users for only three days.

R: Mmm

R: What are your recommendation?

P: I can recommend that we should get a temporal ward while waiting for the new ward which is going to be built next year according to the roamers that I overheard. In the meantime, the burnt mental unit can be renovated so that it can utilized again. We are faced with a serious challenge, we are dying physically psychologically and spiritually. The mental health care users are very powerful even if he is getting old but he is still troublesome. The government should do something about this issue before it can lead to death of other people.

R: Do you think that 72-hour observation ward is replacing the mental health care unit which is no existing in this hospital.

P: I never knew that there is a ward like this, I knew that there is overnight ward which admits patients for one day where the patients are given drips. In mental health it does not work. If you offer 72-hour assessment admission you are making the patient's condition worse.

R: Mmm, what else?

P: On discharge the mental health care user will be dancing as an evidence that is not yet fit to go home. Taking the user home when he is in a condition that shows that mentally he still needs care. He will not sleep at night. One time we decided to take the patient Siloam hospital. They commented that how come that we bypass Tshilidzini and bring the user to Siloam? We were supposed to look into the demarcation issue.

R: Mmm!

P: The nurses sometimes think that we do not want to stay with the patient we want to send them to Hayani hospital so that we remain in a comfortable. It is because the ward called 72-hour assessment if failing to provide proper care. It is better if we can build a new ward for the poor mental health care users.

R: Mmm!

P: I swear if my husband can pass on before me I cannot take care of him instead I will pack my belongings leave to stay with my parents. I believe I cannot cope with the user.

R: You sound to be overwhelmed by this situation, anyway I think now we have come to the end of the interview, thank you for agreeing to talk with me.

PARTICIPANT NUMBER EIGHT

IN-DEPTH INDIVIDUAL INTERVIEWS

P: PARTICIPANT

R: RESEARCHER

P: *Good evening*

R: Evening and how are you today?

P: *I am fine*

R: Today it is very cold

P: *Mmm! indeed it so cold*

R: This year it seems as if it will be the coldest winter as compared to other years. I wonder how it is at Gauteng. How did you fellowship today?

P: *The church service was good*

R: And me too I enjoyed the church service though it was a bit prolonged because we had a birthday celebration of the church. Congregants were celebrating that the church has 20 years of existence.

P: *Okay that sounds good*

R: I attend church at the Tshilivho Living Gospel World Mission

P: *I see you are at Tshilivho*

R: Yes, and you?

P: *I am attending at Apostolic Faith Mission Church at Lufule village.*

R: My church today was out at 14h00 to 15h00

P: *Mmm!*

R: While normally we go around 13h30

Like I indicated previously when we were making an appointment that I will come today to conduct an interview session with you. My name is Mrs Mbedzi

Takalani; I am studying with the University of Venda. My topic focus is mental health titled “the experiences of family members regarding 72-hour assessment admission of mental health care users admitted at the selected hospital in Vhembe district Limpopo province. The objectives of this study is explore and describe the experiences of family members regarding the three days’ observation ward which admits mental health care users.

P: Okay!

R: Your participation in this study is voluntary, you are not coerced to take part. At any stage you may withdraw from the study and your refusal to participate will not affect the treatment you are entitled to receive. The purpose of the study is to make recommendation based on the findings of the study geared at improvement of service delivery in mental health care. Further I will also reassure you about confidentiality, information shared will not be discussed with other people who are part of the study. Your name will not be linked to the information you shared with during the interview process. So feel free to take part in this study.

P: Ok I understand.

R: I am presently working at University of Venda at the same being a student

P: Coughing

R: Sorry! You can some water, silence after a while, can we proceed?

P: I am okay let’s go on

R: what is your experience with regard to the admission of a mental health care user for 72-hour assessment and observation in medical ward designated to provide such services? May be you can raise your voice since I cannot hear you.

P: Do you mean how the ward handled me?

R: Almost that kind of experiences, in other how it was for you as the family member?

P: To be honest with you 72-hour assessment unit is not conducive because when you take the mental health care users who is seriously ill to the hospital, he is admitted for a day, two or three days then he is discharged still looking mentally ill.

R: Mmm

P: In the past the situation was different in the old psychiatric ward where the user would be discharged being mentally stable and sound minded. When you look at the patient you can see by looking at him that he is he is fine. He can even communicate that he will take medication himself may not necessarily need to be checked by other people.

R: Mmm

P: But when the user is discharge from this 72-hour observation ward you cannot notice any behavioral change instead the user will be looking the same conditionally like the day he was brought from home on admission. The mental condition will still be the same like when he was admitted

R: What do you mean when you say the mental health care is not stabilized mentally?

P: I mean the user will be talkative, not communicating well with other people, and displaying irritability of mood. Actually I am saying he will still be looking to be the same conditionally.

R: Mmm! that's how you experienced it.

P: But if he admitted for a reasonable period he I mean for a long period he comes back home being well.

R: Well? How do you see that he is well according to you?

P: This is evidenced by the user when he takes his medication as prescribed by the doctor by himself.

R: I hear you saying if he is admitted in the ward for a long period he is discharged looking stable mentally that is condition satisfactory. How long does he stay in the ward to reach that level of mental stability?

P: Even two weeks can make the user stable

P: The mental health care use will say it openly that he will take responsibility for his medication will not anybody to remind him anymore. By the way he is not always troublesome it happens rarely, “zwi sokou ita zwi tshi rithea.”

R: What led to the user being admitted in the 72-hour assessment ward?

P: The user was refusing to eat, to talk with other people, was talking to himself and when you talk to him he will not respond at times he will want people next to him.

R: what else?

P: Sometimes he prefers to be alone at his corner, chasing people away. When he has relapsed he will not want to mix with others, even his mother he does not want to see his mother next to him. At times he ill not the food that we give him because of the beliefs that the food is poisoned.

R: Mmm how do feel about this?

P: It is painful, furthermore taking him to the hospital is a serious challenge. At the present time he is not doing well he is ill it is now taking about three months since he started to show the signs and symptoms of mental illness.

R: Mmm

P: If tell him that he is not well he completely denies to be suffering from mental illness will actually say he is not mentally ill will say “you are the one who is ill”. We should have taken him to the hospital long ago but we are failing. In the past the police officers were the ones who used to take him to the hospital. Now they are no longer assisting us, they told us that it is not their responsibility.

R: Does the user display violent behaviours toward other people or destroy properties

P: Not always aggressive but sometimes he is. If I understood you well you mentioned that SAPS is no longer assisting the family members to take the mental health care users to the hospital, can you tell me what has happened?

R: The police officers informed us that they are not responsible for taking the user to the hospital when he has relapsed.

Mmm I can see this is challenge faced by family members

P: Yes, this a serious concern you see the users has three months being disturbed mentally. When we pay him a visit he does not want to see us he is. The surrounding of his house very neglected and looks bushy. The mother of the mental health care user is very worried, she liked to be with him but he is against that he is chasing her away and that makes her feel very frustrated.

R: *Oh I see*

P: Recently we hired someone to clean the surrounding he refused told the individual to go and clean his own stand. The people will think that we do not care about him, moreover he is staying alone. We have tried to call the SAPS all was in vain.

R: *Mmm!*

P: Previously when we alert them that we have user who is not well who is in need of hospital service, they used to respond and offer assistance by taking the user to Tshilidzini hospital. They will wait until we are done with the admission process demonstrating a caring attitude toward the community. Now they are no longer helping us to take the user to the hospital, instead they say we should get a way of managing the situation on our own.

R: *Mmm! That sound strange to me I was not aware about that.*

P: I really do not know, as to what else we can do considering that to apprehend a user when he is in a psychotic phase is very difficult.

R: You seemed to be right especially the males are very powerful as such difficult to handle. When considering the fact that he has been ill for a couple of months that indicates that his conditioning will deteriorates leading to poor prognosis. Since when did SAPS stopped to assist you?

P: Since February this year

R: Was the user aggressive when police officers were called?

P: Yes, about three time that I witnessed him being aggressive toward the family members. But now he does look aggressive, he is locking himself in the house. During another time he assaulted his mother and sustained some serious injuries, who was treated at Tshildzini Hospital. She had to be sutured. The incident was witnessed by S.A.P.S when they came to our house and find that there was blood all over spilling everywhere.

R: Tell me about that?

P: What I do not like about the police officers is when they respond to the call when someone is injured but if you call them to say the user has started to be aggressive, they will not respond to the call. They do not believe it will ask us what he did. Like I am saying he is not always dangerous but at times he is a danger to himself and other people around him. The police will ask you did he injured someone or killed a person.

R: You sound frustrated by that process of asking for assistance from SAPS.

P; Yes, it is really frustrating if they do not respond to our request what mist we do in that situation? R: Who is usually accompanies the user to the hospital when he is admitted?

P: Myself with company of the S.A.P.S

R: How was the admission process for you?

P: When we go to the hospital the user is seen by doctor, who assess him asking some questions. The doctor will then confirm that he has relapsed which is evidenced by the way he answered the questions. The user is given injection to calm him in the causality department. Thereafter the user is escorted to the ward on a stretcher. In the ward they will still ask some questions which we are familiar with.

R: If you can estimate how many hours did the admission process take?

P: The process is lengthy, it takes a long time you know, because sometimes I can arrive at the hospital at 13h00 and finish at 17h00 (4hrs)

R: What do you think is causing the delay?

P: In causality you find that there is only one doctor who is attending all the patients there. It takes him a long time to see the patients.

R: I hear you explaining that the doctor is usually busy, are you saying that the shortage of doctors of the only root cause of the delays?

P: Sometimes there is an emergency situation whereby the doctors will rush to go and help the patient. We are expected to wait while the user is tied up.

R: Mmm! I see, how you feel about the mental health care act forms that are completed on admission of the mental health care user.

P: The form also causes some delays of admission process, in that the user is been asked same questions every time for example, how many are in your family, is there any history of mental illness? It will good if this kind of information is kept in the file of the patient for future references

R: Mmm it becomes boring when you are asked same questions. It means that consumes a lot of your time

P: It is better if you have your own care at least you can manage to go home safely. In the ward we do experience some delays but not like in causality. In the ward the nurses assist each other to admit the patient. The user cannot go to the ward without being seen first by the doctor.

R: You are saying in the ward the admission process is better and wonder how is it like that?

P: When arrive in the ward the nurses assists each other, one will be attending this form while the other one complete another form, so it becomes so easy to do that work. In causality department is very busy as such we can understand that the waiting period will be a bit longer.

R: How were welcomed in the 72-hour observation ward?

P: When we enter the ward we felt warmly welcomed by the nursing staff. No problem was experienced

R: Warmly welcomed what do mean!

P: We were greeted and offered a seat, then they ask some questions like how are related to the user and addresses.

R: When you visit the patient what was your experiences?

P: It was nice the nurses were good to us they offered us some chairs so that we can sit down.

R: What do you think is the purpose of the 72-hour assessment ward?

P: I do not know

R: While the user was hospitalized did you had a chance to meet the doctor who is attending the user

P: No! We only met the doctor at causality on admission of the patient.

R: What about the ward doctor

P: No I never met him ever since I started coming to this ward.

R: Were you given any information regarding the purpose of the ward?

P: I was not informed but previously in the old mental health care ward the nursing personnel used to have a conversation with us during visiting times. They give us health talks advising us how we should manage the users after discharge from the 72-hour assessment ward. Presently in this new ward they are not able to do that anymore. In the old ward the nurse will sit down with us discussing issues related to the users such as how he came to the hospital as well as how do we see him now. We are able to explain that the user is reserved he is not talkative. They must not keep him in the hospital because he is quiet that is to say even if he is quiet they need that it is his personality character.

R: How do you experience the treatment program that is implement to treat the user?

P: I am no satisfied about the way users are cared for at the medical ward designated to render 72-hour assessment. The users are discharged before they are mentally stable and you find that they are still psychotic. In the past

mental health care users who were admitted in the acute mental ward they will be discharges being in a stable condition, may stay for three months without showing the signs and symptoms of relapse. During the recent admission the user was taken to the Siloam hospital where he was admitted for two weeks. To my surprise the user was readmitted shortly after being discharged from the hospital. I wonder if the medication that was used in the acute ward is still the same like the one which is given in the observation ward, or maybe they are changed

R: Mmm, when you say the nurses are caring can you tell me more about it?

P: They care because they take history about the patient which will give them the direction of planning for the appropriate care to be rendered to the user on admission.

R: What was the diagnosis of the mental health care user?

P: I was not told

R: When the user was transferred to Siloam, what was your experience?

P: Of course on admission we are informed that the user will be transferred to another health establishment if there is need, i.e. in case he does not get better within three days. The problem that we experience when the user is transferred to Siloam hospital is the distance which is inaccessible for us. Siloam hospital is too far we do not have money for transport. Furthermore, we are not informed when the user is transferred to Siloam hospital.

R: Regarding the environment how was it for you

P: My understanding of the observation ward is unit which act as a receiving mental health facility, which admits users for a brief period where the user can be discharge home if he is stable or transferred to another hospital for care, treatment and rehabilitation. The ward environment is not organized; the space is too small not adequate to accommodate the users. Since the acute ward burnt down it has been a long time the government should have built another ward. Sometimes the user was admitted at Donald Fraser and Hayani hospital when there was no space available at Siloam hospital.

R: How do you it?

P: At least the two health establishment are not that far they are nearer to us and we found that the same mental health care providers from the acute mental ward were working there. This made us to feel more comfortable knowing that the user is familiar with them and the nurses know the user well. The worst painful thing is when there is no vacant space the user is discharged home irrespective of the unstable condition.

R: What is your recommendation?

P: I recommend that mental health care users should be admitted in a separate unit they need to have their own space where they will interact freely with each other. The observation ward deprived them they cannot move around since the space is limited. The user is admitted with a history of roaming around so they need a spacious unit. The police officers should assist us when the user is in need of admission, we find it very difficult to take him to the hospital when he has relapsed because he does appreciate that service as such will not cooperate at all. S.A.P.S used to help us but now things have changed. We do not where can we be assisted? Taking a medically ill individual is easy because he or she is weak but with a mentally ill person it is different.

R: Indeed, this sound to be serious challenge I can see. Now we have come to the end of the interview session. I would like to take this opportunity to thank you for your time and once the information you shared with me. I will make an appointment next time

P: MMM!

R: The aim of the meeting will be to clarify some issues which may not be clear to me and secondly to discuss the result of the study so that I may verify if the what I found out is what you exactly what.

P: You are welcomed, no problem