A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH CARE USERS TO PROMOTE CONTINUITY OF CARE

By

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28.02.2024

DEDICATION

This study is dedicated to:

Elias, my husband, for his unconditional support. My children, Nkhensani, Xivono, Nkavelo, and grandchildren, Minkhenso and Andziso,
for their understanding and support.

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ABSTRACT

Mental healthcare users (MHCUs) often face mental health challenges such as relapse, consequently leading to readmissions due to inadequate continuity of care. The study aimed to develop a social support framework for MHCUs to promote continuity of care.

The study was conducted in mental health institutions and primary health care (PHC) settings in Mopani, Vhembe and Capricorn districts in Limpopo province. A qualitative, grounded theory approach guided the study. Phase one sought to explore and describe the experiences of operational managers, mental healthcare providers (professional nurses and social workers), and MHCUs regarding social support and continuity of care. Purposive sampling was used, and data were collected from five operational managers, 14 professional nurses, three social workers and nine MHCUs using semi-structured face-to-face interviews. A comparison method was used to analyse the data.

Four themes emerged. Theme one described issues related to support for MHCUs, namely the role of the multidisciplinary team (MDT) and other informal support structures, lack of support from family, the community and the Department of Health and significant social institutions in the daily support of MHCUs. Theme two concerned matters essential in relation to the provision of mental healthcare services, namely inter-professional collaborative mental healthcare services, mental healthcare providers' (MHCPs) views on ideal mental healthcare services, knowledge deficits on issues surrounding mental healthcare, and leadership as the core of mental health. Theme three focused on contemporary issues in healthcare impacting mental health, namely COVID-19

restrictions' hindrance to mental health. Theme four highlighted essential steps to move forward regarding the provision of support for MHCUs, namely mechanisms of support, communication media essential in promoting social support, and continuity of care.

The findings of the qualitative, grounded theory approach reflected inadequate social support is being provided for MHCUs, prompting the researcher to develop a conceptual framework to address this phenomenon. Phase two of the study thus sought to develop a social support framework to promote continuity of care. Phase three focused on a group of experts and stakeholders validating the social support framework.

Keywords: continuity of care, framework, mental healthcare provider, mental healthcare user, social support

TABLE OF CONTENTS

CHAPTER 2
LITERATURE REVIEW

CHAPTER 3
RESEARCH DESIGN AND METHODS

CHAPTER 4
QUALITATIVE ANALYSIS, FINDINGS AND DISCUSSION

CHAPTER 5
DEVELOPMENT OF A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTHCARE USERS TO PROMOTE CONTINUITY OF CARE

CHAPTER 6
VALIDATION OF THE CONCEPTUAL FRAMEWORK

CHAPTER 7

SUMMARY OF KEY FINDINGS, LIMITATIONS, CONCLUSION, RECOMMENDATIONS AND PERSONAL REFLECTIONS

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEXURES

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The burden of mental disorders continues to grow and has a substantial global impact on health, social and human rights, and economic circumstances (WHO Health Report 2023). Mental disorders account for a high proportion of all disability-adjusted life years being lost worldwide, and this burden is predicted to increase significantly in the future. An estimated 340 million people worldwide are affected by depression, 45 million by schizophrenia, and 47.5 million by dementia (WHO Health Report 2023). Moreover, depression is described as the most prevalent psychiatric disorder affecting more than 300 million people. A South African national survey found that the prevalence of depression among the South African population varied between 14.7% to 38.8%, which was higher than the global prevalence of mental disorders stipulated by the WHO (Osuch, Motswaledi, Makiwane & Taylor-Memmory 2023:47). Additionally, a white paper recently released by the Developmental Pathways for Health Research Unit (DPHRU) at Wits/Medical Research Council indicated that approximately one in four South Africans, or 25.7%, are likely experiencing depression. The study found that over a quarter of those surveyed showed moderate to severe depression symptoms. The incidence of mental illness varied across South Africa's nine provinces, with the Northern Cape, Eastern Cape, Western Cape, Gauteng, and Mpumalanga showing elevated rates.

World health leaders have thus recognised the need to prioritise mental health and well-being. Due to the burden on health, mental health and well-being aspects have also been included in the Sustainable Development Agenda (WHO 2019). The WHO Mental Health Gap Programme, launched in 2008 and revised in 2024, is also underway and aims to enhance services for mental, neurological and substance use disorders, especially in low- and middle-income countries.

The National Mental Health Policy Framework and Strategic Plan [2013-2020] (2023:11) equally regards mental health as an essential element of health and crucial to the overall well-being of individuals and society. The South African health system has undergone a

major transformation to improve mental health services at the community level and integrate mental health at the provincial level. However, challenges in the availability and quality of follow-up and follow-through care that would improve treatment adherence persist (Hansen, Kvale, Hagen, Havnen & Ost 2018:101).

Despite an acknowledgement of the magnitude of the mentioned challenges and increased policy and programme frameworks suggesting the way forward, health systems globally and nationally have not yet effectively responded to the burden of mental disorders or the need for treatment and its provision. According to Misgan and Belete (2021:1), the global burden of anxiety and depressive disorders increasingly accounts for a high burden of morbidity in low-income countries. Misgan and Belete (2021:1) engaged in research focused on comparing anxiety and depressive disorders' symptoms in patients with medical conditions to those healthy in the community. Findings revealed a higher prevalence of anxiety and depression among the sick than those who were healthy and in the general community. Furthermore, a lack of social support, loss of a parent before age 18, physical or verbal abuse, as well as general medical conditions were found to be significantly associated with anxiety and depressive symptoms. Moreover, a lack of treatment and support contributes to poor continuity of care. Thus, continuity of care and care coordination is an equally critical issue in all healthcare systems, especially for those diagnosed with chronic (mental) health conditions.

According to Hou, Zhang, Cai, Song, Chen, Deng and Ni (2020:2), previous studies have found a relation between social support and mental health, illustrating the importance of socially supporting individuals with mental health challenges. Social support entails individuals' experience of being involved in a social group where people mutually support each other (Hou, Zhang, Cai, Song, Chen, Deng & Ni 2020:2). However, despite strong evidence demonstrating the value of social support, this support is often lacking due to insufficient financial, human, operational and structural resources (Mulaudzi, Mashau, Akinsola & Murwira 2020:4; Santos 2020:11).

This chapter presents an overview of the thesis, the background of the research problem, the aim, research objectives, research questions and the significance of the study. The key terms and theoretical foundation guiding the study are also explained. The

methodology is briefly described, and the chapter concludes with an outline of the thesis's layout.

1.2 BACKGROUND OF THE RESEARCH PROBLEM

While teaching and assessing students in clinical areas (hospitals), the researcher discovered most patient readmissions were attributed to a lack of social support, compounded by a lack of knowledge among mental healthcare users (MHCUs) and family members. The limited support MHCUs receive upon discharge was inadequate to sustain their optimal mental functioning after discharge.

According to the National Mental Health Policy and Strategic Plan 2023-2030 (2023:12), stability in a person's life acts as a buffer to mental illness. Social support in the form of genetic makeup, supportive and stimulating childhood environments and opportunities for learning, work and fulfilment of social roles may moderate genetic and environmental vulnerabilities and confer resilience to stress. However, poor social and moral support for MHCUs has persisted throughout history, manifested by stereotyping, fear, embarrassment, anger and rejection or avoidance. As a result, many MHCUs are socially shunned, which may impact their ability to find work, housing, or make friends (Leeming & Wattis 2022:277; Rosander 2021:1103; Cassidy, Thompson, El-Nagib, Hicking & Priebe 2019:10). Thus, they become socially isolated and unemployed. This lack of reintegration into the community often leads to psychiatric rehospitalisation within two years (Yotsidi & Kounenou 2018:174).

According to Yotsidi and Kounenou (2018:165), areas of treatment, housing, education and entertainment have become more accessible to MHCUs than employment, active citizenship, social relations, social networks and participation in activities in the community. However, Yotsidi and Kounenou (2018:165) emphasise that the social aspects that appeared ignored must be considered for community-based treatment to become more responsive and appropriate for MCHUs.

Elugbadebo, Ojagbemi, Adefolarin and Gureje (2021:1518) attest that subsequent dropout from follow-up care is common and represent hindrances to the provision of mental health services. Barriers include distance from the health service facility, long

waiting times and financial constraints. There seem to be challenges in ensuring continuity of care. It is therefore becoming increasingly important to promote social support for MHCUs and ensure continuity of care. A social support framework for MHCUs, which considers the current challenges yet optimises available resources, could provide a means to address the lack of social support for MHCUs and promote their continuity of care.

1.3 PURPOSE OF THE STUDY

The purpose of the study was to develop a social support framework for MHCUs to promote continuity of care.

1.3.1 Research objectives

The research objectives were divided into three phases:

Phase one: Conduct a situation analysis

- Explore and describe the experiences of operational managers, mental healthcare providers (MHCPs) (professional nurses and social workers), and MHCUs regarding social support and continuity of care.

Phase two: Develop a social support framework

- Develop a social support framework to promote continuity of care.

Phase three: Validate the social support framework

- Invite a group of experts and stakeholders to validate the social support framework.

1.3.2 Research questions

The following questions assisted in clarifying the research objectives across the three phases:

Phase one:

- What are operational managers' and professional nurses' experiences with social support and continuity of care?

- What are social workers' experiences with social support and continuity of care?
- What are MHCUs' experiences with social support and continuity of care?

Phase two:

- What should a conceptual framework consist of to promote social support for MHCUs?

Phase three:

- What are experts' and stakeholders' views of the proposed conceptual framework?

1.4 SIGNIFICANCE OF THE STUDY

Social support has been provided to MHCUs for decades, with inadequate outcomes. The current global mental health service provision situation reflects the provision of mental health activities has changed. The social support framework developed in this study intends to increase social support for MHCUs through the promotion of continuity of care. The nature of the study's findings (see Chapter 4) could prompt other researchers to embark on further research on the topic, further improving social support for MHCUs, resulting in a strengthened mental healthcare system.

The framework's implementation will also assist healthcare providers to focus on delivering mental health services using stakeholder activities, as described in Chapter 5. The framework will serve as a map for the allocation of human and material resources, as the findings in Chapter 4 explicitly indicate such a need.

Moreover, the social support framework is evidence-based and hopes to fill the current void, both theoretically and in practice, by providing social support to MHCUs, thus optimising resources and contributing to the quality of life of these individuals.

1.5 SCOPE OF THE STUDY

This study included professional nurses and social workers who constantly interact with MHCUs in mental health institutions and primary healthcare (PHC) settings, as well as MHCUs who were coherent and stable, and were discharged to the community during

the study. The participants were from Mopani, Vhembe and Capricorn districts in Limpopo province.

The study only covered public mental health institutions and PHC settings in Limpopo province. A qualitative approach was followed, and it encouraged the researcher to immerse herself in the data during interviews, resulting in thick descriptions of the qualitative findings as the researcher engaged in in-depth interviews using open-ended questions. Thus, the nature of the research approach allowed for the transferability of findings to similar geographical areas.

1.6 DEFINITIONS OF KEY CONCEPTS

1.6.1 Continuity of care

Continuity of care refers to a continuous relationship between a patient and identified healthcare professionals and pathways to achieve quality care and patient satisfaction (Dictionary of Nursing 2021). In this study, continuity of care refers to an uninterrupted relationship between healthcare providers and MHCUs, and the related pathways to ensure quality and consistent care levels, with support included as part of mental health care.

1.6.2 Framework

A framework can be described as a logical grouping of related concepts that are created to draw together several aspects that are relevant to a complex situation, such as a practice setting (Ayton, Tsindos & Berkovic 2023:29; Risjord 2018:4). In this study, a framework refers to a schematic representation of the logical grouping of concepts derived from the reiterative coding process.

1.6.3 Mental healthcare provider (MHCP)

A MHCP is a person providing mental healthcare services to MHCUs and includes mental healthcare practitioners (South Africa 2017:s1). In this study, mental healthcare providers

refer to professional nurses and social workers involved in MHCUs' care, treatment and rehabilitation.

1.6.4 Mental healthcare user (MHCU)

A MHCU refers to a person receiving care, treatment, and rehabilitation services or using a health service at a health establishment aimed at enhancing their mental health status (South Africa 2002: s1). In this study, an MHCU means a person receiving care, treatment and rehabilitation under the supervision of the MHCPs and family members at institutional and community levels.

1.6.5 Social support

Social support entails individuals' perceptions or experiences of being involved in a social group where people mutually support each other (Hou et al. 2019:1). In this study, social support refers to the network of hospital staff, family members, relatives, neighbours and community members available in times of need to offer moral, interpersonal and financial support to MHCUs through interaction and any other means that can enhance their well-being.

1.7 PARADIGMATIC PERSPECTIVES

A paradigm is described as a means to examine natural phenomena, and it encompasses a set of philosophical assumptions that guide the researcher's approach to inquiry (Brink, Van der Walt & Van Rensburg 2018:20). Thus, in this study, a paradigm is considered an overarching philosophical framework that supports the production of scientific knowledge.

Kathy Charmaz's constructivist approach to grounded theory, as articulated in her 2014 work, marks a paradigmatic shift from the methodology's positivist origins established by Glaser and Strauss (1967). In this perspective, Charmaz (2014:6) emphasises the co-construction of knowledge between researcher and participants, deviating from the notion of objective discovery (Charmaz 2014:6). This approach recognises the researcher's active role in interpreting data, underscoring the subjective nature of knowledge creation (Charmaz 2004:2014). This paradigm aligns with constructivist principles, values the

contextual and procedural aspects of meaning-making, and thus enriches the exploration of complex social phenomena (Charmaz 2014). Pragmatism informs symbolic interactionism, a theoretical perspective; hence, the researcher found theoretical assumptions imperative in this study.

- ***Theoretical assumptions***

Charmaz (2014:277) states that symbolic interactionism offers grounded theories an open-ended theoretical perspective. Symbolic interactionism forms part of the theoretical underpinnings in grounded theory research, particularly within Charmaz's constructivist approach. Originating from the works of George Herbert Mead and further developed by Herbert Blumer, symbolic interactionism is a sociological perspective that emphasises the role of symbols and language as core elements of human interaction (Blumer 1969).

In the context of grounded theory, especially as reinterpreted by Charmaz, the emphasis on individual experiences and the meanings attributed to these experiences align seamlessly with symbolic interactionism. This theoretical framework aids in exploring how individuals interpret and respond within their social environments, focusing on the subjective interpretations and everyday experiences of people (Charmaz 2014:262).

Incorporating symbolic interactionism into grounded theory research provides a lens to examine the dynamic processes through which individuals shape and are shaped by their social realities (particularly relevant in studies of social processes), identity formation, and interpersonal relationships (Denzin 2017).

1.8 RESEARCH DESIGN AND METHOD

A qualitative grounded theory approach was used in phase one. According to Polit and Beck (2021:800), qualitative research refers to the investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich and narrative material using a flexible research design. The research design is an overall plan for addressing a research question and includes specifications for enhancing the study's integrity (Polit & Beck 2021:801). A conceptual framework was developed in phase two. The study's findings, as outlined in Chapter 4, were analysed and interpreted, followed by the development of a conceptual framework. The framework was assessed using pragmatic

criteria, and Chinn and Kramer's (2022:170) five questions on clarity, simplicity, generality, accessibility and importance were applied to evaluate its structure. A full discussion of the research design and methods is provided in Chapter 3.

1.8.1 Research setting

The research setting refers to the specific place or places (site or location) where data are collected (Brink et al. 2018:47; Grove & Gray 2019:35). This study took place in the Mopani, Vhembe and Capricorn districts. Limpopo province consists of five districts; however, in terms of data collection, the researcher focused on three districts with specialised mental health institutions. MHCUs are referred to these hospitals for further management. All categories of MHCUs are admitted in these hospitals; that is, acute, sub-acute, as well as long-term.

Limpopo is one of nine provinces and the northernmost of South Africa with the highest level of poverty of any South African province; 78.9% of its population lives below the poverty line (Limpopo-Wikipedia 2018:1). According to the National Mental Health Policy Framework and Strategic Plan [2023-2030] (2023:13), people living in poverty have an increased risk of developing mental disorders, face increased obstetric risks, a lack of social support, and increased exposure to violence and worse physical health. The researcher ultimately took note of the prevalence of mental disorders in Limpopo and conducted this research study in the province after recognising a need to address the challenge of inadequate social support for MHCUs.

The Limpopo province shares international borders with districts and provinces of three countries: Botswana's central and Kgatleng districts to the west and northwest, respectively; Zimbabwe's Matabeleland South and Masvingo provinces to the north and northeast, respectively; and Mozambique's Gaza Province to the east. Limpopo province is the link between South Africa and countries further afield in sub-Saharan Africa. On its southern edge, from east to west, it shares borders with Mpumalanga, Gauteng and the Northwest provinces (Limpopo-Wikipedia 2018:2).

The province has the lowest White population (2.4%) in the country, while it has the highest Black population (97.3%) (Limpopo-Wikipedia 2018). Districts are also populated

by particular ethnic groups. For example, most Mopani district inhabitants are Tsonga-speaking, and in the Vhembe district, the inhabitants speak Venda. However, the majority of Limpopo province inhabitants are Bapedi, as more than half of the province is occupied by Northern Sotho-speaking people.

Figure 1.1: Map of Limpopo province depicting the five districts and municipalities (Limpopo-Wikipedia 2018:5)

Mental health services in Limpopo province are mainly guided and governed by the Mental Health Care Act, No. 17 of 2002 (MHCA), mental health regulations and policy guidelines on 72-hour assessments. Mental health services are offered in specialised psychiatric and general hospitals. State MHCUs are admitted to specialised psychiatric hospitals with maximum security. Depending on their location, discharged MHCUs receive follow-up care at nearby mental health clinics or local PHC settings.

1.8.2 Population and sampling

According to Polit and Beck (2021:52), a population refers to all the individuals who are the focus of the research. For this study, the population was operational managers (N=17), professional nurses (N=390), social workers (N=11) and MHCUs (N=1030).

Purposive sampling, a non-probability method, was used to sample participants. This method assisted the researcher in selecting operational managers, professional nurses

and social workers providing mental healthcare services, and MHCUs who were atypical and knowledgeable about the research phenomenon (Brink et al. 2018:126; Grove & Gray 2019:479).

Table 1.1 indicates the sample that was selected per category. The number of participants was informed by staff ratio/availability as well as the role these staff members played.

Table 1.1: Number of participants per category

Category	Number of participants
Operational managers	5
Mental healthcare providers (MHCPs)	14
Social workers	3
Mental healthcare users (MHCUs)	9

1.8.3 Data collection

Data were collected through semi-structured, one-on-one, face-to-face interviews. Thirty-one participants took part in the study. Observations, field notes and memos were also used as data information sources. A detailed discussion of the data collection process is provided in Chapter 3.

1.8.4 Data management and analysis

Data collection, analysis and sampling occurred simultaneously as this is a fundamental feature of grounded theory, as postulated by Brink et al. (2018:108). Creswell and Poth (2018:87) attest that theory-building emerges through simultaneous and iterative data collection, analysis and memoing processes. The researcher used constant comparison to develop and refine theoretically relevant categories. Categories elicited from data were also constantly compared with earlier data so that commonalities and variations could be determined (Brink et al. 2018:108; Polit & Beck 2021:481). A full discussion of the data analysis and management processes follows in Chapter 3.

1.8.5 Rigour in grounded theory

According to Grove and Gray (2019:34), rigour is described as striving for excellence in research, which requires discipline, adherence to detail, precision and accuracy. Ayton et al. (2023:233) affirm that the increasing use of the grounded theory method in nursing research has directed attention to the quality of studies, and rigour is thus used to enhance credibility.

The researcher considered rigour essential in this study as grounded theory encompasses critical aspects and is underpinned by research steps that require scrutiny. Furthermore, rigour is imperative as the main aim of this approach is to yield quality findings or results (Brink et al. 2018:110). A detailed discussion of rigour is presented in Chapter 3.

1.9 ETHICAL CONSIDERATIONS

In aligning with the updated Belmont Report of 2022, a grounded research study must adhere to the principles of respect for persons, beneficence, and justice. Respect for persons mandates informed consent and the acknowledgement of participant autonomy. Beneficence requires the minimisation of harm and maximisation of benefits, ensuring that the research does not adversely affect participants. Justice demands the equitable selection and treatment of subjects, avoiding exploitation. These principles guide ethical decision-making, ensuring the protection and dignity of participants in the research process. A full discussion will follow in Chapter 3.

1.10 STRUCTURE OF THE THESIS

This thesis is arranged into seven chapters.

Chapter 1: Orientation to the study

Chapter 1 outlines the orientation of the study. The introduction, background to the research problem, the purpose of the study, the significance of the study, definition of concepts and philosophical assumptions are outlined. A brief overview of the research

design and methods, data collection and analysis methods are also provided. Measures to ensure trustworthiness and ethical considerations are discussed.

Chapter 2: Literature review

This chapter covers literature on legislative provisions concerning mental health, social support as the basis of continuity of care, as well as continuity of care at the hospital and PHC level across continents.

Chapter 3: Research design and methods

This chapter outlines the research design, approach, population and sampling employed in this study. The research phases, data collection and analysis procedures, measures to ensure trustworthiness and methodological processes used during the study are discussed.

Chapter 4: Qualitative analysis, findings and discussion

In this chapter, the study's findings are analysed, interpreted, discussed and supported with participant quotes. The findings are controlled against literature.

Chapter 5: Development of a social support framework for mental healthcare users to promote continuity of care

This chapter outlines the six elements of the conceptual framework, as described by Dickoff, James and Wiedenbach (1968), that were used in developing the social support framework for MCHUs to promote continuity of care.

Chapter 6: Validation of the conceptual framework

This chapter discusses the framework's validation using Chinn and Kramer's (2022) criteria by posing questions concerning the framework's clarity, simplicity, generality, accessibility and importance. The study's contribution to the body of knowledge is also highlighted.

Chapter 7: Summary of key findings, limitations, conclusion, recommendations and personal reflections

This chapter summarises the study's key findings, limitations and conclusion. Recommendations are made, and the researcher's personal reflections are highlighted.

1.11 SUMMARY

This chapter introduced and described the background of the study. The problem statement and aim, which included the purpose, objectives and research questions, were indicated. Definitions of key concepts were also presented. The foundation of the study, research design and methods used were introduced, and the scope of the study was presented. Chapter 2 provides a review of literature related to the research topic.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter describes the literature that was reviewed related to continuity of care. According to Schurink, Roestenburg and Fouché (2021:94), a literature review is a mechanism for ensuring that the study is rooted in existing knowledge and it describes the discipline within which the study is conducted. The focus of this chapter is on a review of the literature that relates to rehabilitation, or the care given to MHCUs post-discharge at the hospital and community level, the standard or level of rehabilitation in mental health care at this juncture, as well as the mental well-being care legislature's contribution to these specialised services.

In this chapter, continuity of care is the broader concept explained in terms of MHCUs' rehabilitation in order to be consistent with the legislature that mostly refers to aspects related to continuity of care as rehabilitation. Other core concepts explored at greater length due to their proximity to the concept of continuity of care include MHCUs' readmission and follow-up care. Furthermore, the legislative provision for mental health care forms part of the chapter because the researcher believes that continuity of care can be better understood if background information of service providers' efforts directed at mental health services is available.

2.2 APPLICATION OF LITERATURE IN THE STUDY

Polit and Beck (2021:87) offer various reasons for undertaking a literature review. Thorough reviews of literature place researchers in a position to determine what contribution they can make towards the body of knowledge; for example, their findings could be useful in addressing gaps or inconsistencies (Polit & Beck 2021:87; Schurink et al. 2021:94). There are various reasons for reviewing literature; however, in this study, the researcher wished to determine whether clinical practice in a South African context is consistent in rehabilitating MHCUs (continuity of care) as described in different mental

healthcare legislative frameworks (Grove & Gray 2019:152). However, international literature was also reviewed to explore national mental healthcare standards.

In grounded theory, the literature review is most suitable if it is done after data collection. This view is supported by Polit and Beck (2021:87), who indicate that researchers often collect data before reviewing literature in grounded theory. However, Brink et al. (2018:59) claim that literature reviews may differ depending on the type of study. Some researchers prefer to review literature prior to data collection because there might be a need to explore the broader topic and inform the researcher of existing knowledge regarding a particular phenomenon. In this study, literature was reviewed in two phases, that is, at the beginning of the study and after data collection.

The researcher engaged in an early literature review to explore existing knowledge. The literature review was guided by the objectives of the study. A search of literature from 2015 to 2023 included the following: SAGE, Google Scholar, CINAH, PubMed & MEDLINE. These sources were selected based on the credibility of literature they publish, and articles are peer-reviewed. The policy frameworks, guidelines, reports and other sources were also searched to gain insight as sources of information.

The keywords used in the literature searched were social support, continuity of care, mental health, mental illness and framework. The researcher reviewed literature to identify commonalities, differences and gaps. The literature was summarised, and an evaluation occurred to identify what is missing in the literature.

The researcher believed this action would contribute meaningfully to the body of knowledge as the researcher was of the opinion that gaps exist in relation to MHCUs' rehabilitation post-discharge. However, the researcher also upholds the views of scholars who maintain that, in grounded theory, a review of the literature should be preceded by data collection (Polit & Beck 2021:87). In this study, the researcher thus later engaged in a literature review in order to explain, support and extend the framework developed in the study (Brink et al. 2018:59; Polit & Beck 2021:87). Polit and Beck (2021:88) attest that a literature review facilitates the researcher's interpretation of findings after data has been analysed. For this study, the researcher's point of departure is an explanation of

legislative provisions for mental health services to offer background information on mental health services.

2.3 LEGISLATIVE PROVISIONS FOR MENTAL HEALTH SERVICES

The new South African Constitution facilitated transformation related to the rendering of health services to the country's inhabitants. The White Paper for the transformation of the health system was published in 1997 as part of the transformation process after the democratic elections that took place in 1994. This paper describes the delivery of mental health in a new way, focusing on PHC principles. The National Mental Health Policy Framework and Strategic Plan [2023-2030] was developed from the White Paper to address mental health-related issues. However, notably, the National Mental Health Policy Framework and Strategic Plan of 2023-2030 was preceded by the Mental Health Care Act (MHCA), which was introduced in 2004. This document marked a major departure from the past as it attempted to change the negative outlook that people had towards MHCUs by empowering them with rights as well as improving their access to mental health institutions (National Mental Health Policy Framework and Strategic Plan [2023-2030] 2023:9). Strategies to receive healthcare services also improved as the Act stipulated that MHCUs should first consult PHC facilities before visiting the actual health establishment. This action merged health issues related to mental well-being into health services dealing with general issues and promoted the evolution of community-based care.

2.3.1 Merging mental health into primary health care services

Mental health is regarded as the core of health care. As a result, it has to be merged into health policies and practices, with the main aim being to promote better global health and close the gap in treatment for mental conditions as supported by the National Mental Health Policy Framework and Strategic Plan (2023-2030). Moreover, Upagadhaya, Jordans, Adhikari, Gurung, Petrus, Petersen and Komproe (2021:1) state that important developments put in place in the global mental health arena to improve mental health services appear to yield poor results, as MHCUs still do not have access to quality mental health care. Therefore, in order to realise these efforts, the National Department of Health

has developed various strategies. One of the strategies entails merging mental health into PHC services.

The merging of mental health into PHC services forms the basis for effective continuity of care. In order for MHCUs to continue receiving appropriate care post-discharge, mental health services need to be established in different communities; hence, the integration of this section in this chapter. The merging of mental health into PHC services calls upon visionaries who are committed and ready to allocate resources and oversee the implementation of mental health across provinces while offering support (Madlala, Miya & Zuma 2020:1). However, despite all efforts by the National Department of Health to ensure that mental health is accessed by MHCUs, a gap in treatment remains a challenge in South Africa. Hence, the effective merging of mental well-being services into PHC forms part of the National Mental Health Policy Framework's objectives. If this approach is effective, increased mental health treatment and an improved health burden will be evident.

The Mental Health Policy Framework and Strategic Plan of South Africa states the main aims of merging mental health care into PHC are to:

- Ensure larger scale coverage for mental well-being at the PHC level for all stakeholders essential in promoting mental well-being.
- Advance mental health awareness among the general public, thereby fighting the disgrace and prejudice attached to mental illness.
- Advance South Africans' mental well-being through an alliance between the Department of Health and other stakeholders on mental well-being issues.
- Trust local communities, especially MHCUs and providers, to promote mental well-being and recovery.
- Advance and ensure that MHCUs' rights are protected.
- Engage in intersectoral collaboration to make determined efforts with regard to the virtuous circle of poverty and mental health care.
- Establish a system to monitor and evaluate mental health care.
- Offer planning and provide mental health in an evidenced-based manner (National Mental Health Policy Framework and Strategic Plan [2023-2030] 2023:9).

According to the WHO Mental Health Report (2022:211), the merging of mental well-being into services that deal with general health issues has many benefits. For instance, stigma for MHCUs and providers will be reduced as all health problems are tackled together, irrespective of whether they are physical, mental or behavioural. Moreover, advanced screening and treatment will be provided, improving detection rates of MHCUs presenting with vague somatic complaints related to mental illness, resulting in better treatment for the physical aspects affecting MHCUs and vice versa. Administrative advantages include an infrastructure that could be shared, leading to a service that will be cost-efficient. There is also the possibility of mental well-being coverage on a larger scale, and the use of community resources, which can partly offset the limited availability of mental health personnel (WHO Mental Health Report 2022:211).

Notably, the merging of mental health services requires thorough assessments to direct the provision of services, such as care and treatment, at different levels. For example, services such as alcohol intervention strategies could be offered successfully in a primary setting, while acute psychosis can be more appropriately treated in a health facility with doctors who are psychiatrically trained and have laboratories available to conduct investigations and prescribe specialised drugs. In such instances, referrals back to the primary setting could be made to ensure continuity of care, where primary healthcare providers are placed to see to the best interests of patients and can thus provide continuous support to MHCUs and their families.

The WHO (2022:211) further indicates that the manner in which health facilities function and the status quo of primary, secondary and tertiary care levels across countries dictates mental well-being should be merged into healthcare facilities that deal with general health issues. For example, in countries such as Cambodia, India and the Islamic Republic of Iran, the merging of mental health services was successful since the following aspects were taken into consideration by policymakers:

- Health providers who are not psychiatrically trained must be equipped with appropriate knowledge and skills relating to mental well-being, and they must be instilled with a willing spirit to treat and manage MHCUs.

- Adequate staff knowledgeable of psychotropic drug prescriptions and authorised to prescribe them, should be available at clinics and hospitals.
- Psychotropic treatments for MHCUs must be accessible at the first level of care as well as the secondary level.
- General healthcare providers must be encouraged and mentored by mental health specialists.
- A referral system between the first level of care, the secondary and the tertiary level must be instituted and effectively managed.
- A redistribution of funds from tertiary to secondary and first levels of care should be in place, and additional funds must be made available.
- Monitoring, evaluating and updating merged activities should be a continuous process; as a result, recording systems need to be established.

2.3.2 Challenges in merging mental health services with primary health care

Merging mental health services into PHC has benefits and challenges. One challenge is staff not having the expertise to cope with the task. High workloads among healthcare workers, and the smooth running of mental health services could be affected since healthcare workers may lack interest and motivation for change, inconsistent availability of psychotropic medications and there may be low mental health awareness in the community (WHO Mental Health Report 2022:211; Hlongwa & Sibiya 2019:2). Madlala et al. (2020:1) attest that a lack of human and financial resources remains evident in the treatment gap.

Poverty is another element hindering the South African Mental Health Policy Framework and Strategic Plan's implementation, whose focus is the decentralisation of mental health services from hospitals to PHC clinics. According to Samodien, Abrahams, Muller, Louw and Chellan (2021:4), a large part of the population in South Africans struggles to earn a living and thus lives in poverty due to unemployment, alcohol and substance, as well as inter-partner violence. Thus, it is credible that adverse socio-economic and modified epigenetic mechanisms are responsible for physical and mental health diseases, consequently diminishing health outcomes. Findings further revealed that South Africa was the most economically unequal society (out of 149 countries). More than half (55%)

of the population experiences poverty, with childhood poverty at 63%. Currently, the aforementioned percentage of children live in poverty with adverse socio-economic factors known to have a negative effect on development, leading to a plethora of diseases (Samodien et al. 2021:2). Thus, it becomes apparent that social support is imperative given the current living conditions because, if left unattended, it can worsen among future generation (Samodien et al. 2021:2).

Meanwhile, it is essential to note that global mental well-being is dependent on the social and economic status of a country, and mental disorders have been associated with several poverty indicators in low and middle-income countries. Included on the list is education that is provided at a lower level. Other indicators are a lack of security in terms of food, insufficient housing, people's social classification and socioeconomic status, as well as financial burden (Samodien et al. 2021:2; Madlala et al 2020:1).

Interdisciplinary mental health teams in health districts were established, starting with the National Health Insurance (NHI) pilot sites and including non-specialised mental health counsellors as part of the team. The National Department of Health endorsed these teams' establishment, intending to meet the SA MH Policy's objectives. However, its implementation faced financial and human resources-related challenges. Other challenges included the limited number of evidenced-based medication protocols for disorders such as depression and anxiety, which may need other therapies than medication. Ignorance in terms of stigma related to mental disorders was another factor potentially limiting health-seeking behaviour, and the health system's low level of readiness to merge mental health care was another obstacle (WHO 2022:211).

Attempts to merge mental health services into PHC therefore come with significant challenges, and several elements negatively impact these services in South Africa. Hence, the treatment gap remains evident, attributed to limited human and financial resources. Despite the provision of a national level policy and guidelines, insufficient resources are allocated to tertiary health establishments with a predominately vertical model of care (Madlala et al. 2020:5). Other attempts to try and provide sufficient mental well-being services included merging these services into care focused on chronic disease. However, in SA, this strategy has been implemented at a slow rate due to a lack

of knowledge of its feasibility as well as acceptable and effective collaborative care models (Upagadhaya et al. 2021:7).

Despite all the mental health service challenges across South African provinces, mental health service delivery remains a global imperative goal. This is evidenced by the United Nations' (UN) inclusion of mental health in the Sustainable Development Goals of 2015. It states that by 2030, the aim is for all countries to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment to promote mental health and well-being; strengthen the prevention and treatment of substance abuse and implement universal health coverage" (WHO Health Report 2023).

2.3.3 Current mental health service provision

Mental health service provision remains a challenge negatively affecting MHCUs' health outcomes; hence, a mental health treatment gap has been identified by the WHO. As a result, the WHO Mental Health Gap Action Programme (mhGAP) was instituted. The development of this programme led to a Geneva forum on 9-10 October 2017. The forum's purpose was to discuss various health issues related to how the WHO's mental health plan can best be implemented. The programme was aimed at providing larger scale coverage for disorders that are psychologically related as well as neurological and substance use disorders, with the focal point being countries with low- and middle-income. The programme maintains that, with appropriate care, medication and other therapies, many people could receive appropriate medication aimed at treating depression, schizophrenia and epilepsy, among other conditions. This action could benefit all stakeholders as it can aid in preventing suicide and lead to individuals living with mental health conditions regaining a sense of normality (WHO Mental Health Gap Action Programme 2019).

Various strategies were established to address mental health issues based on the identified service provision gap. The Annual Performance Plan is one of them, and it focuses on changing South Africa's health challenges. The National Health Plan's (NHI) (2021:1) planning and systems enablement programme intends to expand coverage and promote access to high-quality health services through policies' formation and implementation. If well executed, this will promote global healthcare provision, reform

health financing, and integrate health systems planning, monitoring and evaluation, as well as research. Based on its broad aim, the NHI has great significance in mental health, as MHCUs will also benefit from its implementation and improved continuity of care.

2.3.4 Consequences of inadequate health service provision

The effective promotion, prevention, treatment and rehabilitation of mental health conditions are of great significance and can contribute to promoting successful continuity of care. However, mental health team members' failure to fulfil this imperative health function can have negative consequences, such as increased mental healthcare costs. According to the Mental Health Policy 2023-2030 (2023:17), health problems emanating from the mental perspective have major cost implications for the state, both economically and socially. These costs directly and indirectly impact MHCUs' recovery and capabilities, as evidenced by reduced work and home productivity. The result will be a loss of employment and income, thereby placing a burden on the MHCUs as well as the financial status of their families. In essence, mental well-being maintenance is more expensive than treatment costs. Treatment costs outweigh maintenance costs by two to six times in countries that are already developed and may even be higher in countries that are still developing.

The first nationally representative survey of mental health-related disorders in South Africa indicated that lost earnings amounted to R28.8 billion among adults with severe mental illness during the previous 12 months (Mental Health Policy [2023-2030] 2023:17). This statement indicated that the GDP in 2002 was at 2.2%, which was far outweighed by direct spending on adults' mental health care, which was approximately R472 million. In other words, it is more expensive to leave mental disorders untreated than it is to treat them in South Africa (Mental Health Policy [2023-2030] 2023:17).

Meanwhile, social costs cause serious damage as they create multiple challenges. These include families that are disorganised in nature, affected social networks, stigmatised states, discrimination, loss of future opportunities, and marginalised and compromised quality of life. Stigmatising beliefs negatively impact MHCUs and often lead to isolation. These individuals are typically feared, ridiculed and exploited by community members. Most people who do not function well due to mental health difficulties suffer rejection,

isolation, neglect by family members and peers, exclusion from social engagements and abuse, as well as a denial of their basic rights. Notably, stigma may lead to challenges such as MHCUs' inability to access basic human rights. They also do not enjoy the benefits of being educated and employable, lack adequate housing, and their basic needs go unmet (Soeker, Hare, Mall & Van der Berg 2021:409; Hampson, Watt, Hicks, Bode & Hampson 2018:207).

2.4 SOCIAL SUPPORT AS THE BASIS FOR CONTINUITY OF CARE

Social support in mental health is imperative due to the status of health at this stage. Rapid changes have been observed in the status of health systems over the last hundred years, and health conditions are increasingly characterised as being chronic and complex. Most of the population lives with different health conditions as part of their daily reality. SA has a high non-communicable disease burden (Samodien et al. 2021:1). As a result, healthcare services face challenges that call for interventions. Pass, Kennelty and Carter (2019:1) thus emphasise interventions are necessary for the management of mental health disorders that are coupled with other chronic diseases. Continuity of care is one of the interventions interwoven with social support and cannot be separated as the former is dependent on the latter.

However, despite the health system's many challenges, families of MHCUs try their best to offer social support, as evidenced in a study undertaken to assess families' strengths in this regard (Mokgothu, Du Plessis & Koen 2015:1). The findings revealed that families draw strength to support their family member suffering from mental illness from internal as well as external sources, with the most prominent strength coming from outside the home. For example, services being rendered by the South African police, traditional healers, and gatherings such as churches were mentioned. Internal sources of strength included engagement in the spiritual realm, prayer, lifting the MHCU's spirit through praise, ensuring that the MHCU is kept busy, as well as applying the calming effect. In addition, some individuals participated in several support activities, such as ensuring early recognition and consultations for the MHCU at either the hospital or clinic as the need may arise, as well as monitoring compliance in relation to medication and follow-up appointments. However, in that research study, little is said about social support being offered to MHCUs by psychiatric services, as evident in the researchers' suggestions.

The researchers indicated that families should be encouraged to use their internal strengths to become equipped with appropriate strategies to support the MHCU. They consequently require health education delivered in a manner that will benefit the families, with the main focus on the mental disorders' diagnosis, causes of mental illness and its consequences for the MHCU's daily functioning. The family should also be informed of the availability of support groups in the community, communication skills and the management of aggression (Mokgothu et al. 2015:1).

Furthermore, social support for MHCUs is of greater importance as various determinants of mental health and illness contribute towards a mentally healthy or a mentally ill individual. Mental health has manifold determinants that relate to humans' biological, psychological and social aspects (National Mental Health Policy Framework and Strategic Plan [2023-2030] 2023:9). These determinants interact in a manner that is beyond comprehension to either protect or expose individuals to the risk of developing a mental illness. For example, genetic vulnerability, together with trauma experienced during childhood and poor living conditions, may lead to major depressive episodes, especially among women. In contrast, genetic resilience, together with an environment that is good for children to thrive in, open opportunities to learn, work, and the fulfilment of social roles result in the protection of the individual's mental health; hence, morale and social support cannot be separated from continuity of care.

According to Mulligan and Pitts (2022:107), behavioural change can be triggered by promoting emotional health. However, complete emotional support arises from the interplay of various sources, with the nurse being at the centre because of their duty to closely monitor MHCUs' health through interactions with different stakeholders. A study by Mulligan and Pitts (2022:107) to explore staff's perceptions and experiences regarding the implementation of a positive behavioural support (PBS) model revealed that the model was perceived as having benefits for the MHCPs and patients and was regarded as a positive behaviour initiator. This model brought change, helped to avoid incidences of violence and aggression, and enabled trusting relationships between MHCUs and MHCPs to develop. However, the model's success is dependent on ongoing organisational and leadership support. Meanwhile, MHCPs must recognise and offer sources that promote reassurance and engage with community-based organisations, peer groups, as well as family and friends. Tang, Lin and Chen (2020:1523) concur that

family and friendship ties are essential in social support, as findings revealed that older adults living alone are more prone to developing depression.

Moreover, social support for MHCUs is crucial as it promotes emotional health. In cases where emotional health cannot be satisfied, ill health, which is characterised by episodes of mental disturbances, may be affected. This may lead to individual imbalances, which may, in turn, disturb the fulfilment of personal, social and community roles. This could be devastating for the afflicted individual since mental illness can be chronic, or recovery might follow after some episodes (National Mental Health Policy Framework and Strategic Plan [2013-2020] 2012:12).

2.4.1 MHCPs' experiences with social support for MHCUs

Townsend (2018:249) states that trust is the basis of every relationship as it results in a feeling of confidence in terms of the environment's predictability. Furthermore, the ability to gain trust in relationships promotes enhanced self-esteem through the installation of self-confidence, optimism and faith. Thus, trust is an essential component of social support. Carta, Moro, Sancassini, Ganassi, Melis, D'Oca, Atzeni, Velluzi Ferreli, Atzori, Gonzalez, Serentino, Anngermeyer and Cossu (2022:3) attest that respect for MHCUs' rights can improve trust and thus promote their mental health. Carta et al. (2022:3) indicate that the use of a human rights-based approach to mental health care leads to clinical improvements in terms of work satisfaction as well as the services MHCUs receive in the mental health unit. Thus, such an outcome calls upon all involved in MHCUs' care to observe their human rights and their relationships with mental health.

Various factors contribute towards the determination of social support for MHCUs, including healthcare providers' acceptance of and respect for MHCUs (Mann et al. 2016:273). Mann et al. (2016:273) further emphasise that such actions could, in turn, help as practical incentives towards improving programmes for individuals who are at high risk for developing mental health problems. Meanwhile, it is imperative to recognise that the basis for offering care to MHCUs also lies in caring for the carers. According to Havermans, Boot, Houtman, Brouwers, Anema and Van der Beek (2017:1), psychosocial work factors, such as an unreasonable amount of work and the absence of social support led to stress, which is a risk factor negatively impacting healthcare providers' physical

and mental health. The result will be a significant absence from work due to ill health. Organisations' and society's financial status will consequently be threatened due to a loss in productivity and increased costs related to health care.

Havermans et al. (2017:4) conducted a study that assessed to what extent the correlation between the psychosocial safety climate (PSC) and stress can be explained by autonomy and social support; findings revealed that healthcare providers exposed to lower PSCs experienced higher stress levels. A PSC is defined as management's readiness to prevent and respond to stressful working conditions. Although the study focused on the correlation between PSCs, autonomy and stress, the researchers further delved into other psychosocial factors and revealed different relationships. Supervisor and co-worker support, for instance, did not change the relationship between PSC and stress. However, other psychosocial work factors could influence the correlation between PSC and stress. Thus, for healthcare providers to contribute meaningfully to MHCUs' social support, carers should also be cared for in health establishments and require an assurance of autonomy and organisational social support from management, which together were found to decrease stress among this population (Havermans et al. 2017:1).

2.4.2 The MHCUs' experience with social support from mental healthcare providers, family members and community

According to the WHO Health Report (2023), the WHO recognised the importance of health and, as a result, decided to change the health definition from being "the absence of disease or infirmity" to a "state of complete physical, mental, social wellbeing". This definition broadened society's view on mental well-being and the gravity of relationships between psychological, physical and social aspects (WHO Health Report 2001:3). Moreover, the Declaration of Alma-Ata came into effect, and a policy on PHC was adopted and recognised as an important method for promoting accessibility to quality health care. Guided by values of unity and equity, WHO members concluded that citizens worldwide have a basic right to health, and it is the government's responsibility to ensure this function is fulfilled. The Astana Declaration later replaced the Declaration of Alma-Ata. The WHO Health Report (2023) and the two declarations ultimately recognise health as a significant social factor.

According to Van den Muijsenbergh and Van Weel (2019:293), in October 2018, the Declaration of Astana was adopted by the WHO in order to strengthen PHC and achieve global coverage in terms of better health care for all. The Declaration of Astana emerged from the 1978 Declaration of Alma-Ata when the WHO first embraced a policy on PHC as an essential strategy to promote access to health care that is of good quality for all. The Astana Declaration was then ratified in the World Health Assembly, represented by the governments of 196 countries in May 2019. Thus, WHO members came to an agreement, according to Van den Muijsenbergh and Van Weel (2019:293). The most interesting part of the declaration is that it recognises PHC as a core function in the health system for attaining universal health coverage, with mental healthcare services forming part of the revitalised health system (Van den Muijsenbergh & Van Weel 2019:293). Furthermore, health coverage is essential; dating back to 1978, evidence indicates that health systems with PHC offerings are a strong base to establish better health care for all citizens (Van den Muijsenbergh & Van Weel 2019:293).

However, despite such efforts to ensure universal health coverage as declared by the WHO, various countries still face challenges with MHCUs' social support requirements. Abol, Mamdouh, Mekawy and Sheikh (2019:65) conducted a study on the psychiatric and social profile of recovering substance-dependent women. Their findings revealed that most control participants (60%, *n*=18) were married compared with only seven (23.3%) cases who were not, and 50% (*n*=15) of recovering substance-dependent women were divorced. Most (90%, *n*=27) reported severe use of drugs and alcohol or mild use of drugs and alcohol. All MHCUs were facing social problems due to substance dependence ranging from moderate (46.7%, *n*=14) to severe (53.3%, *n*=16) degrees. All cases in the study had psychiatric problems attributed to drug dependence. Overall, 66.7% (*n*=20) had severe psychiatric problems relating to substance dependence. Moreover, most cases (70%, *n*=21) had low social competence compared with controls (*n*=0) who had high levels of social competence. Overall, 43.4% of cases had limited levels of social support compared with none of the participants (*n*=0) of the control group, all of whom had a high level of social support. Thus, most of the recovering substance-dependent women were single, divorced and unemployed; showed low social competence; had limited to fair levels of social support in their recovery; and all of them had a psychiatric diagnosis.

The provision of social support for MHCUs also depends on the individual's readiness to seek help. However, seeking assistance for psychological problems may be a challenge for some individuals. This view is supported by Clement, Schauman, Graham, Maggioni, Evans-Lacko, Bezborodovs, Morgans, Rusch, Brown and Thornicroft (2015:11), who agree that the stigma attached to mental illness might be a contributory factor in reducing help-seeking behaviour. Findings in this study revealed that different types of stigma might hinder individuals from seeking mental health services, namely anticipated stigma (anticipation of personality being perceived or treated unfairly); experienced stigma (the personal experience of being perceived or treated unfairly); internalised stigma (holding stigmatising views about oneself); perceived stigma (participants views about the extent to which people, in general, have stigmatising attitudes/behaviour towards other people with mental illness); stigma endorsement (participants' own stigmatising attitudes/ behaviour towards other people with mental illness); and treatment stigma (the stigma associated with seeking or receiving treatment for mental ill health). Clement et al.'s (2015:12) review aimed to explore stigma's negative influence on individuals' help-seeking behaviour for mental health challenges. The review focused on formal services such as primary care, secondary and tertiary mental healthcare, as well as therapy services involving communication.

The association size, the reported barriers and qualitative processes were examined in subgroups relating to age, ethnicity, gender, rural setting, occupational group, participants' mental health status, and whether participants were receiving care at that moment. Asians, Arabians, Africans, Americans and other ethnic groups that are in small numbers; individuals at a tender age; males; and those in military and health-related jobs were the population groups most stigmatised, and they consequently found it difficult to seek help.

Studies relating to individuals with poor mental health experience typically focused more on reports pertaining to shame or embarrassment rather than social rejection, difficulty talking to professionals and confidentiality/anonymous services. Most of the studies (69%, 99/143) were conducted in the USA or Canada, 20 were undertaken in Europe, 10 in Australia and New Zealand, eight in Asia and one in South America. In addition, five of the studies were conducted across more than one continent. Thirty studies (21%) were on students in higher education, and 14 (10%) on learners who were at school at that

moment. Of the 56 students (39%), all participants had either experienced mental health-related problems or were on treatment. Overall, stigma was implicated as one of the primary hindrances to mental health services access, and it created a barrier against seeking help (Clement et al. 2015:14).

Trustworthiness, substance dependence and stigma are not the only factors that could be a hindrance in offering meaningful social support to people experiencing mental well-being problems. A study conducted in KwaZulu-Natal by Dube and Uys (2015:1) revealed that MHCUs at PHC clinics in a certain district did not receive quality treatment as stipulated in institutional mental health guidelines. The study sought to understand whether the Standard Treatment Guidelines for Common Mental Health Conditions' principles were followed by nurses working in the PHC setting while managing MHCUs. The researchers concluded that the treatment MHCUs received was of poor quality because most stipulated principles could not be met.

Other factors contributing to inadequate social support included insufficient training on aspects related to MHCUs, as postulated in a study conducted by Malone, Harrison and Daker-White (2018:279). They indicated that smoking was viewed differently by mentally ill people as well as healthcare providers. According to Malone et al. (2018:279), their study primarily added to the current discourse in the sense that smoking's impact and the difficulty in quitting among persons with mental illness are complicated by the tension that has been created by the different views between MHCUs and mental healthcare providers around the roles and responsibilities of smoking cessation (Malone et al. 2018:279). Their study focused on perspectives of smoking and smoking cessation, and the support offered by providers to quit. According to Malone et al. (2018:277), living with a mental illness remains a challenge, and as a result, MHCUs turned to tobacco as self-medication to minimise symptoms and ensure that their emotions were in control. MHCUs believed that smoking assisted them in relieving stress, depression, boredom and loneliness, and they were afraid that cessation might lead to a failure in the application of the same strategy in future. Thus, MHCUs who succeeded in smoking cessation were fearful, and they said the time they managed to stop smoking was associated with stress and a decline in mental health. As a result, they started smoking again, a practice that was encouraged by healthcare providers as they, too, believed smoking relieved symptoms of mental illness (Malone et al. 2018:277).

Inadequate and inappropriate social support, as evidenced by health providers encouraging MHCUs to smoke instead of promoting smoking cessation, occurred because of a lack of knowledge and confidence among the healthcare team. Thus, the researchers' findings indicated that providers should be routinely trained to empower them with knowledge so that they can deliver information, education and interventions with confidence. Furthermore, Malone et al. (2018:280) maintain that MHCUs require social support from healthcare providers around tobacco addiction, which can only be fruitful in cases where training is provided.

2.5 CONTINUITY OF CARE AT THE HOSPITAL AND PRIMARY HEALTHCARE LEVEL ACROSS CONTINENTS

According to Pereira Gray, Sidaway-Lee, White, Thorne and Evans (2018:1), continuity of care can be used to measure interpersonal care. Continuity of care is defined as repeated contact with an individual patient, a time that offers patients and doctors the opportunity to increase their understanding of each other's views and priorities. This concept is further explained by Pereira Gray et al. (2018:1) as a long-standing feature of health care, characterised by increased patient satisfaction, up-take of health-promoting strategies, better adherence to medical advice, and decreased use of hospital services.

Recognition of continuity of care as part of quality care, as postulated in Pereira Gray et al. (2018:1) remains a challenge. This view is supported by Van den Muijsenbergh and Van Weel (2019:294), who state that key healthcare indicators should be in place to clearly reflect the effects of primary care. However, many key healthcare indicators currently do not take family medicine's importance into consideration, nor continuity of care, person and population-centredness, or comprehensive care. According to these proponents, the recognition of continuity of care being a challenge starts with the acknowledgement that there is an alignment between specific community needs and the needs of the general population. This could help PHC settings to look at social health determinants as part of individual needs. Macdonald, Adamis, Craig and Murray (2019:273) attest that mental health care should be emphasised because no intervention in severe mental illness will ultimately succeed without the development and maintenance of good relationships between patients and staff. These relationships demand a continuity that is prized by the patients and admired by the government agencies.

Continuity of care can meaningfully contribute towards the lives of patients. It is capable of extending patients' lives by yielding outcomes that would be poor under normal circumstances, as postulated by Macdonald et al. (2019:277). In a study conducted by these proponents, findings revealed that a declining relationship in continuity disrupts patients' treatment, impairs communication, and interferes with the best management of schizophrenia.

Pereira Gray et al. (2018:1) assert that, despite modern medicine, interpersonal factors are of greater importance between patients and healthcare providers. As a result, they searched primary peer-reviewed research articles, published in English and reported on continuity of care among patients from any kind of doctor, in any setting, and in any country to establish those patients' mortality rates. Data sources included MEDLINE, Embasse and Web Science within the period from 1996 to 2017 with the hope of retrieving sources that would meet the eligibility criteria. The articles were reviewed to determine the existence of a relationship between continuity of doctor care and mortality (Pereira Gray et al. 2018:1). As a result, studies were analysed to check whether intensified continuity of care contributed towards a lower mortality rate. Twenty-two studies were reviewed, and 18 (81.8%) showed that greater continuity of care was significantly associated with lower mortality rates. Of these, 16 (72.7%) reported lower all-cause mortality rates, whereas two studies found no association between greater continuity of care and subsequent mortality during or following a hospital stay. One study found continuity was not significantly associated with mortality except in general practices in the least deprived areas. Another study checked a range of continuity measures and found that all insurance claim-based measures showed higher levels of continuity of care were associated with higher mortality rates, but greater continuity, as reported by patients, was associated with reduced mortality. This was the only study among all those reviewed showing an association between increased continuity and increased mortality (Pereira Gray et al. 2018:4).

2.5.1 Follow-up care in the primary healthcare setting

Continuity of care and follow-up care are closely interwoven and dependent on one another. Nurses' follow-ups with MHCUs in the PHC setting could boost continuity of care, thereby promoting mental health. Currie, Patterson, Moniruzzaman, McCandless

and Somers (2018:3400) conducted a study on continuity of care among homeless individuals and mental illness. The objective of the study was to determine whether timely follow-up after hospital discharge reduced the risk of subsequent rehospitalisation among homeless people and mental illness. Comprehensive linked administrative data, including hospital admissions and laboratory and community medical services, were used as data sources. In that study, findings revealed that post-discharge, timely follow-up care is a necessity, but not sufficient to reduce the risk of readmission among homeless mentally ill persons. Currie et al. (2018:3409) further indicated that current discharge plans fail to adequately offer detailed information on the housing needs of the MHCUs leaving the hospital. Such failure could contribute to healthcare facilities' inability to meaningfully achieve recovery in terms of discharging patients.

As a result, a discharge plan and interventions that focus on the needs of MHCUs and related situations should be considered. These could ensure that the healthcare system is run with ease and thus establish avenues to promote recovery and prevent readmissions to acute and long-term care (Currie et al. 2018:3410). These proponents indicate that, although continuity of care is an asset that can effectively contribute to the general population's recovery, MHCUs who lack decent adequate housing may not benefit from it. Thus, hospital discharge planning should include proper housing as part of the plan, and there should be collaboration surrounding health issues, housing and social welfare sectors to prevent rehospitalisation and meet the needs of those who are homeless and mentally ill (Currie et al. 2018:3412). Furthermore, the provision of housing to discharged homeless MHCUs is considered essential because actions taken to support continuity of care post-discharge are likely not to yield optimal desired effects if they remain homeless (Currie et al. 2018:3411).

Chung, Ryan, Hadzi-Pavlovic, Singh, Stanton and Large (2017:699) concur that follow-up after discharge is important as a potential mechanism to prevent suicide. A study conducted by these researchers revealed that focusing on the clinical characteristics of individual MHCUs with a high suicide ideation rate might mislead clinicians; they may think that some of these individuals are at low risk after discharge. However, the focus should be shifted from typical clinical characteristics and be geared towards all MHCUs who are discharged from the hospital with suicide as part of their history. Findings by Chung et al. (2017:699) further indicate that 0.28% of all discharged MHCUs may end up

committing suicide, especially in the initial three months post-discharge. Notably, according to the modest statistical strength of suicide risk assessments, the probability of suicide over clinically meaningful time frames will reduce among MHCUs categorised as being at high risk for suicide. Meanwhile, low-risk groups with suicidal tendencies tend to commit suicide at a higher rate than the high-risk group. Thus, efforts to combat suicide should cover all those whose lives are at risk and avoid focusing on a particular group. Furthermore, the main clinical focus in terms of suicidal MHCUs should be on those already hospitalised and the period shortly post-admission for newly admitted cases. However, readmitted MHCUs, especially those with suicidal tendencies, remain high-risk individuals for many years; as a result, regular follow-ups should continue to combat suicide in the community (Chung et al. 2017:700).

Other efforts geared towards follow-up or monitoring of MHCUs to promote mental health and prevent the worsening of symptoms include the use of smartphone apps for those suffering from schizophrenia, as postulated in Firth and Torous (2015:1). Their study aimed to review literature on smartphone apps, specifically as applied to schizophrenic and other psychotic disorders. Findings revealed that gadgets such as smartphones can play a role in socially supporting MHCUs. According to Firth and Torous (2015:1), MHCUs suffering from schizophrenia were interested and willing to make use of smartphones to monitor their own symptoms, engage in therapeutic interventions that are self-directed, and increase their physical exercise. During the trials, researchers noted that retention and adherence rates were high, as evidenced by 92% of participants taking part throughout the trials until the termination of the exercise, and frequently engaging with the apps on approximately 86.5–94% of days throughout the study period. Furthermore, the report did not indicate any negative outcomes due to the use of the app, including exacerbation of schizophrenic symptoms. Schizophrenic MHCUs are generally a group of people difficult to work with; however, in that study, the researchers noted a difference from what has been observed in health establishments because these MHCUs were as engaged as those suffering from Diabetes Mellitus. The highest engagement rate was among MHCUs at risk or those presenting with first episodes, especially young people (Firth & Torous 2015:6).

Sfetcu, Musat, Haaramo, Ciutan, Scintee, Vladescu, Wahlbeck and Katschnig (2017:1) refer to high levels of hospital readmission as a sign of low care quality, which could also

indicate poor social support. Sfetcu et al. (2017:1) reviewed studies on the association between post-discharge variables and readmission after an index discharge with a main diagnosis. The purpose of their study was to identify post-discharge variables that are likely to influence readmission rates for MHCUs with a main psychiatric diagnosis. The study took place in developed countries where people earn high incomes, with the majority (59/80) being English-speaking countries, with more than 50% coming from the USA, almost 15% from Australia, four from the UK, and two from Canada (Sfetcu et al. 2017:3). Findings revealed that 59 post-discharge factors influenced readmissions, classified under four categories: individual vulnerability, aftercare factors, community care and service responsiveness, as well as contextual factors and social support.

Under individual vulnerability, treatment compliance could not be held responsible for rehospitalisation; instead, post-discharge behaviours and dissatisfaction with living situations were found to be risk factors. Mixed results were found under housing in the post-discharge period. Notably, due to the low quality of evidence and the great heterogeneity of the papers, the researchers found it difficult to establish a distinct association between the described factors and readmission rates. In the category 'post-discharge aftercare-related factors', findings revealed that aftercare services rendered to MHCUs, and healthcare providers' efforts were more effective in keeping MHCUs outside the hospital through early referral. Sfetcu et al. (2017:11) indicate that MHCUs attending post-discharge aftercare facilities were advised by staff to attend outpatient clinics, or they were referred to the hospital whenever clinical deterioration began. This is an indication of appropriate social support in this category.

In terms of community care and system responsiveness factors, findings revealed that programmes and interventions such as case management and compulsory outpatient treatment play a role in reducing readmission rates. However, with continuity of care practices and programmes, as a sub-factor under the category of 'post-discharge aftercare facilities', findings revealed that practices or specific interventions were significant except in a few cases (Sfetcu et al. 2017:10). The fourth and last category is called 'contextual factors and social support post-discharge', as postulated by Sfetcu et al. (2017:11). In this category, the researchers focused on the role family support played in MHCUs' readmission, and the findings revealed that readmission could be prevented

by working with families. Thus, healthcare providers' social support for MHCUs could be even more successful if it is coupled with that of family members.

A study conducted by Fontanella, Hiance-Steelesmith, Bridge, Lester, Sweeney, Hurst and Campo (2016:326) revealed that various patient, hospital and community-level factors played a role in timely follow-up among children and youth with mood disorders. Their study focused on identifying patient, hospital and community-level factors related to the care rendered during follow-up after MHCUs' hospitalisation. Areas covered included the four states of California, Florida, Maryland and Ohio, the American Hospital Association and the Area Resource File. Follow-up care is ultimately regarded as part of continuity of care, as postulated by Fontanella et al. (2016:324). These authors emphasise that follow-up is crucial to the achievement of successful outcomes for adolescents. In their study, a number of factors were indicated as influencing timely follow-up care for youths with mood disorders. Findings revealed that multiple patient, hospital and community characteristics influence timely follow-up. Follow-up care in the first month following discharge was found to be five times higher among youths who were previously engaged in treatment. Notably, youths' previous engagement in treatment with a well-established association with a care provider was found to encourage timely follow-up. Psychiatric comorbidity also encouraged timely follow-up as it is associated with greater symptom severity, functional impairment and perceived illness burden. However, the co-occurrence of substance use disorders decreases the likelihood of timely follow-up for psychiatrically hospitalised youths with mood disorders.

Fontanella et al. (2016:328) further indicate that substance use disorders are among the most common comorbidities among patients with mood disorders; they complicate treatment efforts and are associated with negative treatment outcomes. As a result, robust efforts such as psychoeducation, combined with evidence-based methods of MHCU and family engagement, are needed to retain MHCUs in active treatment.

In terms of demographic characteristics, race and age appeared to influence follow-up care following psychiatric hospitalisation. For Afro-American youths, follow-up care post-discharge was less likely to happen than for other racial groups. Members of ethnic minority groups also had negative perceptions and believed that mental health treatment was ineffective. Thus, culturally informed educational and engagement efforts may be

necessary to convince this group about the need for treatment (Fontanella et al. 2016:328). Younger children's dedication to psychiatric treatment was also found to be more promising. This finding was attributed to the care of parents who look after young children rather than youths who often strive for greater independence and input in the decision to seek care. Furthermore, youths tend to have a negative attitude towards treatment and often perceive help as a threat to their autonomy and sense of self-reliance.

Specialised hospitals had a high rate of timely follow-up care with youths, as they are more likely to offer outpatient services than general hospitals (Fontanella et al. 2016:329). Moreover, admission to hospitals with fewer beds was also associated with a high rate of follow-up care because smaller hospitals may have more time devoted to discharge planning and greater engagement with patients and families. Also, a small hospital size might reflect a speciality psychiatric status. Notably, areas with high unemployment rates were associated with lower likelihoods of MHCU follow-ups. These areas were characterised by high rates of poverty, homelessness, substance use and residential turnover, and fewer mental health resources (Fontanella et al. 2016:330). Thus, this study revealed that various factors related to the hospital community and those related to the MHCU contribute towards poor aftercare. This signifies a lack of adequate social support, which could lead to instability in the MHCUs' mental health.

Franken, Parker, Allen and Wicomb (2019:3) undertook a study in the Lentenberg health establishment based in the Western Cape, South Africa, between January and June 2016. They focused on acutely ill adult MHCUs admitted to the health establishment. Findings revealed that the majority of MHCUs were readmitted, as evidenced by merely 28% of all admissions being first episodes. According to Franken et al. (2019:6), these findings might suggest that the current community mental healthcare system is failing to maintain remission rates, potentially due to ill-equipped PHC services and a lack of psychosocial rehabilitation facilities. Furthermore, the repeated admission of patients to specialised psychiatric hospitals could be signifying that the occurrence of relapses demands attention. Franken et al. (2019:6) suggest that comorbid diseases should also be considered, including medical conditions.

Substance abuse, which could be one of the indications of a lack of social support for MHCUs, appeared to be an international problem. Franken et al. (2019:4) attest that

substance abuse in South Africa is comorbid to most psychiatric conditions and is related to several negative effects, such as hostility, forceful acts, non-compliance with treatment, rehospitalisation, and poor integration into the community after discharge. Substance use and violence are some of the salient factors impacting mental healthcare, as the two were found to influence the likelihood of admission. Franken et al. (2019:7) indicate that these factors strain available resources and complicate treatment. As a result, these researchers emphasise the importance of expanding and capacitating mental health facilities at the tertiary level in the Western Cape and across South Africa. This, in turn, could contribute to increased social support for MHCUs.

Marais and Subramaney (2015:86) explored state MHCUs in Sterkfontein Hospital. These authors described the state MHCUs' profiles and determined their outcomes after three years of admission. Among other areas of interest, reoffender rates were explored. The study affirmed the need for improved social support, as evidenced in the recommendations. According to Marais and Subramaney (2015:91), there is a need for improved community psychiatric services in outpatient departments, especially addressing schizophrenia, other psychotic disorders and intellectual disabilities. Improvements in community psychiatric services should mainly focus on strategies to promote treatment adherence and timely detection of MHCUs who stopped taking treatment and ignored follow-up. Another action plan that could be employed is the improvement of community-based services that are psychiatric-related. Daycare services, residential placement facilities and vocational rehabilitation programmes, substance abuse rehabilitation programmes and community education on mental illness are some additional psychiatric community-based strategies that should be improved to promote community psychiatric services in the outpatient department.

Substance abuse was also found to be a contributory element in the precipitation of violent and criminal behaviour and could be implicated in a higher rate of substance abuse in the forensic MHCU population. Furthermore, substance abuse has the potential to influence MHCUs' involvement in repeated offences, as well as relapses. Hence, the researchers recommended a need for substance abuse rehabilitation programmes.

Another finding of great concern was that a third of the state MHCUs remained hospitalised three years after admission, with only 69% returning to the community. This

was found to oppose deinstitutionalisation intentions whose main focus is on the treatment and reintegration of MHCUs who committed a crime while mentally ill back into the community for continuity of care (Marais & Subramaney 2015:90). Findings also revealed that, for the MHCUs, being hospitalised for a long period promoted their mental instability, frequent re-offences and lack of social support. A quarter of the state MHCUs who participated in the study had absconded from the hospital and were back in their communities. This raised a concern for the researchers as such individuals were more prone to treatment non-adherence and substance abuse, well-known factors that increase the risk of relapse and repeated offences (Marais & Subramaney 2015:91).

2.6 SUMMARY

Literature related to continuity of care, social support for MHCUs and the availability of mental healthcare services across countries was reviewed. The findings from the literature revealed that a gap in continuity of care exists, and it is a global challenge that requires social and economic resources. The implementation of related health policies and programmes is also required, as these documents are already in place, especially in South Africa. Chapter 3 discusses the research design and methods employed in conducting this study.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter describes the research design and methods of the study. A qualitative research design was used (Creswell & Poth 2018:42) to structure and guide the researcher in objectively gathering and analysing data relevant to the research question and objectives. The study followed a constructivist, grounded theory approach (Schurink et al. 2021:300).

3.2 THE RESEARCH OBJECTIVES

The research objectives were as follows:

Phase one: Conduct a situation analysis

- Explore and describe the experiences of operational managers, mental healthcare providers (MHCPs) (professional nurses and social workers), and MHCUs regarding social support and continuity of care.

Phase two: Develop a social support framework

- Develop a social support framework to promote continuity of care.

Phase three: Validate the social support framework

- Invite a group of experts and stakeholders to validate the social support framework.

3.3 RESEARCH DESIGN

Polit and Beck (2021:801) explain that the research design is the overall plan used to address a research problem. Brink et al. (2018:112) attest that the researcher's design choice depends on the research problem and purpose; for this study, the choice was a qualitative design. The study aimed to understand participants' actions by exploring and describing individuals' experiences of the research phenomenon. Therefore, this design

assisted the researcher in getting a picture of the participants' experiences through their narrated explanations (Creswell & Poth 2018:82).

Qualitative research is an interpretive and naturalistic approach. This notion prompted the researcher to conduct the study in the participants' places of work (hospitals) and residences (clinics) to study their actions and experiences in their natural settings. The research context is an essential element in grounded theory that enhances rigour, signals openness, relevance, epistemological and methodological congruence, and thoroughness in data collection and analysis processes.

The qualitative approach meant the researcher had to dismiss any preconceived ideas and judgements about the phenomenon and participants and conduct the research with openness (Brink et al. 2018:110; Creswell & Poth 2018:43). Furthermore, collecting data in a natural setting assisted the researcher in understanding and interpreting the phenomenon (social support) under study based on the participants' views as these are important contexts for understanding what the participants are saying (Creswell & Poth 2018:43).

3.3.1 Advantages and disadvantages of qualitative designs

According to Creswell and Poth (2018:47), a strong feature of the qualitative design is that the researcher employs rigorous data collection and analysis methods; hence, it is a critical inquiry. However, limitations in this design also exist, and an explanation of the advantages and disadvantages follows.

As an interdisciplinary field encompassing a wide range of epistemological viewpoints, research methods and interpretative techniques for understanding human experiences, the qualitative design guided the researcher to grounded theory. This approach was deemed most suitable to study the research phenomenon due to its systematic and flexible nature. The phenomenon under study required an explorative, descriptive, constructive approach, leading the researcher to grounded theory.

The design assisted the researcher in generating rich data as it produced thick descriptions of participants' feelings, opinions and experiences, and the researcher then

interpreted the meaning of their actions. With this interpretive approach, the researcher was able to understand the participants' different voices, meanings and events during the study. The design also assisted the researcher in discovering the participants' inner experiences and determining how meanings are shaped through and in culture.

The researcher interacted with participants directly during data collection. Consequently, data collection was subjective and detailed, as open-ended questions were posed during the interviews. The flexible structure of the design also assisted the researcher in constructing and reconstructing the phenomenon under study to a greater extent, thereby eliciting meanings that enriched the study's findings (Charmaz 2014:79; Polit & Beck 2021:481).

The disadvantage of qualitative designs is that contextual sensitivities may be left out as this design focuses on meanings and experiences. The researcher remained contextually sensitive by adopting the grounded theory, where the research process begins in the social and cultural environment. Another disadvantage of qualitative research is that policymakers may ascribe low credibility to the results of a qualitative method as they frequently adopt quantitative findings when research is called upon.

In addition, purely qualitative research may neglect the social and cultural constructions of the variables studied. Smaller sample sizes also raise concerns about the findings' generalisability to the whole population. However, this study aimed to ensure transferability to areas with similar contexts.

Unlike quantitative studies, this design may make data interpretation and analysis more difficult or complex. The researcher thus took considerable time analysing and interpreting the findings, yet the results can only be transferred to the larger population to a very limited extent as the findings are only applicable to similar contexts (Shurink et al. 2021:393).

3.4 GROUNDED THEORY

3.4.1 The historical context of grounded theory

Grounded theory was developed in the early 1960s by Glaser and Strauss, with its theoretical orientation based on sociology (Charmaz 2014:5; Polit & Beck 2021:481). The journey towards the discovery of grounded theory primarily involved data analysis. This is evident in the proponents' attempts to meticulously view typical data analysis strategies from different perspectives. Glaser and Strauss (1960) went beyond the usual method of analysing qualitative data and gave their data explicit analytic treatment. They produced a theoretical analysis of the social organisation and temporal order of dying.

The proponents' construction of analyses of dying contributed towards the enrichment of critical inquiry as it led to the development of systematic methodological strategies that researchers could adopt for studying many topics. Glaser and Strauss (1967) first articulated these strategies and advocated for the development of theories from research grounded on qualitative data rather than deducing testable hypotheses from existing theories (Brink et al. 2018:107; Charmaz 2014:6; Grove & Gray 2019:67). This history of grounded theory assisted the researcher in gaining insight into this approach, and the researcher thus moved beyond qualitative data analysis to apply grounded theory practices that enhanced the rigour of the study.

3.4.2 Developments in grounded theory

The sociologists Glaser and Strauss refocused on qualitative inquiry by encompassing and emphasising the importance of grounded theory in dealing with sociological matters, and this has created a somewhat divergent direction in the theory (Charmaz 2014:11). Their introduction of grounded theory was not an easy task, as evidenced by their victory against the dominance of positivistic quantitative research in the 1960s.

Through the efforts of these sociologists, by 1990 grounded theory became known not only for its rigour and usefulness but also for its positivistic assumptions. Grounded theory continues to gain increasing acceptance among quantitative researchers who adopt it in mixed or unilateral methods.

The existence of grounded theory methods in the world of research benefitted researchers due to their flexibility and legitimacy as they continue to appeal to qualitative researchers with varied theoretical and substantive interests (Charmaz 2014:12). However, the triumph with this theory's recognition is not without challenges, as recent developments view grounded theory in the light of postmodernism and poststructuralism, inspired by social constructivism.

Further developments in grounded theory are evident in the constructivist turn, moving grounded theory away from positivism in both Glaser's and Strauss and Corbin's earlier versions of the method. This finding is elaborated on by Charmaz (2014:12), who indicates that the constructivist turn answers numerous criticisms about earlier grounded theory versions. One of the criticisms against grounded theory occurred in 1990, when postmodern and narrative critics undermined the method's epistemology. Because of this criticism, grounded theory researchers are encouraged to cling to relativism rather than objective, unproblematic prescriptions and procedures because relativism encourages a construction of the researcher's actions, as is the case with objective approaches. This is crucial in grounded theory because viewing the research as constructed rather than discovered fosters researchers' reflexivity about their actions and decisions (Charmaz 2014:13).

The researcher's values are imperative in this regard, as emphasised by Charmaz (2014:13). The author asserts that the constructivist perspective shreds the notions of a neutral, value-free expert observer. This means that researchers must examine rather than erase the manner in which their privileges and preconceptions may shape the analysis, and values shape the very facts that can be identified (Charmaz 2014:13).

The constructivist view also promoted further developments in grounded theory (Charmaz 2014:13). For instance, the introduction of the constructivist view established a different perspective by acknowledging subjectivity and the researcher's involvement in the construction and interpretation of data. Furthermore, constructivist grounded theory aligns well with social constructivism, which stresses the importance of social contexts, interactions, shared viewpoints and interpretive understandings. Thus, constructivists, unlike other qualitative approaches, view knowing and learning as embedded in social life, and they stand against an individualistic stance and radical subjectivism (Charmaz

2014:14). In further developments in grounded theory, Charmaz (2017:34) indicates that constructivism encourages probing questions about the data and scrutinising the researcher and the research process.

According to Grove and Gray (2019:67), grounded theory is a form of qualitative design comprising various approaches. Schurink et al. (2021:301) also explains that a constructivist grounded theory encourages probing questions about the data, and the researcher and research process are scrutinised, unlike other versions of grounded theory. The researcher followed this approach to address the research questions and the study's purpose, focusing on exploring and describing participants' experiences regarding social support for MHCUs to promote continuity of care. Furthermore, the researcher was prompted to adopt this approach because the method is rigorous. The researcher believed that the construction of multiple realities that occurred from the social interaction would lead to the development of an effective social support framework that will promote continuity of care (Brink et al. 2018:107; Charmaz 2014:343; Grove & Gray 2019:67).

The researcher followed a grounded theory approach (Charmaz 2017:167). Grounded theory aims to move beyond explanations and develop a theory grounded in the data collected from participants who have experienced the phenomenon under study. The nature of the approach allowed the researcher to explore and describe participants' experiences regarding MHCUs' social support to promote continuity of care (Creswell & Poth 2018:870).

As an inductive qualitative method, grounded theory allows for simultaneous data collection and analysis, and thus leads to the development of a theory or framework grounded in participants' experiences. Therefore, this approach assisted the researcher in developing a conceptual social support framework for MHCUs to promote continuity of care (Creswell & Poth 2018:82).

Furthermore, the grounded theory gradually led the researcher to generate a theory shaped by participants' views as a theory was needed to reflect their experiences of the phenomenon (Creswell & Poth 2018:870). Moreover, on the practical side, the generated theory assisted the researcher in developing a conceptual social support framework that

explained how the participants viewed social support and continuity of care (Creswell & Poth 2018:870).

The systematic yet flexible guidelines involved in data collection and analysis in grounded theory assisted the researcher in following leads that emerged, thus allowing sufficient opportunity for the theory's generation, shaped by the participants' views, since this approach focuses on a process that occurs over time (Charmaz 2014:1). Data collection and analysis occurred simultaneously and repeatedly when interviewing participants. This approach allowed the researcher to constantly compare data that were gradually collected from various sources of participants with ideas about the emerging theory (Brink et al. 2018:108; Creswell & Poth 2018:83; Polit & Beck 2021:481).

The simultaneous and iterative data collection, analysis and memoing process (that is, the flow of the process that occurred during the study) assisted the researcher in building a theory. The memoing process prompted the researcher to analyse data and develop codes into categories early in the research process. During the process, the researcher stopped, focused, took codes and data apart, compared and defined links between them, and stopped and reviewed meanings and actions (Charmaz 2014:164).

Thus, data collection and analysis were guided by the ideas that were generated through the memoing process (Charmaz 2014:162; Creswell & Poth 2018:87). Moreover, through memoing, the researcher remained involved in the analysis, increasing the level of abstraction of the ideas essential in theory generation (Charmaz 2014:343). By engaging in the grounded theory, the researcher ultimately tried to understand participants' lived experiences by being open to the meaning participants attached to the phenomenon and became immersed in the data until a theory was generated (Brink et al. 2018:105).

The researcher ensured the data analysis procedure was structured and followed a pattern in developing open categories. One category was selected to be the focus of the theory, followed by detailing additional categories (axial coding) to form a theoretical model. The intersection of the categories became the theory, which is called selective coding (Creswell & Poth 2018:83; Polit & Beck 2021:551).

The researcher considered the focal point of grounded theory, namely reality, which is perceived as a social construct (Brink et al. 2018:107). This notion claims that grounded theory focuses on constructing multiple realities rather than social and cultural environments, although data collection begins in the social and cultural environment. However, to generate a theory shaped by participants' holistic views, their social and cultural environment was considered throughout the study. The researcher thus took cognisance of the participants' cultures and refrained from infringing on their cultural rights as they were from different cultural backgrounds. The researcher also became immersed in participants' social environment during data collection, hence the incorporation of social justice in the study. Charmaz (2017:37) indicates that constructivist grounded theory complements the goals of critical inquiry because its pragmatist heritage includes a commitment to social justice.

The researcher aimed to generate a theory grounded in the collected data through a commitment to critical inquiry, which is the basis of scientific knowledge. The researcher thus anticipated that the critical stance in social justice research combined with the analytic focus of grounded theory would broaden and sharpen the scope of the inquiry; hence, the researcher found social justice to be imperative and considered it applicable. Furthermore, the constructivist grounded theory channelled the researcher to follow a systematic approach to social justice inquiry, which assisted in integrating subjective experience with social conditions.

Social justice's inclusion in this study drew the researcher's attention to ideas and actions related to the importance of the participants' fairness, equity, equality, democratic process, status and hierarchy; individual and collective rights; as well as obligations during the research process. This strategy alerted the researcher to consider participants as humans who could create good societies and a better world, providing a clear direction regarding the central phenomenon (Charmaz 2020:165). In this study, the researcher developed a social support framework to offer direction to health professionals dealing with MHCUs' continuity of care, which was the core phenomenon under study. Furthermore, social justice prepared the researcher to learn and look at collective and individual life experiences in new ways (Charmaz 2014:327).

3.4.2 Paradigmatic perspective

A paradigm is described as a means to examine natural phenomena, and it encompasses a set of philosophical assumptions that guide the researcher's approach to inquiry (Brink et al. 2018:20). Thus, in this study, a paradigm is considered an overarching philosophical framework that supports the production of scientific knowledge.

3.4.2.1 Philosophical assumptions

According to Charmaz (2014:9), grounded theory emphasises the pragmatist philosophical traditions and assumes that people should be actively involved in daily activities in the world where they live in, instead of waiting for society to do things on their behalf. In this study, the researcher involved the participants throughout the research process as data collection and analysis were constructed through the shared experience of both the researcher and participants (Creswell & Poth 2018:21).

Social constructivism was deemed essential for this study as the researcher believes this interpretative framework supports the assumption that a series of actions (not what is constructed) form the basis of human existence. Human beings construct this existence by engaging in a series of actions (Charmaz 2014:9). According to Charmaz (2014:65), researchers pose open-ended questions in qualitative studies and listen carefully to what the participants say or do in their setting, thereby addressing the interaction processes as the discussion unfolds. In this study, the researcher posed broad and general questions so participants could construct meaning of the situation that arose due to this interaction.

Creswell and Poth (2018:87) assert that the manner in which things are done is the centre of attention that needs to be addressed. They believe during data analysis, the researcher presents a visual model in which a central view of the phenomenon is identified, explores causal conditions, specifies strategies (the actions or interactions that result from the phenomenon), identifies the context and intervening conditions, and delineates the consequences for this phenomenon.

The researcher engaged in intensive interviewing as recommended in a grounded theory approach. This was coupled with the use of multiple sources, and this process assisted the researcher in identifying the central problem (Brink et al. 2018:84). Thus, the philosophical assumptions that were described add notions of human agency, emergent processes, social and subjective meanings, problem-solving practices and the open-ended study of action to grounded theory (Charmaz 2014:9). Pragmatism also informs symbolic interactionism, a theoretical perspective; hence, the researcher found theoretical assumptions to be imperative in this study.

3.4.2.2 Theoretical assumptions

Symbolic interactionism supports the assumption that subjective and social meanings occur due to interaction and is occasionally seen through somebody's way of doing things. It indicates that subjective meanings emerge from grappling with experienced interactions, occurring as a result of language, and are subject to change depending on reassessments (Charmaz 2014:96; Gray et al. 2017:67). The researcher considered language and meaning as crucial during the interaction by listening carefully and observing cues that accompanied some of the participants' utterances.

Charmaz (2014:277) states that symbolic interactionism offers grounded theories an open-ended theoretical perspective. This theoretical perspective assumes that society, reality and the self are the product of interaction that are dependent on language and communication. This assumption is supported by Polit and Beck (2021:121), who postulate that symbolic interaction is all about the manner in which individuals interact and the interpretation they attach to social symbols.

The basis of symbolic interactionism is language and its meaning (Charmaz 2014:9; Schurink et al. 2021:299). These proponents assert that people act toward things, including each other, based on the meanings they derive through social interactions. These meanings are managed and transformed through the interpretative process. Language and meaning are described at length in this assumption because these symbols are crucial during interviews in grounded theory. The two symbols' impact on the interview process persuaded the researcher to move slower during the interview and insert questions that elicited more detailed responses and cues that were not influenced

by preconceived ideas. This approach, in turn, allowed the researcher to avoid forced responses (Charmaz 2014:94).

The assumption that interaction is characterised by constant change, can be interpreted, and addresses how people create, enact and change meaning and actions is symbolic in nature, as articulated by Charmaz (2014:344). The author asserts that humans act toward things based on the meanings that the things have for them, and the meanings of things arise from individuals' interactions with fellow humans. This explanation prompted the researcher to put aside preconceived ideas about the phenomenon under study and closely observe any bias that could affect the research findings. The responses and behaviours observed during data collection thus came from participants' actions, the meaning they attached to the research phenomenon, and the context in which it occurred. Charmaz (2017:35) further advocates for developing a methodological self-consciousness that will assist the researcher in reflecting on the research process and the empirical world.

This view is supported by Creswell and Creswell (2018:260), who attest that researchers need to be conscious in discussions so that the flow of content or methods is not overruled by their own personal experiences. Moreover, the assumption that "people can and do think about their lives and actions rather than respond mechanically to stimuli" is supported by Creswell and Poth (2018:87). They agree that in grounded theory, the researcher needs to explore the research phenomenon by raising questions with the intent to understand individuals' experiences, the process and manner in which it unfolds, and avoid posing direct questions that will yield information expected of the phenomenon. The researcher ultimately partners with participants in exploring the phenomenon under study, but the core variable lies with the participants. In this study, the researcher thus took the position of a key data collection instrument without any due influence throughout the research process. This strategy is supported by the constructivist approach (Creswell & Creswell 2018:46), which acknowledges the researcher's values and beliefs. In this study, the interaction between the researcher and the participants was viewed as the basis of grounded theory.

3.4.3 Advantages and disadvantages of grounded theory

According to Creswell and Poth (2018:89), grounded theory is neither immune to drawbacks nor perfect. There are many challenges and criticisms attached to grounded theory related to the application of this approach, yet advantages also exist. The main advantages of grounded theory are its intuitive appeal, ability to foster creativity, conceptualisation potential, systematic approach to data analysis, and the fact that researchers using it can gather rich data (Ayton et al. 2023:82).

As a research method with intuitive enquiry, grounded theory assisted the researcher in striking a balance between the participants' views about the phenomenon and the interpretation of actions, behaviours and meanings embedded in the data, resulting in theory generation. Grounded theory's flexibility and ability to foster creativity also assisted the researcher in establishing strategies to solve existing gaps in knowledge by developing a conceptual framework to direct the execution of activities to the best of stakeholders' ability to yield effective social support.

Grounded theory has the potential for conceptualisation, which assisted the researcher in identifying codes from the collected data. The researcher then generated categories and moved to an abstract level of generating themes to give direction to the study. Moreover, the systematic yet flexible nature of grounded theory assisted the researcher in becoming immersed in the data and engaging in the process of iterating data collection and analysis, thereby leading to increased levels of abstraction.

The grounded theory approach enabled the researcher to collect data from different sources, suggesting rich data were obtained. Field notes, face-to-face interviews and observations were additional data sources used by the researcher in gathering data. Professional nurses, social workers and MHCUs were interviewed as multiple sources of information. This enabled the researcher to thoroughly describe the participants' explanations regarding social support for MHCU.

The disadvantage of this approach is that the method is exhaustive and time-consuming. The researcher engaged in the memoing process in the earlier stages of data collection

and analysis, which prevented her from remaining in the data for a long time as early analytic work expedited progress towards the endpoint.

This approach is also subjected to high methodological error as some researchers may select purposeful instead of theoretical sampling, where the emerging theory controls the data collection process. In this study, the researcher explored the grounded theory processes to gain an understanding of the method. This assisted the researcher to remain focused from the beginning of the data collection process to the generation of the theory.

The researcher reviewed literature after the data's collection and analysis to address the literature review challenge, described as a contentious and debatable issue in grounded theory. Also, by considering grounded theory as a qualitative method of inquiry, threats to external validity or generalisability may be limitations of the research being undertaken and warrant consideration by the researcher (Ayton et al. 2023:82; Creswell & Creswell 2018:44). The researcher employed trustworthiness to enhance the study's rigour, and the study was based on participants' actions and behaviour, suggesting results may be transferred to similar contexts but may not be generalised (Polit & Beck 2021:157).

3.4.4 Challenges in grounded theory

Creswell and Poth (2018:88) agree that challenges exist in grounded theory as the investigator needs to set aside theoretical ideas or notions (preconceived ideas) as much as possible so that the analytic, substantive theory can emerge. Through the process of memoing, reflexivity was promoted throughout the study to mitigate this challenge (Polit & Beck 2021:512). The researcher recorded reflections in a reflective journal and used it during data analysis.

The researcher also faced difficulty determining when categories were saturated, or the theory was sufficiently detailed. In order to move towards saturation, the researcher used discriminant sampling, where additional information was gathered from individuals different from those initially interviewed to determine if the theory holds true for these additional participants (Creswell & Poth 2018:88).

Charmaz (2014:95) states that interviewing challenges grounded theorists to create a balance between asking significant questions and forcing responses. Thus, the researcher has a significant role in shaping the data. In this study, the researcher engaged the participants at a slow, reflective pace, allowing additional questions to be posed to explore meaning during the interviews.

3.4.5 Population and sampling

According to Polit and Beck (2021:52), the population refers to all individuals who are the focus of the research. For this study, the population was operational managers (N=17), professional nurses (N=390), social workers (N=11) and MHCUs (N=1030). The target population is defined as the entire set of individuals or elements who meet the sampling criteria (Polit & Beck 2021:805). This study's target population was operational managers, MHCPs and social workers providing mental health care services, and MHCUs.

3.4.5.1 Sampling in grounded theory

Sampling is a process of selecting a portion of the population to represent the entire population (Polit & Beck 2021:802). Theoretical sampling assisted the researcher in gathering pertinent data that focused on the emerging theory's categories and its properties in order to elaborate and refine the categories through a procedure called constant comparison (Charmaz 2014:192; Polit & Beck 2021:501). Creswell and Poth (2018:89) attest that in order for the researcher to establish whether a theory is sufficiently detailed, additional information from individuals different from those initially interviewed should be gathered to determine if the theory holds true for these additional participants.

For this study, non-probability sampling was employed to select participants. Brink et al. (2018:124) state that this type of sampling is convenient and economical and allows for the study of a population in case probability sampling cannot be employed. This type of sampling assisted the researcher in selecting participants who knew about and were able to articulate their experiences of the phenomenon and explain any nuances (Brink et al. 2018:124).

Purposive sampling, a non-probability method, was used to sample participants. This method assisted the researcher in selecting operational managers, professional nurses, social workers providing mental healthcare services, and MHCUs. These individuals were atypical and especially knowledgeable about the research phenomenon (Brink et al. 2018:126; Grove & Gray 2019:248). Therefore, the researcher purposefully selected participants with knowledge about social support for MHCUs. Creswell and Poth (2018:158) attest that the researcher selects individuals and sites for their research because they can purposefully inform an understanding of the research problem and central phenomenon in the study. The following inclusion criteria were employed to select operational managers, MHCPs, social workers trained to offer mental healthcare services, as well as MHCUs readmitted in the facilities. The exclusion criteria entailed social workers not trained in providing mental health services as well as MHCUs who were admitted for the first time in a health facility.

Grove and Gray (2019:482) state that saturation refers to a point during qualitative studies when additional data collection provides no new information, and there is a redundancy of previously collected data. The sample size in qualitative studies thus depends on saturation. For the study, the sample size depended on the study's informational needs. This view is supported by Charmaz (2014:57), who indicates that with grounded theory, researchers engage in intensive interviews to gather needed details for the study.

The researcher selected participants serially and contingently. A plan regarding the sequence of institutions and the group of participants to be interviewed was established, and the first few cases were purposefully selected based on convenience. In the early part of the study, the researcher employed maximum variation and extreme case-finding sampling to gain insights into the range and complexity of the phenomenon under study, that is, social support for MHCUs. The researcher employed maximum variation by sampling male and female operational managers, social workers and professional nurses with diverse roles in assisting MHCUs. The researcher offered the different role players an opportunity to refer other individuals who were more knowledgeable about the phenomenon under study. Additionally, the researcher employed case-finding by involving other MHCPs and professional nurses who were not psychiatric trained but rendered mental health services and with constant exposure to MHCUs.

The researcher's next step was adjusting the sample in an ongoing fashion. The researcher carefully observed the emerging conceptualisations and allowed it to inform the sampling process. The researcher kept sampling until the estimated number of participants was reached, as suggested in grounded theory; in this study, 31 participants were sampled.

Final sampling included a search for confirming cases to test, refine and strengthen the theory (Polit & Beck 2021:504). Charmaz (2014:193) affirms sampling in grounded theory involves moving from initial sampling, which gets the researcher started in establishing sampling criteria for the participants before the field is entered, followed by theoretical sampling.

3.4.5.2 Sample

A sample is a subset of the population comprising those selected to participate in a study (Polit & Beck 2021:802). Data saturation ultimately guides the researcher's determination of the sample size, and 31 participants were sampled in this study. In qualitative research, the sample size is determined by the information needed (Polit & Beck 2021:502).

Table 3.1 indicates the sample that was selected per category. The number of participants was informed by staff ratio/availability and the role the staff members played.

Table 3.1: Number of participants per category

Category	Number of participants
Operational managers	5
Mental healthcare providers (MHCPs)	14
Social workers	3
Mental healthcare users (MHCUs)	9

While Limpopo province has five districts, the researcher focused on three districts with specialised mental health institutions. The mental health institutions were sampled based on the mental health services provided. The three mental health institutions admit all categories of MHCUs (acute, sub-acute as well as long-term), and other hospitals refer individuals to these hospitals for further management.

The researcher employed a qualitative research methodology rooted in grounded theory, and the sample comprised 31 participants. This number was not predetermined but emerged as part of the study's organic process, guided by the concept of theoretical saturation, as outlined by Glaser and Strauss (1967) and further developed by Charmaz (2014:214). Theoretical saturation is reached when additional data collection ceases to bring new insights to the developing theory, a state that was achieved with this sample size.

The participants in this study were diverse, encompassing a range of male and female nurses and social workers with a minimum of five years' experience working in a mental health institution. MHCUs were both male and female with a history of readmission, which was crucial for ensuring a variety of perspectives and experiences related to the research topic. The depth and variability within this group were instrumental in developing a rich and nuanced understanding of the subject matter. Each participant's unique experiences and viewpoints allowed for a thorough exploration of the research topic, contributing significantly to the robustness and complexity of the data.

The process of working with this sample size was dynamic and reflexive. A continuous evaluation of the sample's adequacy in addressing the research questions and objectives ensured that the emerging theory was deeply grounded in the data. This reflexivity, combined with the participants' rich contributions, underscored the study's credibility.

3.5 RESEARCH METHODS

Research methods are techniques used to structure a study and gather and analyse information relevant to a research question.

3.5.1 Data collection in grounded theory

The researcher noted that data collection techniques in grounded theory are the same as in most other forms of qualitative research and entail participant observation and unstructured interviews. However, the difference is that in grounded theory, the researcher obtains data by using different kinds of sources in an endeavour to develop an explicit theory.

The researcher collected data from November 2020 to December 2020. Data collection outlines the plan the researcher intends to use to answer the research question (Brink et al. 2018:133). Semi-structured, face-to-face, audio-recorded interviews, observations, field notes and memos were used to collect data from participants.

Five operational managers, 14 MHCPs and three social workers were interviewed through semi-structured face-to-face interviews that lasted 40 to 60 minutes. Nine MHCUs were also interviewed individually for 40 to 60 minutes. The researcher was the main research instrument during data collection (Creswell & Poth 2018:43).

Researchers must ensure ethical measures are observed during the data collection process, setting boundaries through sampling and recruitment, collecting information through observations and interviews, documents, visual materials, as well as establishing a protocol for recording information (Creswell & Creswell 2018:261). The information gathered during data collection depends on the data-gathering instrument, influenced by aspects such as conceptual relevance and whether the instrument will yield high-quality data (Polit & Beck 2021:279). Additionally, Brink et al. (2018:160) state that data-gathering instruments should be assessed for sensitivity, efficiency, appropriateness and ability to generalise to ensure high-quality findings.

3.5.1.1 Semi-structured interviews

Semi-structured interviews, as a qualitative data collection method, are anchored in the theoretical foundations of interpretivism and constructivism, which posit that reality is socially constructed through individual experiences and interactions. This method aligns with the epistemological stance that knowledge is subjective and co-created by the researcher and participant. In semi-structured interviews, open-ended questions facilitate a flexible and participant-led dialogue, allowing for the in-depth exploration of personal perceptions, experiences, and meanings. This approach enables researchers to delve into complex social phenomena and gain insights into the nuanced, often context-dependent nature of human experiences and social realities. The dynamic nature of these interviews fosters a deeper understanding of the participants' perspectives, making it a powerful tool for exploring subjective experiences and constructing rich, detailed narratives.

Semi-structured interviews create an opportunity to gain in-depth information, are flexible in terms of gathering data, and thus offer distinct advantages. Furthermore, researchers can ascertain basic issues or problems, how sensitive or controversial the topic is, how people conceptualise and talk about a problem, and what range of opinions or behaviours exist relevant to the topic. Moreover, this type of interview may help elucidate the underlying meaning of a pattern or a relationship repeatedly observed in more structured research (Polit & Beck 2021:521).

- ***Advantages and disadvantages of semi-structured interviews***

Semi-structured interviews allow probing questions to be used to increase detailed feedback. Such questions give the interviewer an opportunity to clarify and expand on responses and explicate meaning. Thus, the researcher is able to gather the rich information required in grounded theory. Semi-structured interviews also enhance rapport between the interviewer and interviewee, given the proximity of the individuals as well as the level of interaction, unlike in structured interviews where the interviewee usually interacts with documents such as questionnaires (Brink et al. 2018:144).

The disadvantage of semi-structured interviews is that qualitative self-reports are extremely time-consuming and demand strong data-gathering skills (Polit & Beck 2021:520). The researcher carefully listened to what participants were saying to develop appropriate follow-up questions, mitigating low-quality data. Another challenge is that semi-structured interviews provide indirect information filtered through participants' views (Creswell & Creswell 2018:264). Furthermore, interviews require the interviewee to be prepared for strong emotions such as anger, fear or grief to surface (Polit & Beck 2021:520).

3.5.1.2 Face-to-face interviews

Face-to-face interviews occur between an interviewer and interviewee and are the most respected method of data collection; thus, interviewers meet participants in person. Although they tend to be costly, face-to-face interviews are regarded as the best data collection method because of the quality of information they yield. Furthermore, refusal rates tend to be low, suggesting adequate data may be collected due to participants' availability (Polit & Beck 2021:234).

The researcher used face-to-face interviews to collect data from all the participants. The face-to-face interviews assisted the researcher in controlling interactions, ensuring the targeted participant was the right respondent, following responses with questions that elicited more clarity, as well as asking probing questions. The researcher also found this method more advantageous as emotional and non-verbal cues such as discomfort and enthusiasm could be easily captured.

3.5.2 Data collection procedure

3.5.2.1 Interviewing in grounded theory

The researcher engaged in intensive interviews, as supported by Charmaz (2014:57), who affirms in-depth interviews suit grounded theory methods well. Engaging in intensive interviews facilitates an open-ended, in-depth exploration of an area in which the interviewee has substantial experience. The researcher followed a constructivist grounded theory approach, as rich data were collected that allowed for the development of a theory grounded in the data (Brink et al. 2018:107). The researcher listened carefully to the construction of the participants' stories and used silence as a prompt. Mutuality was also encouraged in support of the approach.

The researcher asked a few questions to allow the participants to share their stories without the researcher preconceiving the content or the direction the interview would take. Moreover, the aforementioned aspect helped the researcher to avoid interrupting the data collection process. Furthermore, the researcher had ample time to engage in the iterative practice of moving back and forth between data and analysis, as this is a common strategy in inductive qualitative inquiries (Brink et al. 2018:107; Creswell & Poth 2018:84). In addition to constructivist practices, the researcher considered language and discourse essential, as the constructivist approach alone does not suffice for in-depth interviews (Charmaz 2014:95). The researcher paid attention to participants' language and meaning by creating a balance between asking significant questions and forcing responses. The researcher also picked up on cues during the interviews and showed an interest in knowing more. This elicited a greater depth of subjective meaning and gave the researcher a clear analytic direction to pursue by asking probing questions (Charmaz 2014:95).

The researcher used an interview guide to ask open-ended questions, and participants could respond to the questions posed as they saw fit and deliver unexpected insights about the phenomenon (Polit & Beck 2021:282). The researcher used multiple forms of data collection strategies and captured tempo, silences, statements and the flow of questions and responses, in addition to jotting down notes, in order to obtain the participants' views about social support for MHCUs (Creswell & Poth 2018:162).

The participants were notified about the remaining time during the interviews. A summary of their shared experiences was also outlined to confirm the researcher's interpretation was accurate. At the end of data collection, data sources (audio recorder, field notes and memos) were kept private and safely stored.

The researcher also interviewed individuals other than the ones scheduled to close gaps that might have occurred during data collection. MHCPs (professional nurses) who are not psychiatrically trained but render mental health services to MHCUs were also involved in the study as they have constant exposure to mental health care. According to Polit and Beck (2021:500), these additional individuals' involvement creates opportunities for learning from the most unusual and extreme informants. The assumption underlying this strategy is that extreme cases are rich in information because they are special in some way.

3.5.2.2 Preparations for the interview

The researcher circulated letters to request approval to conduct the study at the research sites to the Chief Executive Officers and primary healthcare managers. The researcher contacted participants and amended the interview schedule depending on the participants' availability. Polit and Beck (2021:520) state that researchers who conduct qualitative research must, to an even greater extent than quantitative researchers, gain and maintain a high level of trust with participants. Researchers need to develop strategies in the field to establish credibility among those being studied. Thus, the researcher ensured the building of rapport and gaining trust by being sensitive to ethical issues. The researcher explained the purpose of the study, voluntary participation and confidentiality of the information. The researcher further indicated that participants'

identities would be protected and remain anonymous; no information could be linked to the participants. This essential information was written in the consent form, which was given to each participant to read.

Data were collected after obtaining ethical clearance and permission from relevant authorities and institutions. The researcher visited hospitals and clinics prior to actual data collection days to prepare for the interviews. The researcher presented an overview of the data collection strategy to the assistant and operational managers. An agreement about the candidates, as well as the allocation of offices where interviews could be conducted, was reached. The researcher had an opportunity to meet and make final arrangements with the participants, and a date for interviews was agreed upon between the researcher and participants.

The researcher conducted a pilot interview in one of the general hospitals with an acute mental health unit prior to actual data collection. The pilot interview aimed to assess the time required to administer the interview and determine ambiguity in questions (Polit & Beck 2021:280). Brink et al. (2018:45) attest that pre-testing a data collection instrument allows researchers to refine the instrument, identify faulty areas and assess its timelines.

For the pilot study, two professional nurses and two MHCUs were recruited, and semi-structured face-to-face interviews were conducted in different settings from where the primary study took place. The findings from the pilot study were not included in the research findings even though no flaws were identified; therefore, the instrument was not refined or rephrased. Furthermore, the voice recorder used for capturing information was checked for audibility, and the audio sound was deemed sufficient and accurate.

The researcher visited the hospitals and clinics on the agreed-upon dates for data collection. Offices were arranged with the managers for data collection in both hospitals and clinics. Doors were labelled indicating that interviews were in progress and there was no disturbance or noise by staff members. The participants' names were not mentioned during the interviews to maintain their privacy and confidentiality.

The researcher prepared semi-structured interview questions to be covered with each category of participants. The researcher established a relaxed environment, and this

encouraged responses from participants who could freely share their stories in their own words. The semi-structured interview technique assisted the researcher in obtaining in-depth information, yet the flexibility embedded in qualitative methods elicited essential information as individuals were given latitude to express themselves freely (Polit & Beck 2021:514). Each semi-structured interview lasted 45 to 60 minutes. The researcher explained the use of the digital recorder to the participants, stating that it would be used to capture accurate information and avoid any data loss.

Interviews with the professionals were conducted in English in the administrative offices of mental health institutions and clinics in order to ensure privacy and minimise distractions. The interviews with professionals took place outside of their official office hours. Vernacular Xitsonga was used to interview MHCUs as the majority expressed themselves well in their own language. Participants were from different cultural backgrounds, as indicated in the research setting; however, they all communicated in Xitsonga, as the research setting was a Tsonga-dominated area.

The researcher used an interview guide (Annexures L and M) to collect data and employed responsive listening skills, such as maintaining eye contact and being conscious of body language and participants' posture. The researcher portrayed empathy, concern, as well as acceptance of participants' responses, and this assisted in establishing rapport. Following the main question, subsequent facilitative communication techniques such as probing, clarification, reflections and summaries were used. Consent to participate in the study and audio record the interviews was obtained from participants before commencing with data collection.

The researcher reduced the research questions to a few overarching central questions, as recommended by Creswell and Poth (2018:137). According to Creswell and Poth (2018:137), drafting central questions could take considerable work. To reach an overarching central question, the researcher stated the broadest question possible to address the research problem.

The following central questions were posed to the different populations:

Operational managers, nurses and social workers:

"What actions do you take to ensure successful continuity of care during the discharge of MHCUs?"

"What can be done to provide social support and continuity of care to MHCUs?"

MHCUs:

"What help did you receive from the hospital or clinic after your discharge?"

"What help did you receive from family, friends, or neighbours after your discharge?"

3.5.2.3 The role of the researcher in qualitative data collection

For this study, the researcher acted as a key data collection instrument as the one collecting data, unlike in the quantitative approach where instruments such as questionnaires are used (Creswell & Poth 2018:43). As a result, the researcher engaged in self-preparation before collecting the data. Brink et al. (2018:161) state that researchers face challenges based on their personal values, past experiences, biases, prejudices and orientations during data collection, which could alter research results. In support, Creswell and Poth (2018:261) affirm that researchers must disclose their understanding of their biases, values and experiences being brought to a qualitative research study from the onset so that the reader understands the position from which the researcher undertook the inquiry.

The researcher engaged in reflexivity throughout the study using the memoing process to mitigate any undue influence from her prior knowledge or personal biases (Charmaz 2014:155). Furthermore, the researcher guarded against emotional involvement that could compromise her ability to collect meaningful and trustworthy data. The researcher also tried not to become overwhelmed and thus put aside participants' emotions during the data collection process (Polit & Beck 2021:512; Brink et al. 2018:161). The researcher also recorded observations based on perceptual differences and observer variations in view of the research factors that can affect the research process (Brink et al. 2018:161).

The researcher's perceptions were shaped by personal experiences. From 1996 to 2003, the researcher served as a professional nurse in clinics rendering mental health services. From 2005 to 2015, the researcher served as a nurse educator in the Psychiatric Nursing

Science Department and was involved in student nurses' theoretical and clinical teaching in class and hospitals/clinics, respectively. The researcher also facilitated students' research whose focus was mental health-related issues. From 2015 to date, the researcher has managed a Psychiatric Nursing Science discipline (mental health). The researcher believes her experiences dealing with mental health-related issues, in either form mentioned above, served as corrective measures to perceptual differences and observer variation that could have arisen during data collection. Educational and administrative background knowledge also sharpened the researcher's views to attain a positive outlook on the explored issues, thereby fighting personal experiences.

The researcher acknowledged the possibility of biases before data collection and scrutinised methodological processes accordingly. Participants' lack of openness during interviews as well as researcher subjectivity may distort or skew information, and were considered when interpreting the study's findings (Brink et al. 2018:83).

3.5.3 Challenges experienced during data collection

The data collection plan was disrupted because some participants withdrew during interviews. Other potential participants chose not to participate, and their responses could have been valuable based on their experience with the research phenomenon. An arrangement was made with the operational managers to interview additional participants to curb the gap caused by those who withdrew from participating in the study. A date for an interview was set and identified volunteers were interviewed.

The researcher was allocated offices with adequate space for data collection, but while staff kept noise to a minimum, MHCUs were noisy due to their mental status. At one point, staff members had to call one MHCU to order as he wanted to enter the office while interviews were in progress.

- ***Field and observation notes***

The field and observational notes taken during data collection assisted the researcher in obtaining more information about the research phenomenon (Polit & Beck 2021:525; Grove & Gray 2019:81). Notably, the researcher considered field notes an essential part

of data collection as they contain a narrative account of what is happening in the field and thus serve as a data source for analysis (Polit & Beck 2021:521).

According to Polit and Beck (2021:526), field notes can include content, metacommunication and context, and the researcher's reactions and immediate responses to what transpired. The researcher also wrote observational notes by observing and noting non-verbal cues participants elicited during the interviews. The cues helped the researcher clarify participants' meanings and enriched the collected data.

In this study, the researcher focused on descriptive notes as they allowed the researcher to jot down objective descriptions of observed events and conversations, and information pertaining to participants' actions. Dialogue and context were also recorded as completely and objectively as possible (Polit & Beck 2021:525).

- ***Memos***

The researcher engaged in memo writing, a crucial element in grounded theory. Engaging in the aforementioned action prompted the researcher to analyse data and codes early in the research process, as postulated by Charmaz (2014:162). The researcher kept writing successive memos throughout the research process, an essential element that kept the researcher involved in the analysis and helped increase the abstraction of ideas. Memo writing, if properly done, helps certain codes stand out and take form as theoretical categories as successive memos are written; this is what happened in this study.

Furthermore, memo writing assisted in catching the researcher's thoughts, comparisons and connections, and crystallised questions and directions to pursue. In this study, memo writing created an interactive space for the researcher to converse about data, codes, ideas and hunches. As a result, questions arose, and new ideas were developed during the act of writing (Charmaz 2014:162).

3.6 DATA MANAGEMENT AND ANALYSIS

Data management and analysis in qualitative research are inseparable and sequential, as the researcher cannot attempt the latter without considering the former as it is

reductionist in nature. It thus assists in converting masses of data into small, manageable segments, thereby assisting the researcher to better analyse data as the volume is reduced (Polit & Beck 2021:543). Creswell and Poth (2018:174) indicate that managing qualitative data's storage is imperative as the approach to storage reflects the type of information collected; hence, the researcher attempted to meticulously manage the data.

3.6.1 Data management

The researcher guarded against confusion by ensuring all data from a single subject were kept together (Creswell & Poth 2018:185). The researcher further ensured data management by assigning a subject code number to each form/transcript and storing forms in colour-coded file folders to allow easy access to data. The researcher ensured data were coded and entered into the computer as soon as possible after data collection to reduce the loss or disorganisation of data (Creswell & Poth 2018:185). Electronic data were stored in the researchers' personal computer with a security code to prevent unauthorised persons' access to the information, and files were developed to guard against loss of information (Creswell & Poth 2018:186). Electronic files were deleted with the assistance of professional IT personnel who deleted the electronic records using best practice standards. Paper documents were shredded using a desk shredder.

3.6.2 Data analysis

Grove and Gray (2019:470) state that data are analysed to reduce, organise and give meaning to the data. Furthermore, as a constructionist, data analysis involves combining segments into meaningful conceptual concepts (Polit & Beck 2021:543).

Following the organisation of the data, the researcher engaged in analysis by getting a sense of the whole database, reading the transcripts in their entirety several times, stopping and analysing ideas about the codes that occurred during a particular moment, and immersing herself in the details while trying to get a sense of the interview as a whole before breaking it into parts. This was followed by writing memos in the margins of field notes and transcripts (Charmaz 2014; Creswell & Poth 2018:187).

The researcher used three phases of coding, namely open, axial and selective coding in order to follow the grounded theory requirements, which emphasise the use of detailed analysis procedures (Creswell & Poth 2018:203). Grounded theory provides a procedure for developing categories of information (open coding), interconnecting the categories (axial coding), building a “story” that connects the categories (selective coding), and ending with a discursive set of theoretical prepositions.

During the open-coding phase, the researcher examined the text (transcripts, field notes) and observations for salient categories of information supported by the text. Using the constant comparative approach, the researcher ensured that categories were saturated by continuously looking for instances that represented a category and continued looking and interviewing until new information could no longer provide further insight into the category (Creswell & Poth 2018:203).

The researcher identified a single category from the open-coding list as the central phenomenon of interest that the participants extensively discussed. The researcher selected this one open-coding category (a central phenomenon), positioned it as the central feature of the theory, returned to the database, and collected additional data to understand the categories related to the central phenomenon. Specifically, the researcher engaged in axial coding, where the database was reviewed, and new data were collected to provide insight into specific categories related to the central phenomenon (Creswell & Poth 2018:203).

Information from the specific coding categories was organised into a figure, a coding paradigm that represents a theoretical framework of the phenomenon under study. In this way, a theory was generated. From the theory, the researcher interrelated the categories in the coding paradigm, called selective coding (Creswell & Poth 2018:203).

3.7 RIGOUR AND GROUNDED THEORY

According to Brink et al. (2018:82), rigour is described as striving for excellence in research, which, in turn, implies paying disciplined attention to detail and meticulous accuracy. Ayton et al. (2023:233) affirm that the increasing use of the grounded theory

method in nursing research has directed attention to the quality of studies, and rigour is thus used to enhance credibility.

The researcher considered rigour essential in this study as grounded theory encompasses critical aspects and is underpinned by research steps that require scrutiny. Furthermore, rigour is imperative as the main aim of this approach is to yield quality findings or results (Brink et al. 2018:110).

The application of rigour as a method to enhance quality in qualitative approaches (grounded theory) raised arguments since this concept fits well in quantitative approaches. Thus, rigour has been considered inappropriate in quality enhancement and is not suitable for construction or critical paradigms (Polit & Beck 2021:567; Brink et al 2018:110). However, Glaser and Strauss (1967; cited in Charmaz & Thornberg 2021:310) argued that the first-hand information collected during qualitative studies could lead to theory construction. Emphasising, theorising and conducting high-quality research should be asserted based on direct knowledge of the studied phenomenon. Thus, studies of direct experiences could be conducted with rigour. Moreover, Glaser and Strauss (1967; cited in Charmaz & Thornberg 2021:313) indicate that criteria for evaluating quality vary, and applicability depends on the version of the grounded theory.

Generally, credibility and applicability are used in grounded theory, as suggested by Glaser and Strauss (1967). However, the researcher focused on credibility, originality, resonance and usefulness as the four main criteria for grounded theory studies using a constructivist approach. Additionally, auditability and fittingness were also explored. The researcher applied the criteria to enhance the standards of rigour in the study, as suggested by Charmaz and Thornberg (2021:313).

3.7.1 Methods for enhancing credibility in grounded theory methodology

In qualitative research, credibility is demonstrated when participants and readers who have had a human experience, recognise the described experiences as their own. Credibility relates to the trustworthiness of the findings (Creswell & Poth 2018:261; Polit & Beck 2021:564). The following methods of research practice were applied to enhance credibility:

- ***Letting participation guide the inquiry process***

The codes identified during the interviews were used to guide the inquiry process by adding them to the interview guide as questions. Repeated data from different participants were noted, guided the inquiry, and were retained due to their common occurrences, leading to the elimination of data that seemed not to guide the inquiry. Thus, modifying the interview guide, research questions and content areas of the emerging theory according to incoming information from participants guided the inquiry process and helped to enhance credibility (Creswell & Poth 2018:261).

- ***Checking the generated theoretical construction against participants' meaning of the phenomenon***

The theoretical construction was checked against participants' views of the phenomenon during this study. Two levels were involved in checking the constructed framework. First, the codes were developed (based on incoming data from the participants), and questions in the interview guide were changed. Second, as the theory was constructed, codes were checked and verified by directly questioning their relevance to participants' meaning. In this way, participants were invited to refine, develop and revise the emerging theoretical structure (Charmaz & Thornberg 2021:314; Creswell & Poth 2018:204).

- ***Using participants' actual words in the framework***

Polit and Beck (2021:579) state that it is important to acknowledge the potential for distorting or inaccurately representing a participant's intended meaning of a word, relationship or action, especially when using single words or segments of interview data to describe the phenomenon. In this study, this issue was addressed in two ways. First, excerpts from interview data supported each word, relationship, and action. Second, the varied meanings and contexts in which participants used a word were delineated in terms of its different meanings.

- ***Articulating the researcher's personal views and insights regarding the research phenomenon***

According to Charmaz and Thornberg (2021:315), credibility also involves the researcher's views and actions. Hence, explaining the researcher's own construction of the phenomenon and acknowledging how these affect the inquiry is important to

enhancing credibility. In this study, two tools were used to limit the influence of the researcher's pre-existing knowledge. First, a post-comment interview sheet was used as a self-monitoring tool to note aspects of the interview data that provided excitement and surprise. The tool assists the researcher to remain open and calm in matters not supported by participant data irrespective of the potential and excitement they provided (Charmaz & Thornberg 2021:315; Polit & Beck 2021:571; Brink et al. 2018:110). The post-comment interview sheet was also used as a medium for memo writing to keep track of insights and analytical ideas during data collection and analysis. Second, the researcher used a personal reflexive journal to record her own views of the phenomenon, which assisted in identifying aspects that were upheld by the researcher but had no theoretical relevance to participants. In this way, the researcher was theoretically sensitive and did not selectively look for views that were identified before and noted as being of importance to the researcher during data collection (Creswell & Poth 2018:261; Polit & Beck 2021:571).

- ***Originality in grounded theory***

Furthermore, Charmaz and Thornberg (2021:316) indicate that originality as a criterion for enhancing quality in constructivist grounded theory varies considerably. This criterion can bring in new insights, provide a fresh conceptualisation of a recognised problem and establish the significance of the analysis. The researcher enhanced quality by constructing fresh concepts from the inductive data, checked and developed through abduction (Charmaz 2014:342). Codes were formulated from fresh data collected during interviews and developed to an abstract level from categories to themes unique to the study. As such, the study offers new insights into the research phenomenon.

- ***Resonance in grounded theory***

Moreover, resonance as a criterion for enhancing quality, assisted the researcher in redefining codes and categories as guided by the emerging categories (Charmaz 2014:343). During interviews, questions that elicited swayed responses forced the researcher to reconstruct the phrasing, and these were regarded as leading aspects during data collection. Thus, the researcher listened to participants' views from a new standpoint, thereby enhancing quality (Charmaz & Thornberg 2021:316).

- ***Usefulness in grounded theory***

Usefulness, as a criterion, ensured the quality of the study by assisting the researcher in unlocking the best practices of some activities already being done in mental health facilities, PHC settings and the community. Others were developed, adding to those activities in existence and enhancing the quality of mental healthcare provision (Charmaz & Thornberg 2021:316). The developed framework encourages the use and application of policies and standard operating procedures, adding to the quality of mental health services being rendered (Charmaz & Thornberg 2021:317; Risjord 2018:7).

The codes identified during the interviews were used to guide the inquiry process by adding them to the interview guide as questions. Repeated data from different participants were noted, guided the inquiry, and were retained due to their common occurrences, leading to the elimination of data that seemed not to guide the inquiry. Thus, modifying the interview guide, research questions and content areas of the emerging theory according to incoming information from participants guided the inquiry process and helped to enhance credibility (Creswell & Poth 2018:261).

- ***Checking the generated theoretical construction against participants' meaning of the phenomenon***

The theoretical construction was checked against participants' views of the phenomenon during this study. Two levels were involved in checking the constructed framework. First, the codes were developed (based on incoming data from the participants), and questions in the interview guide were changed. Second, as the theory was constructed, codes were checked and verified by directly questioning their relevance to participants' meaning. In this way, participants were invited to refine, develop and revise the emerging theoretical structure.

- ***Using participants' actual words in the framework***

Chiovitti and Piran (2003) state that it is important to acknowledge the potential for distorting or inaccurately representing a participant's intended meaning of a word, relationship or action, especially when using single words or segments of interview data to describe the phenomenon. In this study, this issue was addressed in two ways. First, excerpts from interview data supported each word, relationship, and action. Second, the

varied meanings and contexts in which participants used a word were delineated in terms of its different meanings.

- ***Articulating the researcher's personal views and insights regarding the research phenomenon***

According to Chiovitti and Piran (2003), explaining the researcher's own construction of the phenomenon and acknowledging how these affect the inquiry is important to enhancing credibility. In this study, two tools were used to limit the influence of the researcher's pre-existing knowledge. First, a post-comment interview sheet was used as a self-monitoring tool to note aspects of the interview data that provided excitement and surprise. The tool assisted the researcher to remain open and calm in matters not supported by participant data irrespective of the potential and excitement they provided (Chiovitti & Piran 2003).

The post-comment interview sheet was also used as a medium for memo writing to keep track of insights and analytical ideas during data collection and analysis. Second, the researcher used a personal to record her own views of the phenomenon, which assisted in identifying aspects that were upheld by the researcher but had no theoretical relevance to participants. In this way, the researcher was theoretically sensitive and did not selectively look for views that were identified before and noted as being of importance to the researcher during data collection (Chiovitti & Piran 2003; Creswell & Poth 2018:261; Polit & Beck 2021:571).

3.7.2 Methods for enhancing auditability in grounded theory methodology

Auditability is demonstrated when another researcher is able to follow the audit or decision trail of all the decisions a researcher made at every stage of data analysis (Polit & Beck 2021:577). In this study, the following methods were applied to enhance auditability:

- ***Specify the criteria built into the researcher's thinking***

Charmaz and Thornberg (2021:313) indicate that it is necessary to delineate and specify the criteria used when approaching the transcribed interview data using grounded theory

methodology. In this study, the researcher ensured criteria built into her thinking were specified by delineating standard questions that were consistently asked while analysing the transcribed interview data. These questions were:

- What is happening in the data?
- What does the action in the data represent?
- Is the conceptual label or code part of the participant's vocabulary?
- In what context is the code/action used?
- Is the code related to another code?
- Is the code encompassed by a broader code?
- Are there codes that reflect similar patterns?

These questions were asked in the identification, development and refinement of all codes (Charmaz 2014:343). A consistent coding format, referred to as the paradigm model, was used to determine each code's relationship to the overall framework. Relationships between different levels of codes were examined regarding the different features of the theory in the paradigm model. Consequently, the paradigm model was used as a guide to ask the following questions of the data:

- What feature of the theory does the code denote in terms of the paradigm model?
- Is the representation of the context of continuity of care an antecedent condition of continuity of care, an action/interaction of continuity of care, or a consequence of continuity of care?

This meant that each code was considered in terms of the paradigm's model. Hence, by delineating the data questions, the researcher could audit the research process while leaving an audit trail for other researchers (Creswell & Poth 2018:262; Polit & Beck 2021:577).

3.7.3 Methods for enhancing fittingness in grounded theory methodology

Fittingness (transferability) means there is a common understanding among other researchers engaged in similar situations (Polit & Beck 2021:570). In this study, two methods of research practice were employed to enhance fittingness:

- ***Delineating the parameters of the research in terms of the sample, setting and level of theory generated***

The sample's demographic characteristics included years of experience in psychiatric nursing, employment status, gender, educational preparation, and cultural group. Some setting characteristics included the average length of hospitalisation, the number of registered nurses, the psychiatric patient population, and the number of hospital beds in the unit.

In addition to describing the scope and context of the research in terms of the sample and setting, delineating the level of the theory that was generated allowed the reader to assess fittingness. The framework generated in this study is substantive because it evolved from the study of a phenomenon situated in a particular situational context. In this study, the context was psychiatric nursing units in three specialised psychiatric hospitals and the specific phenomenon of continuity of care was targeted. The researcher followed the grounded theory approach, and it was important to reflect on and identify the level of the theory being generated. In reporting on the theory, the researcher stated the theory's level, because if this information is omitted, it leaves the reader insufficiently informed about the scope of the theory and impedes the assessment of its fittingness (Charmaz & Thornberg 2021:314).

- ***Describing the literature pertaining to each category that emerged in the theory***

In demonstrating the probability that the research findings have meaning to others in similar situations (transferability), the researcher described literature relating to each category in the theory. By highlighting similarities between the study's findings and previous theoretical constructs in the literature, the researcher could show the potential transferability of the phenomenon being explored to other situations in health care (Shurink et al. 2021:103).

3.8 ETHICAL CONSIDERATIONS

The researcher considered that the study involved humans and thus exercised care during the study, with a clear understanding of the importance of protecting research participants' rights (Polit & Beck 2021:137; Brink et al. 2018:27). The researcher

conducted the study with an understanding of the obligation to prevent or minimise harm to participants. The benefits of the research outweighed its risks, and the researcher thus continued with the study (Polit & Beck 2021:137).

The research study was conducted in Limpopo province, South Africa, one of the countries in Africa, hence the researcher's consideration of ethics in Africa.

3.8.1 Research ethics in Africa

Ethical considerations are part of every piece of writing related to research, especially when the research concerns human beings and animals. Strydom and Roestenburg. (2021:117) indicate that good ethical practice means human beings and their well-being are of primary concern. Therefore, the research process should be based on mutual trust, acceptance, cooperation, promises, and accepted conversions and expectations between all parties involved in the research process.

In this study, the researcher considered research ethics in Africa since the study was conducted in Limpopo Province, South Africa. Research ethics in Africa, with its challenges and perspectives as experienced by researchers, thus assisted the researcher in understanding ethical issues from an African perspective. The information from diverse authors further opened the researcher's thoughts regarding the continent's health status. Individualism, as opposed to community interdependence, forms the basis of understanding the application of ethical principles from an African context.

According to Mavhandu-Mudzisi (2023:1), in a South African rural context, the individual is always seen from the perspective of the significant others in the community. Thus, in order to be ethically congruent in South Africa's rural context, there is a need to advocate for ethical principles that recognise participants' cultural diversity, not only as individuals but as interactive persons whose existence is interdependent on significant others (Mavhandu-Mudzisi 2023:5). The notion of individualism versus community interdependence is supported by Hlabangwane (2019:44), who argues that individualism, embedded in the ethical code, extracts the individual from the community to which the individual belongs and where security and completeness are found. Moreover,

individualism encourages separation that is detrimental to the community, while the strength of the community lies in relations of beneficence.

Meanwhile, Nkosi, Seely, Chimbindi, Zuma, Kelley and Shahmanesh (2022:1) argue about individual autonomy versus community responsibility, emphasising that community responsibility should focus on the relationships between the two parties. However, “ubuntu”, an African perspective on relationships, may inadvertently place limits on the individual’s autonomy.

3.8.1.1 Informed consent in an African context

According to Mavhandu-Mudzisi (2023:5), ethical principles should not be prescribed but flexible to embrace the diverse context of Africa. The application of ethical principles in an African context came under scrutiny due to the socio-cultural background of Africans. As the point of departure in data collection, informed consent, in particular, raises concerns. Hence, Mavhandu-Mudzisi (2023:2) indicates that it is helpful to consider the community’s rights as well as those of the group sampled when conducting community-based research.

Generally, voluntary consent is individualised and obtained only when the individual demonstrates a clear understanding of the informed consent form (Brink et al. 2018:34). However, in an African context, consent to participate in a study may be familial or communal. In some African rural communities, a woman’s participation in a study requires the consideration of a spouse or partner, mother, sister, a community member and all role players (Mavhandu-Mudzisi 2023:5). Additionally, in other areas, depending on the research setting, obtaining consent may involve various gatekeepers with power and influence in the community, such as tribal authorities.

Gatekeepers’ consent to participation instead of individuals’ consent in an African rural context may be related to protecting the community’s sacred information. However, the challenge in this regard is the possibility of coercion overruling voluntariness as the actual individual consenting for participation is the gatekeeper (Nkosi et al. 2022:6). Meanwhile,

in the African context, consent may also be beneficial as researchers are observing culture.

Appiah (2021:11) also argues about the possibility of missing out on important keywords and phrases during translations of information from indigenous languages to English. Additionally, Appiah (2021:11) states that most individuals in low-income communities may have had no opportunity for formal education, hence the need for translation.

Polit and Beck (2021:137) claim that a major requirement for ethical research involving human subjects is informed consent from potential participants. The researcher observed this ethical obligation by offering participants an opportunity to choose whether they wished to participate in the study, respecting their autonomy (Strydom & Roestenburg 2021:122). The researcher ensured additional protective measures for MHCUs, classified as a vulnerable group, by obtaining consent forms from legal guardians (Grove & Gray 2019:106).

For this study, participants, including the legal guardians, were adequately informed about the study's aims, methods, potential risks and anticipated benefits. The right to participate voluntarily and withdraw consent at any time during the research process was also highlighted (Polit & Beck 2021:139). The researcher took MHCUs' decision-making capacity into account as they are considered vulnerable to exploitation. The researcher thus ensured consent was free from coercion (Grove & Gray 2019:106; Polit & Beck 2021:139; Strydom & Roestenburg 2021:122).

3.8.1.2 Research vulnerability and exploitation

Brink et al. (2018:34) consider MHCUs a vulnerable research population at risk of exploitation or harm during research processes. The researcher maximised their protection by posing questions that were directly relevant to the MHCUs; there was no other group of participants that could be used as a replacement; and for this study, it was essential to include this group in the research (Grove & Gray 2019:106; Polit & Beck 2021:143).

3.8.2 Protecting the rights of the institution

The researcher obtained permission to undertake the study from the ethics committee of UNISA's Department of Health Studies (Annexure A). The researcher requested permission from the provincial ethics committee functioning under the Department of Health in Limpopo Province (Annexure C) to conduct the study. Polit and Beck (2021:137) state that in cases where humans are used as study participants, care must be exercised to ensure that their rights are protected; hence, the researcher observed the rights of the institution and participants as described below.

3.8.3 Informed consent

The researcher obtained informed consent from participants prior to the collection of data (Annexure K). Participants were informed of the study's process, purpose, and significance. The researcher emphasised that participation was voluntary and that participants could withdraw from the study at any time without penalty. They could choose whether to participate by signing an informed consent form without any influence to do so (Polit & Beck 2021:137). Permission to record the interviews was also sought from participants.

3.8.4 Right to self-determination

The researcher considered participants' autonomous status and notified participants of their right to withdraw from the study at any time, refuse to give information, and ask for clarification about the purpose of the study. The researcher further respected the participants' right to self-determination by not using any form of coercion or penalty. The decision to participate in the study was voluntary (Brink et al. 2018:29; Grove & Gray 2019:106).

3.8.5 Right to privacy and confidentiality

The researcher observed the participants' right to privacy by refraining from covert data collection (Brink et al. 2018:30). Confidentiality refers to the researcher's responsibility to prevent all data gathered during the study from being linked to individual participants,

divulged, or made available to anyone. As a result, the researcher ensured the study was conducted in a way that information could not be linked to the names of the participants (Brink et al. 2018:30; Grove & Gray 2019:100).

3.8.6 The principle of beneficence

The principle of beneficence requires a researcher to secure the well-being of participants who have a right to protection from discomfort and harm; be it physical, psychological, emotional, spiritual, economic, social or legal. The researcher observed the principle of beneficence by carefully structuring the questions and monitoring the participants for any signs of distress during data collection. The participants' well-being was also ensured by offering debriefing sessions in order to uphold the principle of beneficence (Brink et al. 2018:29; Grove & Gray 2019:96).

3.8.7 Potential risks

According to Polit and Beck (2021:133), foreseeable risks (physical, psychological, social, or economic) should be communicated to participants, as well as all efforts taken to minimise risks. The study is medium risk as there is some potential risk of emotional or psychological harm and MHCUs who are categorised as vulnerable groups were included as participants. To deal with this situation, the researcher arranged and referred any participants who felt uncomfortable to a counsellor, without any cost to them. Participants experiencing discomfort were encouraged to stop the interview. This strategy was also applied even if the interview had just commenced.

3.8.8 Rethinking the ethical boundaries of the grounded theory approach

Like any other qualitative method, the grounded theory approach is not without ethical issues that might impact the research process and need careful ethical considerations. However, Parker (2018:3) argues that since no robust evidence exists about potential harm in relation to behaviours that may be exhibited by participants in qualitative research in general and grounded theory in particular, there should be flexibility in the application of ethical principles. This suggests that researchers should rethink whether greater freedom might be allowed to those using a grounded theory approach. This notion is

supported by Hlabangwane (2019:46), who posits that the 'potential harm' issue is centuries old and conserved by the prevailing protocols, whose definition of doing harm is short-sighted if not cynical. Moreover, Mavhandu-Mudzisi (2023:8) concur that ethical principles should not be prescriptive, but used flexibly to embrace the context of the study's research setting; especially in situations where the principle of beneficence supersedes privacy and the consent to participate in a study by the significant other.

Parker (2018:3) indicates that the main ethical issue in most qualitative research, especially when using the grounded theory approach, is the potential to cause distress to the participants. It is not always possible to know exactly what type of emotions will be invoked due to information emerging from the interview guide. Hence, the necessity of instituting preventive measures (Creswell & Poth 2018:54). Despite Parker's (2018:3) views, ethics committees remain concerned that some questions might cause participants embarrassment or emotional distress, to the extent that a research participant might need professional support.

Kalman (2019:343) states that qualitative research is difficult and complicated in nature, making it challenging for novice researchers to conduct studies using this approach. Therefore, for this study, the researcher took Kalman's recommendation to heart that novice researchers in grounded theory require strong support from supervisors experienced in qualitative research. Participants' discomfort that could arise during the interview could also not be overlooked. The researcher was thus under the constant supervision of an experienced qualitative researcher. The notion of supporting novice researchers is thus emphasised by Kalman (2019:368), who maintains that the self-directed and support strategies to overcome difficulties experienced by novice researchers include support from supervisors, friends and colleagues knowledgeable in the area of qualitative research. Additionally, a counsellor was available to participants who felt uncomfortable at no cost.

3.9 PHASE TWO: DEVELOPMENT OF A CONCEPTUAL FRAMEWORK

Phase two consisted of a conceptual framework that was developed based on the research findings and literature control. Dickoff et al.'s (1968a:201) nursing practice survey list was used as a thinking tool and provided the researcher with propositions that

assisted in expanding knowledge and ideas related to the main research purpose. The researcher used Dickoff et al.'s (1968a:201) six elements, namely the context, agent, recipient, dynamics and outcome in developing the conceptual framework.

In this study, the context serves as the host as it houses the activity performed by the agents and individuals who undertake the activity, either formally or informally. The recipients are the MHCUs and families or guardians who receive mental health services in a procedural manner (process). It involves the execution of activities in a specific manner in order to achieve an effective outcome, the endpoint of the activity. However, the activity's performance depends on the impact of the dynamics, the energy sources essential to steer the process, which embraces the notion that the execution of activities with a particular aim need not run as smoothly as expected. A detailed discussion of the conceptual framework is provided in Chapter 5.

3.10 PHASE THREE: VALIDATION OF THE CONCEPTUAL FRAMEWORK

The researcher adopted Chinn and Kramer's (2022:170) criteria to validate the framework by posing questions regarding its clarity, simplicity, generality, accessibility and importance. The researcher presented the framework to a panel of experts and stakeholders and outlined the background information and reasons for validation using PowerPoint during a meeting. Additionally, a brief explanation of the components, with an emphasis on the concepts and their interrelatedness, was offered. This was followed by a presentation of the framework's structure in its original form.

Generally, frameworks undergo evaluation or validation to identify the concepts that the framework consists of, the relationship between concepts, and the framework's structural form. However, in this study, the panel also focused on identifying problems in future use. This was followed by corrections where applicable.

The pragmatic and epistemic criteria (Risjord 2018:7) were also considered part of the validation. Pragmatic criteria are concerned with the model or framework, content, and the researcher, whereas epistemic criteria evaluate the model based on scientific knowledge (Risjord 2018:7). The pragmatic and the epistemic criteria attempted to outline the framework's detailed theoretical relevance. These criteria explicitly explained

concepts about the framework based on its usefulness, abstraction, values, operationalisation, precision, empirical and theoretical support, suggesting the criteria promoted an understanding of the framework based on broad scientific knowledge.

Risjord (2018:7) claims the aforementioned criteria assist in the analysis and evaluation of a phenomenon. Conversely, Chinn and Kramer (2022) focus mainly on the structure of the framework, hence the consideration of both criteria. The panel of experts and stakeholders finally agreed on the framework's implementation and indicated it would contribute to MHCUs' social support, and continuity of care will be promoted as a result, thereby enhancing mental healthcare services in terms of care, treatment and rehabilitation.

3.11 SUMMARY

This chapter discussed the qualitative design and grounded theory approach that was followed in conducting this study. The research process was described with an emphasis on the key components of the research design and methodology. The choice of the design and approach were elaborated on and included an explanation of the research population, sample, and sampling methods. The data collection instrument, namely semi-structured interviews, was explained. Field notes, an audio recorder, memos and observations were also discussed. Data management and analysis were highlighted, and the rigour to enhance the study's credibility and ethical considerations were described. The conceptual framework's development and validation were also presented. Chapter 4 presents the analysis and discussions of the collected data.

CHAPTER 4
QUALITATIVE ANALYSIS, FINDINGS AND DISCUSSION

4.1 INTRODUCTION

This chapter provides an analysis and discussion of the findings of phase one of the study. It also addresses the research objective, which focuses on the experiences of nurses, social workers and MHCUs concerning social support for MHCUs. An interview guide was used to collect data through face-to-face interviews. The interview guide's content aligned with the study's aim and objectives. It attempted to elicit how MHCUs are supported socially to promote continuity of care. Purposive sampling was used to select relevant participants, and a thematic analysis was used to analyse data.

The study's findings, themes, categories, codes, and relevant supporting literature are discussed in the sections that follow. In the discussion, quotes are presented in italics.

4.2 PARTICIPANTS' DEMOGRAPHIC PROFILES

The research study comprised 31 participants. The categories of the participants are presented in Tables 4.1 to 4.3.

Table 4.1: Demographic data for nurses

PARTICIPANT	AGE	GENDER	EXPERIENCE
N1 A01	40 yrs	Female	12 yrs
N2 A02	46 yrs	Female	10 yrs
N3 A03	41 yrs	Female	20 yrs
N4 A04	36 yrs	Male	5 yrs
N5 A05	51 yrs	Female	10 yrs
N6 B07	42 yrs	Female	19 yrs
N7 B08	49 yrs	Female	23 yrs
N8 B09	63 yrs	Male	20 yrs
N9 B10	48 yrs	Female	12 yrs
N11 C12	57 yrs	Male	35 yrs
N12 C13	54 yrs	Male	26 yrs

PARTICIPANT	AGE	GENDER	EXPERIENCE
N13 C14	57 yrs	Female	30 yrs
N14 D16	50 yrs	Female	25 yrs
N15 D17	50 yrs	Female	21 yrs
N16 D18	48 yrs	Female	23 yrs
N17 E19	45 yrs	Female	20 yrs
N18 E20	31 yrs	Female	5 yrs
N19 F21	55 yrs	Female	15 yrs
N20 F22	33 yrs	Female	11 yrs

Table 4.1 depicts the demographic data of professional nurses working in different hospitals' psychiatric units in Limpopo province. Of the 19 participants, four were males aged between 36 and 63, with five to 35 years of service experience. Sixteen were females aged between 40 and 57, with between five and 30 years in the profession.

Table 4.2: Demographic data for social workers

PARTICIPANT	AGE	GENDER	EXPERIENCE
SW1 A6	48 yrs	Female	3 yrs
SW2 B11	49 yrs	Female	20 yrs
SW3 C15	48 yrs	Female	15 yrs

Table 4.2 depicts the demographic data of social workers working in different hospitals in Limpopo province. All participants were females aged between 48 and 49, with three to 20 years' experience.

Table 4.3: Demographic data for MHCUs

PARTICIPANT	AGE	GENDER	ETHNICITY
M1 E23	30 yrs	Female	Tsonga
M2 E24	63 yrs	Male	Sotho
M3 E25	62 yrs	Male	Tsonga
M4 D26	34 yrs	Male	Tsonga
M5 D27	59 yrs	Male	Tsonga
M6 F28	53 yrs	Male	Tsonga
M7 F29	58 yrs	Male	Tsonga

PARTICIPANT	AGE	GENDER	ETHNICITY
M8 F30	61 yrs	Female	Tsonga
M9 F31	53 yrs	Female	Tsonga

Table 4.3 depicts the demographic data of MHCUs attached to different clinics in Limpopo province. Of the nine participants, six were males aged between 34 and 63. The majority were Tsonga-speaking, except for one participant who spoke Sotho. Three were females aged between 30 and 61. All female MHCUs were Tsonga-speaking.

4.3 THEMES, CATEGORIES AND CODES

Table 4.4 provides an overview of the main themes, categories and codes.

Table 4.4: Overview of the main themes, categories and codes

THEME	CATEGORY	CODE
Theme 1: Issues related to support for MHCUs	4.3.1.1 The role of the multidisciplinary team (MDT) and other informal support structures	a) Rehabilitation services
		b) Monitoring of MHCUs through follow-up care, home visits and reviews
		c) Traditional leaders' and healers' involvement
	4.3.1.2 Lack of support from family, the community and Department of Health	a) Stigmatisation and discrimination
		b) Relapses and readmissions
		c) Inadequate service delivery and shortage of treatment supplies
	4.3.1.3 Significant social institutions in the daily support of MHCUs	a) Rejection or neglect, acceptance and abandonment by family
		b) Supervision and family involvement
		c) Lack of relationships with friends
		d) Community involvement

THEME	CATEGORY	CODE
		e) Workplace social support
Theme 2: Matters related to mental healthcare services	4.3.2.1 Inter-professional collaborative mental healthcare services	a) Communication and interaction
		b) Mental health coordinators and follow-up teams
		c) Involvement in care management and stakeholders' collaboration
	4.3.2.2 MHCPs' views on ideal mental healthcare services	a) Provision of infrastructural support services
		b) Financial support for mental health activities and services
	4.3.2.3 Knowledge deficit on issues surrounding mental healthcare	a) Misconceptions about mental illness
		b) Non-compliance with treatment
	4.3.2.4 Leadership as the core of mental health	a) Shortage of human and material resources
		b) Establishment of transfer and discharge protocols
Theme 3: Contemporary issues in healthcare impacting mental health	4.3.3.1 COVID-19 restrictions' hindrance to mental health	a) Mental health promotion activities and home visits
Theme 4: Moving forward to support MHCUs	4.3.4.1 Mechanisms of support	a) Education for the family and MHCUs
		b) Empowering CHWs and MHCPs
		c) Education for the community
		d) School visits by nurses
		e) Support groups, self-help skills and other mental health activities
	4.3.4.2 Communication media essential in the promotion of	a) Mental health promotion through radio broadcasts,

THEME	CATEGORY	CODE
	social support and continuity of care	local newspapers and social media

Social support is an essential element in the daily lives of MHCUs to improve individuals' sense of self-efficacy, and it also leads to greater understanding, respect, encouragement, courage and self-fulfilment. The above-mentioned attributes have the potential to help individuals maintain stable emotions even under pressure (Qi, Zhou, Guo, Zhang, Min, Li & Chen 2020:517). Additionally, Qi et al. (2020:518) suggest that MHCUs require social support from different categories of people with whom they are in contact, with special reference to social workers and psychologists, expected to offer psychological support to those with depression and anxiety.

4.3.1 Theme 1: Issues related to support for MHCUs

The MDT plays a major role in providing mental health services to MHCUs. However, success in the execution of mental health activities depends on the support of relevant structures responsible for the provision of material or human resources. According to participants, inadequate resources lead to inefficacy and denote a lack of support.

4.3.1.1 Category 1.1: The role of the MDT and other informal support structures

Different role players provide mental health services in a mental health setting, known as MDT members providing services such as rehabilitation. These members play different roles in ensuring MHCUs' mental stability. This study revealed that MDT members were available in different mental health institutions as part of staff establishments. Still, the services rendered were inadequate, thus hampering the smooth running of service provision as planned. However, there were instances where some of the MDT members contributed meaningfully to the lives of MHCUs as per their expected roles.

a) Rehabilitation services

Occupational therapists generally offer rehabilitation services in a mental healthcare setting. In this study, findings revealed that MHCUs' rehabilitation is inadequate based

on several issues. Participants indicated that there were inadequate MDT members compared to the number of wards, and there is a lack of information about rehabilitation services because some MDT members may not have performed assessments before meetings to discuss a particular MHCU, thus delaying the whole process. Participants commented:

> "*Qualified occupational therapists we are having two, they are being assisted by what we call comm community serves, umm, two comm serves. So, these people are not enough, especially with the occupational therapists because they are the core in rehabilitating the MHCUs" (N6 B07)*

> *"Unfortunately, we are failing with rehabilitation centre, we are failing, we have got no rehabilitation centres. Our skilled people, their skills are not utilised due to their mental status, is very clear" (N12 C14)*

> *"Mmm, the challenges we experience as MDT members is that, because some per discipline we are having one, now it is better because they are two, two, two occupational therapists, two physiotherapists*, *and you find that when we are about to discuss a patient, this is committed, this one is not there, some are not available to assess the MHCU, so when you are about to discuss, there is no information for this one. So, you have to wait, so that is the challenge that we are having" (N2 A02)*

Findings also reflected inadequate rehabilitation services post-discharge, which compromised MHCUs' overall quality of care. However, in some instances, MHCUs' rehabilitation extended beyond the institution since MHCUs found employment based on the skills they acquired during their hospital stay. Participants' comments concerning inadequate rehabilitation services post-discharge were:

> "*Let me give an example, uh... what is most important is that we need to render a thorough social support, but let me give an example, in the communities we don't have rehabilitation centres" (N8 B09)*

“Mina, I think there is a lot that is not being done and we were supposed to be doing out there, because we were supposed to be having social clubs, I don't know if am putting it right, whereby MHCUs, depending, like they will be playing soccer, keeping them busy” (N2 A02)

In support of these findings, Alhamidi and Ayosef (2020:905) focused on exploring recovery and its role in mental health care. Their findings concurred that people experiencing mental health problems often face daily challenges and constraints. Inadequate rehabilitation services, being one of the challenges, could later delay MHCUs’ return to work and even affect their functioning. In line with this study’s findings, Alhamidi and Alyousef (2020:913) also explored perceptions of the concept of recovery and reported that MDT members lacked the skills to offer advanced mental health services despite the advanced training they received.

Lexen, Emmelin, Hansson, Svensson, Porter and Bejerholm (2020:1058) also concur that MHCUs typically receive inadequate rehabilitation services, as reflected in their research findings where rehabilitation professionals engaged in rehabilitation workers’ training. Findings revealed that training increased the rehabilitation professionals’ knowledge and changed their attitude and behaviour towards their employers and MHCUs. This signifies a rehabilitation service provision gap existed before professionals acquired the related knowledge.

Despite various challenges related to MHCUs’ rehabilitation, some participants shared positive comments about rehabilitation services:

“When she comes to the hospital, and then it is found by learned people at the hospital that she is fit for discharge, remember there is this OT involved, who will be taking care of his ability to work. Then if we say one can go home then he can do your laundry, he or she can do your laundry” (N10 C12)

“They are in projects and that is done in preparation for their discharge. Some are in car wash, some gardening and pillow making but we do this hand in hand with the OT” (N2 A02)

b) Monitoring of MHCUs through follow-up, home visits and reviews

Monitoring MHCUs through follow-up or home visits is essential in ensuring their stability. Home visits are a vital component in verifying supervision and support to ensure MHCUs' treatment compliance, thereby preventing treatment default or relapse. Generally, nurses follow up with MHCUs in the community after discharge, and some MDT members also take on this role. However, in most instances, nurses and social workers are more engaged in this task, given their scope of work. In this study, findings revealed that in some institutions, staff members lost contact with the MHCU immediately after discharge, and they may only come in contact again during readmissions.

Furthermore, the findings also revealed that nurses conduct home visits inadequately. Meanwhile, social workers are appropriately engaged, but various challenges limit their capabilities in this regard. There is also a third category of health workers, namely community health workers (CHW), engaging in this action. The quotes below indicate that nurses rarely conduct home visits:

> *"We are not providing any social support to MHCUs after discharge, to be honest. Once we discharge them back home or back to hospital C as a reference, then we are done. Mmm, until the person comes back" (N6 B07)*

> "*Two or three patients came here. They were gone for two to three months with the boyfriends. The other one came back with a Gangrene, they had to amputate that leg, and you see, is a problem" (N19 F22)*

> *"…and those people at the clinic, they don't care, they don't do the home visit or counselling sessions or just to go and check how the MHCU is. They are not doing and they will tell you we are overworked here, seeing different people" (N2 A02)*

Consistent with this study, findings by Turker and Weber (2021:552), whose study attempted to develop an understanding of MHCPs' perspective on their role in working with the community, revealed barriers such as the inability to establish links and a scarcity of resources pointing to inadequate MHCU monitoring. Reid, Brown and Mowat (2020:56) examined the perspectives of family physicians and other team-based primary care

providers with respect to caring for children with ongoing mental problems. Their findings similarly revealed a need for ongoing monitoring and coordination between providers and across sectors. Additionally, participants indicated that the systems of care were unable to provide resources and coordination (Reid et al. 2020:56).

Conversely, Wu, Hung, Fung and Lee (2023:5) examined whether an upgrade in home visit frequency could predict a need for emergency services. They determined nurses played a very important role in the timely assessment of MHCUs' conditions and provided crisis intervention in the community. They suggested home visits were conducted, but an increase in the number of visits improved the strategy's efficacy.

The following quotes from the social worker participants reflect that home visits were conducted:

> *"We do not have a programme for home visits; we just go out when there is a need for us to go out. We don't have a programme because we will be having a programme if we were dealing with MHCUs only, but just because we are dealing with all medical problems here, it is difficult for us to make a programme" (SW3 C15)*

> "*Mmm, it will depend, it will depend on the cases of that month, but in most cases on my site, I used to do home visits once a month, but in other words, they used to… sometimes it will depend, uh, twice a month, it will depend on the merit of the cases" (SW2 B1)*

> *"The Area Social workers also have their own KRAs, but she is of assistance because, as a Social worker at the hospital, I have my own work of patients who are residents in the institution, so, those who are out there, it is not always, how I can say it, it is not always easy to go there" (SW1 A6)*

MHCUs confirmed they were most often visited by CHWs. However, home visits by CHWs may not suffice in terms of providing all necessary mental health services in the community, given their level of education and the processes involved in taking care of

MHCUs. The CHWs did not receive any formal training on mental health. MHCUs explained:

> *"The home-based carers are the ones who come and deliver treatment. We have never received nurse's visitation" (M4 D26)*

> *"But they don't understand properly on mental, they are not learned about mental health care users" (N18 F21)*

> *"So, our mental health care users need the MDT team to do follow-up since they need someone who understands psychiatry" (N6 B07)*

> *"They either come on Wednesdays or Mondays. They greet me and ask if I took my treatment and if I haven't taken my treatment, I take it there and then. They only attend to what I mentioned and then go" (M3 E25)*

Home visits by CHWs may therefore not yield the results expected. The CHWs' actions described above are for all chronic patients, as they are not specifically trained to care for MHCUs. In support of these findings, Connolly, Vanchu-Orfosco, Warner, Seidi, Edwards, Boath and Irgens (2021:579) alluded that the use of trained CHWs could benefit mental health services, especially in underserved communities. However, both weaknesses and strengths in relation to home visits by CHWs were uncovered from their results. This implies that stakeholders who are planning psychiatric services cannot rely on trained CHWs as their contribution is a partial solution to bridge the gap in mental healthcare provision.

Mabunda, Oliveira, Sidat, Cavalkanti, Cumbe, Mandlate, Weinberg, Cournos and Mari (2022:12) explored cultural adaptations and the sustainability of psychological interventions offered by lay health workers (LHWs). Their findings conversely revealed psychological interventions rendered by LHWs were effective and accepted in sub-Saharan Africa. However, mental health experts suggested the inclusion of aspects such as monitoring, evaluation, participation in qualitative work and digital technologies to hasten training and supervision in mental health. Similarly, Pullikkuth, Kumar, Manickam, Cherian, Bunders-Aelern and Regeer (2021:433) emphasised that LHWs' psychological

interventions were effective, and appropriate competency levels were noted after training was provided on caring for MHCUs in the community.

c) Traditional leaders' and healers' involvement

Traditional leaders play an important mediation role between community members and other stakeholders. They are considered gatekeepers in the community as they have authority over community members. Similarly, traditional healers play a pivotal role and are also considered stakeholders in MHCUs' social support. In this study, findings revealed that MHCPs gain access to community members through traditional leaders to provide mental health information. This includes conducting educative campaigns, especially in cases where MHCUs committed murder or arson, and the community consequently wants revenge. The study's findings further revealed that some MHCUs and families practise dual consultation, leading to relapse. While one participant perceived dual consultation as a factor leading to relapse, others reflected a positive outlook on the practice, and it was considered part of social support. Participants commented on traditional leaders' and healers' participation in MHCUs' social support by stating:

> "…*and also, maybe to get the support from the mainly of the Chief to allow us in the area; to come and have those awareness campaigns. …because sometimes they won't understand that this person is.... did that because of the mental condition, they will think that he did that deliberately, so then we educate them" (SW1 A06)*

> *"And then sometimes we are forced to uh... to go to the Chiefs, for asking them to call the meeting, the community meetings so that we will be able to teach them about the mental illness, but it is rare. We do experience the problem during discharge wherein uh... some of the people they can pay the revenge" (SW2 B11)*

> *"If the relatives, are not doing dual consultation. … because dual consultations make most of the patients to relapse" (N11 C13)*

"…*you must supervise him to take our treatment every morning before you do anything, make sure that he takes his treatment as prescribed and you as a Traditional healer you work your part" (N8 B09)*

"They consult these people some even refuse to take medication and say spiritual healer E said we should not take medication, so, we have to work together with them…" (*N6 B07)*

Traditional leaders' or healers' involvement in MHCUs' care, as quoted above, is consistent with the findings by Pham, Koirara, Wainberg and Kort (2020:785). They postulated that collaboration with traditional healers is essential and further recommend forming a team to focus on the limits between culture, medicine and psychiatry as well as local indigenous healing and mental well-being. Additionally, this study's findings resonate with Upeniek's (2020:500) view that religious discussions that involve MHCUs do play a buffering role among church attendees. Thus, MHCUs equally benefit from such meetings.

Knobi and Swartz (2018:8) examined faith healing for mental disorders from a neo-prophetic Ghanaian Christian perspective. Their findings similarly revealed that MHCUs consulted faith healers and were exposed to prayer and prayer aids, such as holy water, fasting, speaking in tongues, and counselling as a form of diagnosis and treatment. Noteworthy, although the spiritual focus was emphasised in healing mental disorders, the traditional healers were not opposed to biomedical care and referred MHCUs to hospitals, which seems contradictory to the spiritual management of spiritual illness.

In line with the study's findings, Esan, Appiah-Poku, Othieno, Kola, Harris, Nortje, Makanjuola, Oladeji, Price, Seedat and Gureje (2019:400) determined that complementary and alternative mental health providers (CAPS) are an important part of the mental health system and a source of inpatient care in many countries, contributing meaningfully to the health system as traditional healers underwent training for a certain period just like conventional medical practitioners. As such, they are able to treat both physical and mental illnesses. Conversely, Esan et al. (2019:400) state that CAPS also engage in harmful practices such as beatings, shackling, scarification, starvation and the use of prolonged seclusion and isolation.

4.3.1.2 Category 1.2: Lack of support from family, the community and Department of Health

A lack of support from relevant structures such as family members, the community and the Department of Health could lead to inadequate social support for MHCUs, which could end in undesirable results. In this study, findings revealed that a lack of support from families, the community and Department of Health led to stigmatisation, discrimination, segregation, relapses, readmissions and social problems.

a) Stigmatisation and discrimination

Stigmatisation or discrimination against MHCUs is common, especially in community settings. In this study, MHCUs were not the only category affected by stigma; families and MHCPs also suffered stigmatisation or discrimination from community members and colleagues in the workplace, respectively. Participants commented:

> "…*and then the other issue is that when the community stigmatises the patient "nee" that is the problem that we usually get that the MHCU was aggressive because people were passing and call him mad or crazy person and, in that way, the MHCU end up fighting with them" (N3 A03)*
>
> *"These people should be supported by the community, by everyone. They should not be discriminated" (N9 B10)*
>
> *"There is no relationship with neighbours. At times they will just shout at me, they call me names, saying I am mentally disturbed as I take rounds around my home" (M4 D26)*
>
> *"Uh... in our trace am meaning for the health professionals who are dealing with this mental illness, in most cases you may find that the family is traumatised by what has happened, and then we will be dealing with stigma" (SW2 B11)*

Similar MHCU experiences concerning stigma were cited by Soeker et al. (2021:409), who postulated that stigma remains a major issue whether an MHCU is working or not.

In support, Hana, Arnous, Heim, Aeschimann, Koschorke, Hamadeh, Thornicraft, Kohrt, Sijbrandij, Cuijpers and El-Chammay's (2022:9) findings revealed that MHCUs raised concerns regarding community members who openly displayed stigmatising actions.

Likewise, Mulhim, Dehneen, Alabbad, Alhababi, Alhijab, Almometan, Sultan, Alhashem, Albahrani, Alluwaym, Almarzoog, Alhababi, Zaid and Alrasasi (2018:770) determined a high prevalence of mental illness stigma and its association with quality of life and reported that most MHCUs experienced moderate to severe stigma in the community. Additionally, about 15% of MHCUs indicated that MHCPs neglected them due to their mental status history.

Participants commented as follows about stigmatisation from MHCPs:

> "*Even if they suspect Covid (laughing), even if…the fact that he is a MHCU, they say we can't manage this patient because he is a MHCU; how can we manage them…" (N12 C14)*

> "*If somebody says you are working in the "dekgafi" department, then I get confused, that means he is moving me away from the support of the patients" (N8 B09)*

> *"Remember with psychiatry there is this thing of stigma. So, when you go to a general hospital, when you come in maybe from hospital D, they will say what-what these ones are from hospital D. There is still this stigma even us professionals" (N6 B07)*

Yanos, DeLucas, Salyers, Fisher, Song and Caro (2020:18) concur; their study focused on applying Clinician Associative Stigma Scale (CASS) to assess associative stigma among MHCPs. They reported that African American MHCPs experienced associative stigma based on the prevalence of mental illness, which was found to be higher among this ethnic group. Similarly, Picco, Chang, Abdin, Chua, Yuan, Vaingankar, Ong, Yow, Chua, Chang and Subramaniam (2019:6) used latent class analysis to understand patterns of associative stigma among each of the classes of MHCPs. They reported 48.7%, 40.5%, and 10.8% of the staff working in mental health establishments

experienced no or low, moderate and high stigma, respectively. This raises a concern as half of the staff (48.7%) experienced associative stigma. Moreover, Arriola-Vigo, Stovall, Moon, Audet and Diez-Canseco (2019:716) concur with this study's findings that stigma associated with mental health is not only present in the community but also among healthcare workers in the clinics.

b) Relapses and readmissions

In most cases, many readmissions resulted from relapses while MHCUs were discharged and back in the community. This study revealed a higher number of readmissions than new cases. During the interviews, none of the MHCPs (nurses and social workers) reflected any positive views concerning MHCUs' admission statuses; instead, concerns were raised on several occasions regarding relapses. Relapses occurred despite MHCUs being placed on medication and monitored by CHWs. This finding is supported by the quotes that follow:

> *"So, it's a problem and that gap, if not closed by someone being responsible, it will be just business as usual, just treating them and they go home whether they are well or not well, we will see them when they come back "va ri" relapsed" (N19 F22)*

> *(emphasising) "…'revolving door syndrome', they keep on coming through the same door (laughing), that is the thing, that is the problem we are having, we are readmitting same patients, so, the re-admission rate is high" (N6 B07)*

> *"The patients that we usually admit here, they are re-admissions, you can find four (4) new maybe we can have a total of twenty-eight (28) and then the new cases, maybe you can find they are (two) 2 or (three) 3. Usually they are re-admissions" (N12 C14)*

Consistent with the findings, Owusu, Oluwasina, Nkire, Lawal and Agyapong (2022:17) examined readmissions in an acute psychiatric institution to determine predictors and interventions to reduce the readmission rate. Non-adherence to treatment was identified as one of the factors contributing to high admission rates. Similarly, Dlamini and Shongwe (2019:6), whose aim was to explore MHCPs' perceptions of factors leading to increased

admissions, stated that non-adherence to treatment contributed to high admission rates. *I*n further support of the study's findings, Soeker et al. (2021:409) affirm that MHCUs who are psychotic typically experience residual symptoms, a decrease in functioning and relapse despite being placed on treatment.

c) Inadequate service delivery and shortage of treatment supplies

Inadequate service delivery was cited as a major concern among participants. Health services were declared free for all, yet MHCPs were forced to advise MHCUs to either buy their medication or transport themselves to the hospital to collect medication using their own money. MHCUs raised a concern that they may not have money for either activity and end up borrowing money and having to repay it. One participant emphasised that nurses perform rote tasks without any oversight, and no one monitors mental health services at the clinics. Participants commented:

> *"So, no one is checking do you have this, do you have that, that do you have Serenace, do you have whatever. So, we just work, and the relatives will have to take the patient with their own transport" (N19 F22)*

> *"I think I should find other ways of increasing the income; at times, we are advised to buy our treatment due to treatment shortage" (M4 D26)*

> *"They usually say that I should go and collect my treatment from the hospital. I phone my brother; he will come and take me to the hospital or gives me money to take a taxi to the hospital to collect my treatment" (M3 E25)*

These findings align with Mulaudzi, Mashau, Akinsola and Murwira's (2020:4) views that there is a shortage of essential drugs, which consequently leads to MHCUs' relapse. Mulaudzi et al.'s (2020:4) assertions were further supported by some of the participants, who indicated that there was a high readmission rate attributed to relapse.

In support of the study's findings, Madlala, Miya and Zuma's (2020:35) participants attested that their duties are hampered by a lack of material resources, such as medication, despite its vital role in helping MHCUs to remain stable. Their study focused

on exploring professional nurses' experiences with the integration of mental health services into primary health care. Likewise, Reid, Brown and Mowat (2020:57) examined the perspectives of family physicians and other team-based primary care providers with respect to caring for children with ongoing mental problems. Their findings reflected an inability to access treatment as one area needing urgent consideration.

4.3.1.3 Category 1.3: Significant social institutions in the daily support of MHCUs

MHCUs' success in their mental health journey depends on support from social structures such as family, the community and their workplace. Additionally, the Department of Health plays a major role as an overseer of service delivery; hence, inadequate service delivery affects mental health services negatively. Findings revealed that there is inadequate social support from families, the community and workplace institutions. However, some form of heterogeneity existed concerning the family. MHCPs' thoughts concerning social support were negative, whereas most MHCUs insisted they received social support from family members.

a) Rejection or neglect, acceptance and abandonment by family

The family plays a significant role in socially supporting MHCUs. MHCPs emphasised that MHCUs are rejected, and relatives would like the Department of Health to keep them admitted since no one is available to take care of them upon their discharge. One participant emphasised that social support is imperative as MHCUs are neglected by both families and the community. Participants commented:

> *"But some of their relatives, they reject them, they said uh... the Department, don't discharge these patients they can stay for a long... in other words, they need to...to... for a long stay, they don't want them to go back to the... the..." (N11 C13)*

> *"I think it is very important for the family and community to support them because most of the MHCUs are being neglected maybe by families and, also by community" (SW C15)*

"And then many of them they will say, nobody is going to take care of him at home, and then we don't know, we should keep the user here until when?" (N9 B10)

Moorkath, Vranda and Naveenkumav (2019:308) attempted to understand the sociocultural factors influencing family rejection. Their conclusions were consistent with this study's findings, and they revealed that families abandon and reject mentally ill persons due to social or religious customs rooted in shame, a cultural belief upheld in the ethnic group.

Similarly, Yotsidi and Kounenou (2018:173) explored MHCUs' views on barriers and facilitators of their integration into the community. Their findings revealed impediments in relation to trust, mutual fears and mutual exclusion among MHCUs and the community, suggesting rejection by the community. They also determined that in most areas of life, such as education, MHCUs have trouble exercising their rights. Yang, Gao, Li, Wang, Wang and Wang (2022:6) concurred that the family's presence is significant in the life of the MHCU, and they should support relatives fighting mental disorders.

b) Supervision and family involvement

Treatment compliance is dependent on family or guardian support. In this study, participants highlighted a need for supervision and family involvement concerning matters surrounding mental health, such as medication collection and compliance. Furthermore, family involvement will encourage continuity of care. The following quotes support the above statement:

"…because we cannot do these things "hina ku ri na vanhu lava" those who stay with the patient, who can help more, because we stay at the clinic even that home-based carer is at home. She won't be saying with that patient or they know, but those ones must also help, the community" (N19 F22)

"…if the family can be involved in collection of treatment, I think they will also be involved in supporting of taking of treatment because if they don't accompany the MHCU to the facility, how do we make sure that they will support…" (N3 A03)

"Uh… continuity of care, we can, uh… involve other stakeholders or other community members who are very close to our MHCUs to help them continue with the support that they need, especially family members, because they spend most of the time with MHCUs than us" (N4 A04)

Consistent with these findings, Cameron, Tchernegovski and Maybery (2022:14) reviewed literature regarding MHCUs' views of family involvement and their engagement with service and care. Findings revealed a need for family involvement, coupled with benefits. However, it does not always occur, and an understanding of individuals' needs and preferences for family involvement is required. Chang and Chen (2021:375) also concurred and indicated that families' quality of life depends on enhanced emotional support and fewer negative family interactions, as stigma is an issue of concern in some cultures and can affect family interaction.

Hansson, Romoren, Pederson, Wemand, Hestmark, Norheim, Ruud, Hymer and Heievang (2022:14) also found that families' involvement in caring for MHCUs is essential. However, MHCPs lack comprehension regarding this aspect and thus require training in psychoeducation and ongoing supervision, followed by clinicians who will also be exposed to the same experience.

c) Lack of relationships with friends

Establishing and sustaining friendships when one is an MHCU is not an easy task. In this study, findings revealed that most MHCUs did not have friends. Some demonstrated a lack of trust in others and preferred to keep friendships within family ties. Participants commented:

"I used to have a friend, but I no longer have one. Yes, I do not have a friend; when I meet someone as a friend is for that moment, not for life. In fact, my friend is my wife. I share everything with her, and she is able to keep my secrets in her heart." (M4 D26)

"I do not have a friend nor a wife. I only meet them on the streets, I do not have a close friend with whom we can discuss serious issues together. As of now, I walk around with my younger brother, I do not have friends" (M2 E24)

"My only friend is my brother-in-law. He is the one who is always near to me and he checks how am I doing. The one from family B. I do not have a female friend" (M3 E25)

Cassidy, Thompson, El-Nagib, Hicking and Priebe (2019:10) similarly asserted that friendship in mental health care is distinct and sometimes challenging, suggesting that peer relationships are unique and there is no ideal type of befriending relationship. Similarly, Crompton, Hallet, Ropar Flynn and Fletcher-Watson (2020:1446), whose focus was on examining autistic adults' experiences spending time with non-autistic family and friends, determined participants reported they experienced difficulties spending time with non-autistic individuals who were not family and friends.

Long, Gardini, McCann, Sweeting, Trammer and Moore (2020:6) attempted to discover the social processes linking disruptive behaviour disorders and anxiety with adolescent friendship. Their conclusions contradicted this study's findings and revealed that there is an increased likelihood of adolescents diagnosed with disruptive behaviour disorders being befriended. However, those suffering from anxiety disorders did not receive the same attention.

d) Community involvement

Involvement from the community in caring for MHCUs was identified as an essential feature of mental health by participants. MHCUs emphasised that community members should try and understand MHCUs as 'others' who are not always dangerous. They should also partner with families and take responsibility for issues such as offering MHCUs employment and supervising them in their treatment compliance. Participants commented:

"…but if the whole community can try and understand this, the relatives, whoever is in contact with, or whomever she goes to stay with, they have an idea that this

patient is an MHCU, and they do follow-ups, they take responsibility also" (N19 F22)

"…they turn to think that this person is dangerous whilst there are some MHCUs that are not dangerous, and they tend to fight with him; rather if they find a mental health care user, is better to contact the family we saw somebody here in our community, can you please come and fetch him" (SW3 C15)

"The community members can assist these users, let's say by if he stays next to me and I see that this one is not working and give her or him a piece job, and also when I make friends with this person am being in a position can ask did you take the medication today" (N10 C12)

The findings of this study concur with Arriola-Vigo et al.'s (2019:720) conclusions that the community's involvement in mental health, in the form of community engagement activities, automatically results in consistent and standardised services for MHCUs. Positive outcomes are generated, improved efficacy is evident, and reduced MHCU care costs are noted. Additionally, the availability of community mental health models in healthcare institutions is a potential solution to fight stigma and increase community involvement.

Haldane, Singh, Srivastava, Chuana, Koh, Chia, Perel and Legino-Quigley (2020:435) examined communities' involvement in planning and implementing chronic condition programmes in high and upper-middle-income countries. Their findings concur that community involvement can change priorities for health improvement, strengthen awareness and the mobilisation of resources, change community practices as a result of learning, and support community resilience by encouraging collaboration, building trust and fighting stigma. Likewise, Taguibao and Rosenheck (2021:325) reflected a need for increased public awareness in Philippine medical communities. They emphasised the importance of ensuring that mental illness is tackled from the grassroots; that is, the community level.

e) Workplace social support

The life of an adult MHCU revolves around three institutions: family, work and the community. The workplace was cited as a context where the MHCU experiences challenges such as segregation, stigma and a lack of support from employers, leading to early retirement. Participants commented:

> *"Even those who are working, you find them, they will say that I am going to quit because they call me by names" (N15 D18)*

> "*It is very painful, am telling you, I know we have a lot of teachers, right now they are not working because at school they said this teacher is not coping. We gave him a pension to go and sit at home" (N8 B09)*

> *"The other problem we are encountering is for those who are... who are working because you may find that some of the employers, they are not welcoming our patients when they go back to work, that is another problem" (SW2 B11)*

In line with these findings, Chauhan, Leeming and Wattis (2022:277) asserted employment for MHCUs is full of challenges. However, when MHCUs are supported to gain skills that are considered imperative by others, a positive effect can be seen on recovery. Likewise, Rosander (2021:1103) determined a strain-stressor association where mental health problems lead to subsequent workplace bullying, reflecting that mental health problems are associated with an increased risk of being bullied either in the form of negative attitudes towards the MHCU or victimisation.

In support of the study findings, Peters, Spaner, Rodoschewski and Bethge (2018:822) emphasised the importance of perceived social support for self-rated mental health. They explored psychological consultation in the workplace and determined a need for more social support in restoring and maintaining mental health and workability, purporting the existence of inadequate support in the workplace.

Despite typical inadequate support from employers due to fears of hazards or violence, some participants insisted that MHCUs can continue working based on acceptance. They

shared that an adjusted environment with orientation among colleagues, MHCPs' participation in MCHUs' placement and follow-up, and an appreciation for the rehabilitation received at the hospital enhanced MHCUs' capabilities. The following quotes support the above statement:

> *"Even in the working environment, the employer must make sure that he orientates the co-workers, you must not say this person is mentally ill shouting at that level, you must accept this individual with his mental condition" (N8 B09)*

> *"…and the one was here in section A kokwani'' X, uh..." u tirha ka... cheap, va ri hi kwini naa... ka '' Car wash. So, he was involved ka car wash in the hospital, but outside. ''Se ha cheka kuri'' how are they coping" (N2 A02)*

> "*…when she comes to the hospital, and then it is found by learned people at the hospital that she is fit for discharge, remember there is this OT involved, who will be taking care of his ability to work. Then if we say one can go home then he can do your laundry, he or she can do your laundry*" *(N10 C12)*

In support of the study's findings, Chauhan et al. (2022:280) shared their participants alluded that continued work experience, training and skills development gave MHCUs a feeling of being wanted and needed, resulting in positive experiences. Soeker et al. (2021:410) also attested that work preparation, vocational rehabilitation programmes and therapeutic interventions contribute positively to the worker's role, thus enabling MHCUs to reintegrate well into the workplace.

Likewise, Richard, Lemaire and Morel (2021:3238), whose study focused on managing and supporting MHCUs in sheltered workshops, indicated that an examination of human resource management practices concerning individuals with mental health conditions arose as a new practice. It goes beyond the prototypic characteristics of the disability category and puts the individual back at the centre of attention.

4.3.2 Theme 2: Matters related to mental healthcare services

Successful mental health management requires an interplay of various elements. Participants' responses on this aspect demonstrated that social support success occurs where there is collaborative action through stakeholders' involvement. They also expressed the need to ensure a conducive working environment for MHCPs, address knowledge deficits in mental health, and for leadership to provide support services as needed.

4.3.2.1 Category 2.1: Inter-professional collaborative mental healthcare services

The provision of mental healthcare services requires collaboration among various professionals, families and the community. In this study, findings revealed stakeholders' collaboration could prevent MHCUs' relapse and readmissions, thereby enhancing compliance with treatment. However, there should be interventions or involvement from multiple professionals, availability of MHCPs, as well as teams to facilitate effective interaction among professionals, families and the community.

a) Communication and interaction

Communication gives rise to collaborative action among stakeholders in mental health services. In this study, findings revealed inadequate communication among the categories of support providers involved in caring for MHCUs. Participants indicated that they used phones to communicate with MHCUs and families, which limits their interaction. Another participant indicated that there is no interaction at all post-discharge. Participants commented as follows concerning interaction and communication:

> *"That is the only way we communicate, communicating without seeing what is happening. Sometimes the family can tell you things that are not really taking place, you see, mmm" (N3 A03)*

> *"When they are home "nee" … we are not interacting with them" (SW3 C15)*

The benefits of communication, as quoted above, were also emphasised by Schiavo (2018:5), who recognised an inadequacy in communication despite its importance. The author purported that it is time to have an honest, credible conversation about mental health issues since current communication has various boundaries. Similarly, findings by Martens, De Haeck, Van De Vondel, Destoop, Catthoor, Dom and Van Den Broeck (2023:2), whose aim was to explore professionals' and MHCUs' views about physically caring for people with severe mental illness, perceive communication among MHCPs as an essential element in improving mental health. Also, in support of the study's findings, Leung, Wandler, Pringsheim and Santana (2020:558) agreed that services provided by different professionals and sectors, such as community services and clinics, are fragmented and without clear communication channels.

Although some participants reported inadequate interaction and communication, others were positive about this issue, indicating that they networked with colleagues from the community to promote MHCUs' continuity of care. They were also accessible and available for MHCUs and their families, and gave them their cell phone numbers to call if needed. Participants commented:

> "*So, that Social worker, because from here the Social worker, can't like to go to township D, so the area Social worker there will be connecting, so she will take over, with the family so that she will connect" (N2 A02)*

> *"And then in this hospital, this social support it assists us a lot because we use to give the family members uh... our personal phones so that they can just call us or contact us if they encounter problems about anything, whether it is positive or negative" (SW2 B11)*

> "*We also encourage them to contact us if there is anything they want to ask" (N12 C14)*

b) Mental health coordinators and follow-up teams

Supervision is essential in the provision of health services to avoid fragmentation, thus ensuring the success of services being rendered. In this study, findings revealed

inadequate mental health service provision due to a lack of mental health coordinators and follow-up teams. Participants emphasised a need for a focal person to deal with mental health issues, the establishment of district and institutional coordinators, as well as mental health teams that will go around the villages and check on MHCUs. The following was emphasised concerning mental health coordinators and mental health teams' availability:

> "*We must have a focal person who will deal specifically with mental health that will help, to trace to do all those things and also to check the needs of those patients. It is really needed and not only at a facility level but also at a district level" (N19 F22)*
>
> *"Number two, we have… there must be that team, the team to come and check the patient regularly" (N16 E19)*
>
> "*Yes, so, currently, I won't tell you who is our district clinical coordinator, I can't tell you so much, so, such people are needed before we can formulate our own institutional mental health coordinators" (N6 B07)*
>
> *"There should be a team that goes around, maybe the villages" (N18 F21)*

Research findings by Stuber, Seiferied-Dubon, Rieger, Gundel, Ruhle, Zipfel and Junne (2021:217) revealed that leadership interventions have the potential to be effective in improving organisation and behaviour, which consequently creates an opportunity to foster and maintain employees' mental health in the healthcare system. Similarly, Khoury and Ruelland (2020:96), whose aim was to determine the impact of community mental health programmes on MHCUs' mobility around the city to seek mental health services, claimed the availability of mental health teams promoted positive change, and MHCUs were no longer confined to hospitals. Still, they sought mental health services at facilities of their own preference through the mental health team's facilitative process.

Martens et al. (2023:2) explored professionals' and MHCUs' views about the physical care people with severe mental illness receive. In support of this study's findings, they

reported a need for intensive care coordination or network-based community care for people with severe mental illness.

c) Involvement in care management and stakeholders' collaboration

Involvement in care management incorporates related factors such as MHCU stakeholders' collaboration. In this study, collaboration among stakeholders appeared positive. Participants indicated that they involved other MDT members when one of them had an opportunity to consult with the family to ensure continuity of care and form relationships with stakeholders located nearer MHCUs' residences for monitoring purposes and reports. Participants commented:

> "…*we work together, even sometimes when there are sessions family we talk "ku ri na" I have invited the family and am going to address this. Will you like to see them? There is a channel of communication we are working well together" (SW1 A06)*

> *"Okay, the actions that we take to ensure successful continuity of care during discharge of MHCUs is that: we involve all members of the MDT in the hospital" (N2 A02)*

> *"Sometimes you form a relationship with them so that if something comes up, you can call and say, I have so and so, this is what am hearing; maybe the family members call and say this is what is going on; could you if you are around there, check what is going on and give me some information, so that I know what to do uh... that is how they are helpful" (SW1 A06)*

A study by Abella, Landers, Ismajli and Carmona (2022:307) revealed that committee members, direct service staff and clients involved in a collaborative service provision improvement task alluded that successful behavioural health services have the potential to create a well-functioning system, provided sufficient staff is available to identify and coordinate services. Likewise, Duncan, Stergiopoulos, Dainty, Wodchis and Kirst (2022:6), whose study focused on the impact of public funding change outcomes in communities with stakeholder engagement, concur that stakeholder engagement is

powerful. Additionally, positive service delivery outcomes are apparent in the presence of high-quality stakeholder engagement.

In support of this study's participants' views, Bridgman, Ashby, Sargent, Marsh and Barnett (2019:446) noted a shift in staff culture due to the outreach approach and the success was attributed to collaborations with youth health services with a full range of support in place. Their study focused on staff's involvement across services in improving referrals and intake processes.

However, while most participants were positive about MDT members' activities, some were concerned because, in certain institutions, MDT members were not present during meetings. Participants commented:

> *"Since the issue of sectional heads accounting, you have to account as a sectional head why are your people are not here, because sometimes you find that people were not turning up, they are on duty, but they are not available, they, umm..."* (*N2 A02)*

> *"Some of the MDT, they are reluctant to come, to sit down with the patient, they used to say they apologise*" *(N11 C13)*

Reid et al. (2020:57) examined the perspectives of family physicians and other team-based primary care providers with respect to caring for children with ongoing mental problems. They noticed limited cross-sectional collaboration was one of the areas of concern highlighted by their findings. Similarly, Leung et al. (2022:553) explored parents of children with complex mental health needs' experiences in accessing healthcare, and findings revealed a lack of collaboration and communication among healthcare professionals in different departments, schools and communities. Anttila, Yitalo, Kurki, Hipp and Valimaki (2020:8) also attempted to describe school nurses' perceptions, individual learning needs and developmental suggestions for mental health promotion among adolescents at school. They reported that only 10 to 15% of adolescents with mental health problems received treatment as expected from healthcare services, and collaboration with other professionals was challenging.

4.3.2.2 Category 2.2: MHCPs' view on ideal mental healthcare services

MHCPs wished for improvements in the delivery of mental health services. According to participants, the provision of infrastructural support services and financial support for mental health activities and services, as well as a review of the supermarket approach (provision of all services that the MHCU needs by different healthcare providers in one clinic), form part of the ideal mental healthcare services MHCPs recommend.

a) Provision of infrastructural support services

Participants suggested that rehabilitation centres be made available for MHCUs to fill the gap in catering for this population after discharge from the hospital. Additionally, they emphasised that MHCUs are often forced to continue their treatment without any rehabilitation in the community. Others raised concerns about mental health institutions with long-term services and consultation rooms in PHC settings, indicating that both are inadequate.

> *"No rehab centres, let me indicate what I mean, some of the patients, they need safe places at home where they can be kept safely so, the safety of the patient that is discharged is not guaranteed" (N8 B09)*

> *"I wish they add more consultation rooms. Yes, they are inadequate, the more the consultation rooms, the faster will be the queue, and this will assist in those who are in a hurry, to leave the clinic earlier" (M4 D26)*

> *"The other way is that I think the Department also should do something because we have a shortage of long-term hospitals and there are many patients who need to go there for admission" (SW3 C15)*

Consistent with these findings, Arriola-Vigo et al. (2019:716) revealed that healthcare providers raised concerns regarding inadequate space to expand community engagement activities. Likewise, Yusefi, Sharifi, Nasabi, Davarani and Bastani (2022:8), whose study focused on the exploration of health human resource challenges during the COVID-19 pandemic, concurred a lack of infrastructure was one of the legal challenges

encountered. Wannasewok, Suraaroonsamrit, Jeungisragulwit and Udomrath (2022:108) explored community mental health development and concurred that developing community rehabilitation service facilities for MHCUs with severe mental illness is a challenge in mental health care.

b) Financial support for mental health activities and services

Mental health activities help disseminate health information to MHCUs, families and communities; hence, they are recognised as vital in mental health institutions. In this study, participants reported funding for mental health activities and MHCUs' employment by the government (to curb high unemployment rates among this population) was challenging, indicating that mental health activities are not supported financially, unlike others, such as the Tuberculosis Direct Observations (TB DOTS) programme. Participants also emphasised there are no coordinators, groundskeepers, ward attendants and administrative clerks in mental healthcare settings. Participants explained:

> "*So mental health within the province, I will say it is not supported… From the province. Because we need to have coordinators from the province who are actively allocated for mental health, they fund the mental health…" (N6 B07)*

> "*Even here, for example, being a groundsman some they can manage to do that, they can clean the yard, some they can be ward attendants, some can be even admin clerks like that" (N15 D18)*

> *"…even before the, the, isn't that the hospital produces something like the TB DOTS even for the TB patients, but you see, they exclude our mentally ill, some they say, they still fear them, to take care, so we rely on the clinics" (N8 B09)*

A study by Arriola-Vigo et al. (2022:716) revealed a similar scarcity of finances and logistical resources to undertake home visits or facilitate psychosocial club activities. Furthermore, financial burdens related to extramural activities and lack of transportation were identified as hindrances to undertaking community engagement events. Madlala et al.'s (2020:5) study focused on professional nurses' experiences integrating mental

health services into primary health care. According to their findings, participants indicated that the budget does not favour mental health since this programme is not on the prioritised list of health services. Meanwhile, programme implementation requires adequate staff and material resources.

Likewise, Duncan et al. (2022:6), whose study explored the impact of public funding change outcomes in the community when there is stakeholder engagement, concurred insufficient funds compromise MHCUs' level of care.

4.3.2.3 Category 2.3: Knowledge deficit in issues surrounding mental healthcare

A lack of mental health knowledge was cited by MHCPs, and this phenomenon included fellow MHCPs, MHCUs, families and the community. Misconceptions about mental health issues and non-compliance were identified as the main attributes signifying a need for mental health education.

a) Misconceptions about mental illness

Participants indicated that the community still regards mental illness as a taboo, influencing their actions and decisions regarding mental health issues. In some instances, families considered the MHCU to be healed and discontinued treatment. Additionally, others attributed mental illness to witchcraft. Participants commented:

> *"When we teach them out this treatment, we usually give them examples. Isn't that mental illness is a problem to our culture they see it as a taboo. Being mentally ill, you see" (N12 C14)*

> *"In most cases, the patient or the family members, they may find that rather they may think that after the discharge it means that the patient is healed, sometimes that they don't understand that we are looking at the stability of the patient and there is no way that our patient may not continue with the medication" (SW2 B11)*

> *"Sometimes you find that the family members they don't believe that this person is ill, they just think that there is the source of witchcraft" (SW3 C15)*

In support of these findings, Hampson, Watt, Hicks, Bode and Hampson (2018:203) said community workers commented that mental health is still a taboo and there is significant fear about this aspect. Moreover, Gonzalo and Benuto (2022:852), whose study aimed to minimise stigma and increase mental health knowledge in communities, noted that older adults attributed mental health challenges to witchcraft or bewitchment. Dlamini and Shongwe (2019:5) explored MHCPs' perceptions concerning contributory factors towards an increased number of admissions, and their findings concurred some relatives of MHCUs first consult a traditional healer before they seek medical help because they believe the MHCU has been bewitched.

b) Non-compliance with treatment

Non-compliance with treatment occurs due to a lack of supervision and follow-up by families and MHCPs, respectively. In this study, findings revealed that MHCUs stopped taking their prescribed medication due to side effects, an issue that needs to be addressed to promote change. Furthermore, participants attributed treatment non-compliance to a lack of disability grants and family and community support. Participants commented:

> *"…but the nursing is there to see, you can find that the MHCU stopped taking treatment because of the side effects so they can address that issue, that maybe there be a change" (SW3 C15)*

> *"Uh... according to my viewpoint if socially they are not supported, uh... (clearing voice) let's say MHCUs, at home, they don't get a social support grant and even the "family or the community does not support them, in that manner "nee" they will not be able to comply to treatment" (N3 A03)*

These findings align with those of Alemagehu, Afsaw and Girma (2022:10); they assessed the magnitude and factors related to non-compliance to treatment. Their findings revealed medication side effects as one of the related factors inhibiting MHCUs from complying with treatment. In support, Dlamini and Shongwe (2019:4) explored MHCPs' perceptions regarding factors leading to increased admission rates and found that MHCUs default treatment and are readmitted due to inadequate support from

relatives. Similarly, Du Plessis, Poggenpoel, Myburg and Temane (2021:7) described family members' lived experiences of non-compliance to psychiatric treatment, and their findings revealed various factors impact MHCUs' inability to comply with treatment, with depression being a major element.

4.3.2.4 Category 2.4: Leadership as the core of mental health

The success of an institution depends on leadership that ensures the smooth running of the organisation through the availability of adequate human and material resources and observation of processes such as protocols and policies that guide staff in executing their duties. Thus, success is likely to be hampered without or with fewer leadership efforts directed toward mental health issues.

a) Shortage of human and material resources

A shortage of staff and transport remains a serious challenge in health service institutions. In this study, findings revealed a shortage of MDT members in the mental health institution compared to the number of wards. Some participants attributed staff shortages to sick leave and a lack of replacements for those who retired. Additionally, MHCPs indicated the extent to which the unavailability of resources, such as a shortage of transport, affects mental healthcare service delivery in the community. They explained a lack of home visits was one of the resultant factors, as well as inadequate community outreach activities, such as campaigns. Participants commented:

> *"They are available, but the challenge that we have is the shortage of staff. Our hospital is big, we have a… I will say thirteen (13) wards whereby there are very few of the MDT that we are having…" (N6 B07)*

> *"Hmmm, there is a shortage of staff because people who are going for retirement, are not being replaced, and people nowadays are sick more than some years earlier; most of us right now are, people are not in good condition, that is, I think those are the causes of shortage" (N15 D18)*

“Okay, this is district X, we only have one psychiatrist. So, every patient in our area, they are being referred to one psychiatrist” (N4 A04)

“And then, the shortage of transport is also problematic to us because we are no longer doing outreaches like before” (N12 C14)

“*The thing is due to resources, we are not able to be there all the time, we do provide support, but with the unavailability of resources, you cannot provide for home visits as often as possible*” *(SW1 A06)*

Mulaudzi et al. (2020:4) agreed with these findings and affirmed that staff shortages lead to an unbearable workload, resulting in work-related stress and burnout. Additionally, strategies to deal with the high workload consisting of different programmes were not in place, especially in the PHC setting. Findings by Mulaudzi et al. (2020:4) further outlined how the shortage of resources and staff, mainly psychiatrists and mental health-trained nurses, impacts the health system. In support of this study’s findings, Madlala et al. (2020:3), who explored professional nurses’ experiences in integrating mental health services into PHC, revealed a lack of trained professional nurses to implement the additional programme.

Likewise, Santos (2020:11) explored public health, social work, and psychological counselling service graduates’ plans to work in industries outside their academic stream. Their findings revealed that due to limited resources, they were unable to establish a centre in their field to work in, unlike in other countries and cities.

c) Establishment of transfer and discharge protocols

The availability of protocols in a working environment such as mental health institutions frees the minds of MHCPs as it serves as a guide in managing difficult MHCUs who may, for instance, present with aggressive behaviour. Ensuring the availability of protocols is the duty of health service managers, who are deemed supporters of employees. In this study, participants indicated that there were no clear guidelines on the management of conditions, and they were not sure if they were doing the right things since protocols might have changed. This view is indicative of inadequate support by the Department of

Health in relation to mental health services. Participants also mentioned handover reports of discharged MHCUs during transfers are not properly completed and often contain incomplete information. Participants explained:

> *"So even those patients, nothing specifically, to say this patient was having this and that, then we did this, and then take over, this is Schizophrenia or something with this problem that he was admitted, then take with this and that, you know, something like that, to give us the background of this patient" (N19 F22)*

> *"So, I think from the report that is written, Hospital C will hand it over to the family and but it will only be nurses and doctors report by the way, social workers and everything because I have never seen us giving a social worker report to hand it to hospital C it's only the medical part" (N6 BO7)*

> "…*because nothing is happening, whether we are doing things right or we are not doing things right. I mean, we do the old way, the way we know things must be done this way, maybe the protocols have changed, who knows" (N19 F22)*

Similarly, a study by Yin and Feng (2022:130) on the effect of COVID-19 safety protocols on hospital workers' mental health revealed that workers felt safer working in an environment where clear protocols were in place, which reduced their anxiety. Yin and Feng (2022:3) further explained anxiety as a dangerous factor to human life that can damage the body's organs. Thus, in this study, MHCPs felt unsafe, and this could lead to anxiety, which could be detrimental to MHCPs' health. Yusefi et al. (2022:8), whose study explored human resource challenges during the COVID-19 pandemic, confirmed a lack of applied protocols for the personnel's safety and health during the pandemic.

Also, in support of this study's findings, Dlamini and Shongwe (2019:5), who examined MHCPs' perceptions of factors contributing to the increased number of admissions, revealed a need for the institution's management to establish strategies to deal with drug stockouts.

4.3.3 Theme 3: Contemporary issues in healthcare impacting mental health

Recently, the world faced unexpected turmoil and fear. The healthcare system is sometimes challenged by pandemics that may be fatal, such as COVID-19, which recently spread across the globe. Such unexpected occurrences may affect the healthcare system's functioning.

4.3.3.1 Category 3.1: COVID-19 restrictions' hindrance to mental health

While the world faced difficulties socially, psychologically, economically and in other spheres of life, the healthcare facilities where the study occurred experienced the same challenging conditions. During the interviews, most participants mentioned COVID-19 and its consequences, such as a lack of meetings and activities geared towards promoting mental health. Generally, COVID-19 changed the usual work routine and consequently disrupted various programmes.

a) Mental health promotion activities and home visits

MHCPs engage in community outreach activities such as mental health awareness campaigns, family days and home visits. Families visiting MHCUs in mental health institutions also play a role in the promotion of mental health. However, in 2020, such interactions were prevented due to COVID-19 restrictions. In this study, participants indicated that awareness campaigns were not provided due to COVID-19, MHCUs did not engage in support groups due to fear of infection, and they could not be visited by family members while admitted at the hospital. Furthermore, due to many restrictions, MHCPs could not enter communities and deliver health services. Participants commented:

> *"Yeah ... I can say that yeah... yeah... the awareness campaign even this time of moment we are not doing it because of this Corona because we cannot do the gatherings" (SW3 C15)*

> *"…so, we have no support group because the chronics were divided uh... the MHCU were given their own date so that they can be able to be together, but right*

now every day is for everything, so..., and due to Covid-19 even those support groups that we were having on different conditions is no longer done because of the fear of the infection" (N15 D18)

"Uh... before Corona "nee," the relatives used to come here, so we used to sit down, "nee," to instil insight to the relatives, so that they mustn't reject them at home" (N11 C13)

"Uhmm, eish, now honestly we are having a problem, we are having a problem because we are not allowed to go, there are many restrictions, we cannot uh… go out to any type of a health service" (N3 A03)

Consistent with these findings, Simon, Helter, White, Van der Boor and Laszewska (2021:1) recommend that public health policy planners consider lockdown matters such as restrictions and improve social support levels to increase public resilience. Additionally, social support was seen as a strong resilience factor despite the restrictive health measures. Thus, there is a need for future policies to consider the strong association between the capabilities of mental health institutions, current mental health and social support levels to minimise long-term health, social and emotional issues (Simon et al. 2021:10). Similarly, Gao, Zheng, Jia, Chen, Mao, Chen, Wang, Fu and Dai (2020:8) revealed a need for governments to pay more attention to mental health among the general population during pandemics, as a high prevalence of mental problems associated with social media exposure was noted during COVID-19.

In support of this study's findings, Johnson, Dalton-Locke, Juan, Foye, Oram, Papamichali, Landau, Olive, Jeynes, Shah, Rains, Lloyd-Evans, Carr, Killapsy, Gillard and Simpson (2021:31), who investigated staff reports of COVID-19's impact on mental health and mental health service users in its early weeks, revealed that some mental health teams engaged in face-to-face contact sessions and conducted home visits. In contrast, others adhered to restrictions and avoided community activities.

4.3.4 Theme 4: Moving forward to support MHCUs

Most participants in this study indicated a need for interventions (in the form of education) among different stakeholders. Political and church meetings, schools, and support groups can assist in disseminating mental health information and provide self-help skills and other activities.

4.3.4.1 Category 4.1: Mechanisms of support

Mechanisms of support that could promote change in the management of MHCUs were identified as educating families and MHCUs; empowering CHWs and MHCPs to reduce stigmatisation from fellow MHCPs; educating or providing mental health awareness campaigns to the community, churches and political meetings; and nurses conducting school visits. Support groups, self-help skills and other activities were also mentioned. In this study, findings revealed that for MHCPs to offer mental health education as a mechanism of support to the MHCUs and their families, they should also be capacitated.

a) Education for the family and MHCUs

Educating families and MHCUs based on their condition and treatment plan is vital. In this study, MHCPs indicated that education is provided to MHCUs and their families. Mental health education mainly focuses on medication compliance as per prescriptions and potential side effects. However, based on the findings, a gap in mental health education still exists. Although most participants maintained that mental health education is being provided, they still insisted on improving continuity of care and making more effort. Most explained there could be partial understanding concerning mental health, resulting in families disowning MHCUs due to a lack of knowledge concerning the illness and an inability to manage the MHCUs at home due to inadequate mental health knowledge. The following quotes support the above statement:

> *"We just tell them to take the medication as prescribed, the time should be, what? If he takes medication at 06h00, every day it should be 06h00, 02h00 and then in the afternoon like that, uh..." (N3 A03)*

"Well, we also tell this user if he feels somehow about the treatment, he must not stop taking it, the better thing to do is to go the clinic and then tell the clinic staff that is experiencing this and that then they can send him here then we can investigate" (N9 B10)

"…because even the family members themselves they need to be taught about mental illness; because sometimes even when you talk to them you can see that they need continuous, continuous health education about this type of mental illness. Because sometimes you can find that they understand partially, you see" (N3 A03)

"…because they, like, if the patient relapses when they arrive at hospital, they will say: here is your person, which means they disown the patient, just because now am a nurse the patient belongs to me, yes the patient belongs to me together with them, I think is lack of knowledge concerning the illness itself" (N7 B08)

"I think education is the best support that we can give to both the family and the MHCU himself or herself so that they can be able to deal with them at home" (N18 F21)

In support of these findings, Abonassir, Siddiqui, Abadi, Al-Garni, Alhumatyed, Tirad, Almotairi, Asiri, Asiri, Alshahran and Abonassir (2021:1014) asserted that mental health education leads to positive outcomes. Participation among family members, sensitisation to care and social integration contribute to understanding and countering the stigma mostly affecting individuals who are affected by mental illness (Abonassir et al. 2021:1014).

Likewise, Ma et al. (2018:125) asserted there were positive results in their participants' knowledge, skill and attitudes toward families of MHCUs after they went through training. Additionally, the findings resonate with existing research by Abayneh, Lempp, Rai, Girma, Getachew, Kohrt and Hanlon (2022:10), who affirmed that training for service users (MHCUs) and MHCPs created a change in behaviour. Some of their participants reported that they reduced or stopped drinking alcohol, improved medication use, attended health facilities and experienced improvements in family and community relationships.

Conversely, Zhang, Lo, Ng, Mak, Wong, Hung, Lo, Wong, Lui, Lin, Siu, Yan, Chan, Yip, Poon, Wong, Mak, Tam, Tse and Leury (2023:14) investigated the effects of a mindfulness-based family psychoeducation programme on caregivers and young adults facing a first episode of psychosis. Findings revealed that a brief psychoeducation programme could not relieve the disease burden on caregivers of people who recently experienced a first episode of psychosis. Thus, MHCPs should ensure caregivers receive adequate support tailored to their needs.

b) Empowering CHWs and MHCPs

Some years back, home visits were primarily conducted by MHCPs. Currently, this task has been transferred to CHWs, a category of health providers that target all patients on chronic medication. However, some MHCPs still conduct home visits. In this study, findings revealed that MHCPs were not satisfied with transferring this task to CHWs because they have not learned about mental illness; people attending to MHCUs should have psychiatric training and be able to understand psychiatry. The above statement is supported by the following quotes:

> *"But they don't understand properly on mental, they are not learned about mental health care users" (N18 F21)*

> *"So, our mental health care users need the MDT team to do follow-up since they need someone who understands psychiatry" (N6 B07)*

Consistent with the study findings, Willems, Iyamuremye, Misage, Smith-Swintosky and Kayiteshonga (2021:6) concurred a gap in mental health knowledge exists, and they recommended that CHWs undergo training to increase their basic knowledge and ability to recognise mental health problems. In line with this study's findings, Liana and Windarwati (2021:7), whose study focused on CHWs' role in the rehabilitation of MHCUs, revealed a need for training, emphasising it enhances the CHWs' skills in executing activities such as providing education and treatment to the community.

Similarly, Connolly et al. (2021:578) investigated CHWs' mental health interventions' effectiveness and revealed that professionally trained CHWs could provide effective

mental health interventions. However, the provision of mental health interventions should be labelled as a partial solution to mental health, given the unequal distribution of resources and vast disparities in mental health.

In conjunction with empowering CHWs, MHCPs (social workers and nurses) were cited as needing empowerment in the area of psychoeducation. According to social workers based at the hospital, area social workers lack an understanding of mental illness. Similarly, some nurses could not differentiate between some medications, to the extent that they wanted to replace Clopixol injections with Fluanxol, a drug with entirely different effects. However, because of the open communication channels between the hospital and the PHC staff, they were advised to refer the patient to the hospital. Meanwhile, another participant indicated that they were unsure whether they were doing things correctly due to a lack of supervision. It is also anticipated that educating MHCPs will combat mental health challenges such as the stigmatisation attached to psychiatric hospitals by colleagues. Participants commented:

> *"But if they are not, we refer, we refer the cases to the area social workers, even though we experience problems because most of our social workers, they don't understand mental illness" (SW2 B11)*

> *"Those who are not sure of mental health care users, they phone, we communicate, uh… The patient is here and we don't have Clopixol depot; we are having Fluanxol. Can we give them him or her Fluanxol? We say no, don't give them refer him or her to the hospital so that we can give if we have" (N12 C14)*

> *"The person will help us with different support groups and maybe, new information about MHCUs that we must also know because nothing is happening, whether we are doing things right or we are not doing things right" (N19 F22)*

These findings resonate with existing research; Smith, Altman, Meeks and Hinrichs (2019:200) queried MHCPs' competency, training and barriers to providing care to LGBT older adults in long-term care settings. Their findings revealed a lack of training, exposure to issues specific to the LGBT community, and readiness to learn about the provision of care to the LGBT community.

Similarly, Grant, Petersen, Mthethwa, Luvuno and Bhana (2022:7) focused on evaluating mental health education tools. They determined that low mental health literacy, lack of knowledge about service availability, stigma and misinformation about treatment posed barriers to help-seeking behaviours. In support, Kigozi-Male, Heunis and Engelbrecht (2023:5) findings revealed that many PHC nurses seemed to lack knowledge about MHCUs' employment status, recovery and help-seeking behaviour. Meanwhile, professional nurses are expected to be more knowledgeable about mental health issues than the public.

c) Education for the community

Families' and communities' involvement in socially supporting MHCUs cannot be separated; both institutions are essential for MHCUs, since they depend on each other for social interaction. A community that lacks mental health knowledge may stigmatise families with MHCUs, consequently leading to relapse. Given the high number of attendees, church and political meetings were identified as suitable forums for providing mental health education. Other community gatherings identified by participants included funerals, Imbizos and parties. Participants recommended that the community be informed of mental health issues by ensuring that they gain knowledge and understanding about mental illness through awareness campaigns so that they can support MHCUs. Participants commented:

> *"You see the way they communicate with them; they will be chasing them, whereas the community members need to understand this mental illness so that they give support, especially the family members I don't think they are aware they understand the condition of the family members…" (N7 B08)*

> *"…eish the community it still lacks knowledge, because, uh… we just have to strengthen our awareness campaign, you see, just to teach our community members that uh… that mental illness is just like any other medical condition, even if it can't be cured but it can be controlled" (N3 A03)*

“So, I think it is also important to even at churches where there are mental health care providers whereby you ask a slot from your church to give information about MHCUs” (N7 B08)

“*Like for example, maybe the Political party A will be having a caucus meeting on such a day then when they come, you know about the meeting, and also, when you go there you have already requested a slot, 5 minutes or 10 minutes slot then you talk about mental illness” (N7 B08)*

“Uh… and even if during the funerals you can get a slot and educate the people, during gatherings, community gatherings., funerals, parties, you can get a slot and talk about mental illness” (N17 E20)

Consistent with these findings, Hampson et al. (2018:207) revealed a need for more public awareness and comprehension of serious mental disorders. Further, they suggested a change in mental health disorders’ perception and confrontation of misconceptions, myths and prejudices. The authors (Hampson et al. 2018:203) professed their participants’ knowledge of mental health conditions was derived from television (often in a negative way); hence, the need for appropriate public awareness campaigns. In line with these findings, Arriola-Vigo et al. (2019:715) found that mental health education workshops and campaigns yielded positive results and were essential to educate MHCUs and the community on the promotion and prevention of mental health disorders. Through workshops, MHCUs were able to discuss relevant mental health topics. In support of this study’s findings, Akena, Kiguba, Muhwezi, Kwesiga, Kigozi, Nakusujja and Lukweta (2021:1) studied the effectiveness of a psychoeducation intervention delivered by a village health team, and they reported a low level of mental health literacy manifested in an unawareness of common mental disorder symptoms, among other factors.

Contrary to this study’s findings, Bink and Corrigan (2022:177) examined the relationship between mental health education overload, topics of interest and health-seeking behaviour, and their results indicated participants who felt overloaded about mental health information lost interest in learning more. Thus, this calls for proper planning and

observation of health education principles when providing education on health-related topics.

d) School visits by nurses

Learners are often affected by mental illness when they reside with parents, guardians and siblings who are mentally disturbed. Others abuse substances, making the provision of mental health education at schools imperative. Participants recommended that mental health education be given in schools so that learners may get an understanding of mental health challenges; those who stay with MHCUs can then spread the message. Participants commented:

> *"…and, also giving the health talk to the community to the nursing schools so that they can have a better understanding of mental, especially these school kids they need to know the that substances are major causes of this mental illness, they need to understand better" (N7 B08)*

> "*There are, okay, I can mention a few; we target schools because those pupils stay with the MHCUs at home, mental illness. So, seven out of ten (7/10) pupils at school might be affected with mental illness, so is simple for them to spread the word or the news about mental illness at home" (N4 A04)*

> *"We can just go to the clinic, the community hall and even at schools, for rendering our services" (SW2 B11)*

These findings resonate with existing research; Hampson et al. (2018:207) attest that formal education can be vital in promoting mental health education and increasing individuals' comprehension of disorders. Furthermore, findings revealed the need for community education to start earlier during the school years and be incorporated into the curriculum, as most teachers and school learners have limited exposure to mental health conditions. In support of the study's findings, Allan, Ungar and Eatough (2018:168) asserted engagement in learning arouses emotional awareness, meaning exposure to learning allows an individual to perceive an aspect differently. Likewise, Anttila, Yitalo, Kurki, Hipp and Valimaki (2020:8) attempted to describe school nurses' perceptions of

individual learning needs and developmental suggestions for mental health promotion among adolescents at school. Their findings indicated that school nurses are vital in promoting adolescents' mental health, and schools are appropriate settings for this task.

e) Support groups, self-help skills and other mental health activities

A support group's existence is of paramount importance in mental health. MHCUs belonging to support groups are more likely to listen to advice or instructions due to encouragement in a group where different mental health issues are discussed. Support group meetings could be a platform where MHCUs can meet and engage in small talk. Meanwhile, self-help skills and other mental health activities were identified by participants as mechanisms that could contribute to MHCUs' continuity of care and consequently promote mental health. Gardening is one of the self-help skills participants identified and they emphasised the produce could be sold. Additionally, participants reflected on the importance of mental health activities by indicating that families and communities received support during family day meetings and gained a different view of mental illness. Family conferences, open days and mental health awareness days are therefore events that could be used to promote mental health awareness. Participants further indicated that MHCUs aged 12 to 29 could learn new skills such as dancing, singing and whatever they want as a way of promoting mental health. The following quotes support the above statement:

> "*They sometimes, but is not common, we do have a common day that they meet, they talk, have that small gathering being themselves" (N16 E19)*

> *"Akere' people from that team will be doing home visits, they will be doing open days, community outreach, will be celebrating this mental health day, just to make people aware of mental illness will be promoting mental health in a way" (N6 B07)*

> *"Another thing we can involve the patient in the activities here at the clinic. We can do activities; we can teach them even the garden, uh… they can do gardening…uh, they can do gardening here at the clinic, and sell the products" (N17 E20)*

"I wanted to say that they are very important because with events like family day is where we give support from the family and the community, this is when people started to have a different view about mental illness" (N6 B07)

"For example, for the youth, it will be better if there is a youth, where teenagers or people from the age of twelve (12) to twenty-nine (29) can attend so that they can be taught Hmmm, they can do activities such as dancing, singing whatever they want to do, those particular group of people." (N15 D18)

In support of these findings, Vickery (2022:2388) asserted that support groups are valuable and significant for men experiencing distress, from depression and anxiety to loneliness and social isolation. Additionally, a support group setting helps to create a social network and a community that enforces the availability of social support, healthcare information, purpose, routine and companionship. Similarly, Lee, Goh and Yeo (2023:13), who examined factors influencing Malaysian youths' mental health, revealed that exposure to media concerning mental health topics could improve learners' awareness of the aspect at hand and consequently increase their awareness of mental health issues. Meijer, Schout and Abma (2019:464) professed mental health activities are beneficial because various family group conferences ensure the accessibility of information and create a learning platform for professionals, MHCUs and families, thereby empowering the latter.

4.3.4.2 Category 4.2: Communication media essential in the promotion of social support and continuity of care

Communication media is commonly used to disseminate information to people. In this study, participants raised concerns regarding communities' mental health knowledge, indicating that there is a lack of understanding regarding mental health, which calls for health education in the community. Additionally, participants further suggested that communication media such as radio broadcasts, local newspapers and social media be used to enable the health department to cover a larger community scale.

a) Mental health promotion through radio broadcasts, local newspapers, and social media

Participants indicated that broadcasting through the radio or television, where a slot is given to an MHCP to discuss an aspect of mental health, could be better than engaging in campaigns, as more people will be able to access the information. Local newspapers and pamphlets were also cited as media sources that could be used to disseminate mental health information to the community. Social media platforms, such as Facebook and Twitter, will be even more beneficial because adults, as well as youths, are in possession of smartphones, and it is easy for them to access mental health information as they browse through social media platforms. Furthermore, a blog could be created so that children and adults can access mental health information through cell phones. Participants commented on communication media by stating:

> *"Even the community radio if they can just give a slot to any mental health care provider to give information about the mental health promotion, it will be much better" (N7 B08)*

> *"The other means for reaching them can be thorough local newspapers" (N3 A03)*

> *"Have a portion of the social media maybe once a week, where they can discuss MHCUs so that people can understand. It can be on the TV or radio" (N18 F21)*

> *"Isn't that there are no longer those pamphlets? Previously there were some pamphlets for mental conditional which will take them and put them on the OPD there so that everybody who comes can take the paper and get information" (N12 C14)*

> *"(Silent for some time). Let me see, is not the only social media that can be used, is just that when people talk about social issues, you see that, you know this language they will say: did you see that such and such topic is trending on Facebook, so, uh…they talk about a topic trending on Facebook, on Twitter (laughing)" (N3 A03)*

Consistent with the study's findings, Liu (2022:9), who focused on the communication path of mental health using new media technology in combination with literary works, revealed that media (cell phones, computers, newspapers or radio) could help in the dissemination of mental health education information and literary works are contributory factors. In support of these findings, Duara, Chowdbury, Dey, Goswami and Madill (2022:1940) asserted pamphlets are an effective medium to disseminate information as youths and the general public reacted positively to this medium in their study. Additionally, in response to an evaluation of visually informed community mental health education material, posters effectively disseminated imperative information about youths' mental health endeavours. These findings resonate with existing research; Braghieri, Levy and Makarin (2022:3689) concurred that Facebook is a user-friendly media source because the content is rich, information can be accompanied by videos, and can be accessed at any time or place through a smartphone.

Conversely, Gao et al. (2020:8) assessed mental health problems' prevalence and their association with social media, and they reported a high prevalence of mental health problems associated with social media exposure during the COVID-19 outbreak. Their findings suggested the government should pay more attention to mental health among the general population.

4.4 SUMMARY

In this chapter, the findings derived from the qualitative design using a grounded theory approach were presented in four themes, with each theme's categories and codes supported by quotes. The findings overall highlighted inadequate social support for MHCPs, MHCUs and families. Chapter 5 examines appropriate concepts to integrate the results and develop a social support framework for MHCUs to promote their continuity of care.

CHAPTER 5
DEVELOPMENT OF A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTHCARE USERS TO PROMOTE CONTINUITY OF CARE

5.1 INTRODUCTION

Chapter 4 presented and discussed the study's findings using grounded theory. It outlined how social support was perceived by MCHPs (nurses and social workers) based at hospitals and primary healthcare settings (clinics) and MHCUs who are the recipients of mental health care.

This chapter examines the most appropriate concepts from the findings to integrate the study's results and develop a social support framework for MHCUs to promote continuity of care, using the survey list of Dickoff et al. (1968b:423). Major concepts conceptualised from the collected data were outlined following a rigorous grounded theory approach. The concepts are related to the social support process, provide a structure, and depict the integration of those involved in care to create the core of the action to promote continuity of care. It focuses on the aspects related to MHCPs' and MHCUs' perspectives to contribute to the functionality of social support.

5.2 CONCEPTUAL FRAMEWORK

The conceptual framework deals with abstractions (concepts) that are assembled due to a common theme's relevance, thereby expressing abstract ideas in simple terms. Additionally, a framework helps organise the study and provides a context in which the researcher examines a problem and gathers and analyses data (Brink et al. 2018:21).

5.2.1 Development of a framework

Brink et al. (2018:21) point out that conceptual framework development occurs by identifying and defining concepts and connecting them in an interrelated manner, thereby creating a distinct overview of a phenomenon. Furthermore, the ability to develop a

framework with organised ideas indicates that the study is coherent and is a logical extension of current knowledge.

In this study, concepts from the findings were classified and conceptualised according to Dickoff et al.'s (1968:202) six elements and comprised the agents, recipients, context, dynamics, procedure, and outcome. The context serves as the host as it houses the activity performed by the agents and individuals who undertake the activity. It is either formal or informal, depending on the stakeholders' role in rendering mental healthcare services. The recipients, namely the MHCU and their family or guardian, receive mental health services in a procedural manner (process) that involves the execution of activities in a specific way in order to achieve an effective outcome, the endpoint of the activity. However, the activity's performance depends on the impact of the dynamics as the energy sources essential to steer the process, which embraces the notion that the execution of activities with a particular aim need not run as smoothly as expected.

In this study, a constructivist grounded theory (a method with systematic yet flexible guidelines) was followed to collect and analyse data so a theory rooted in the data could be constructed (Charmaz 2014:1). Collected data were contextualised, meaning the researcher collected data within a specific context (hospitals and PHC settings), the original setting of the research process. Data were collected from agents and some recipients (MHCPs and MHCUs) during one-on-one interviews, suggesting data are original, a notion supported by grounded theory. Later, the researcher engaged in data analysis, which involved following a procedure (process) to establish effective outcomes in relation to MHCUs' social support by constructing theories from the generated data (Dickoff et al. 1968a:201).

Table 5.1 depicts the application of Dickoff et al.'s six elements.

Table 5.1: Dickoff et al.'s (1968) components of the practice theory and application to the study

Components of the theory	Application to the study
Context	▪ Departmental legal framework and Constitution of SA ▪ Community environment ▪ Hospital and clinical environment
Agents	Formal agents ▪ MDT members (social workers, occupational therapists, psychologists, psychiatrists, psychiatric nurses and religious leaders) ▪ CHWs Informal agents ▪ Traditional healers ▪ Religious healers ▪ Traditional authority
Recipients	▪ MHCUs ▪ Family members or guardian
Procedure or Process	▪ Quality leadership ▪ Stakeholders' collaboration ▪ Provision of human and material resources ▪ Empowerment and education ▪ Monitoring of mental health services
Dynamics	▪ Reciprocal equity
Outcome	▪ Social support to promote continuity of care for MHCUs

A presentation of each element follows. In each case, the visual image of the element is depicted first, followed by a detailed description.

5.2.1.1 The context

Figure 5.1 presents a visual image of the agents of the framework. The context refers to where the activity occurs (Dickoff et al. 1968). In this study, the context consists of the departmental legal framework (MHCA and National Department of Health guidelines), the

Constitution of South Africa, the community environment, mental health and PHC facilities.

The colour of the context is indigo and signifies tuition, wisdom and spirituality (Psychological Colour 2022). Education is provided through teaching and instruction, thus giving rise to wisdom due to teamwork among the management team and staff members. This approach suggests successful social support is achieved based on stakeholders' collaboration at the managerial level and quality leadership guided by individuals' skills and knowledge acquired as indicated in the developed framework. The stakeholders at the managerial level work in one spirit and wise decisions are made in the process, given the range of different views. The hospital and clinical environments contain departmental frameworks such as organisational policies and procedures that encourage teamwork through embedded directive roles.

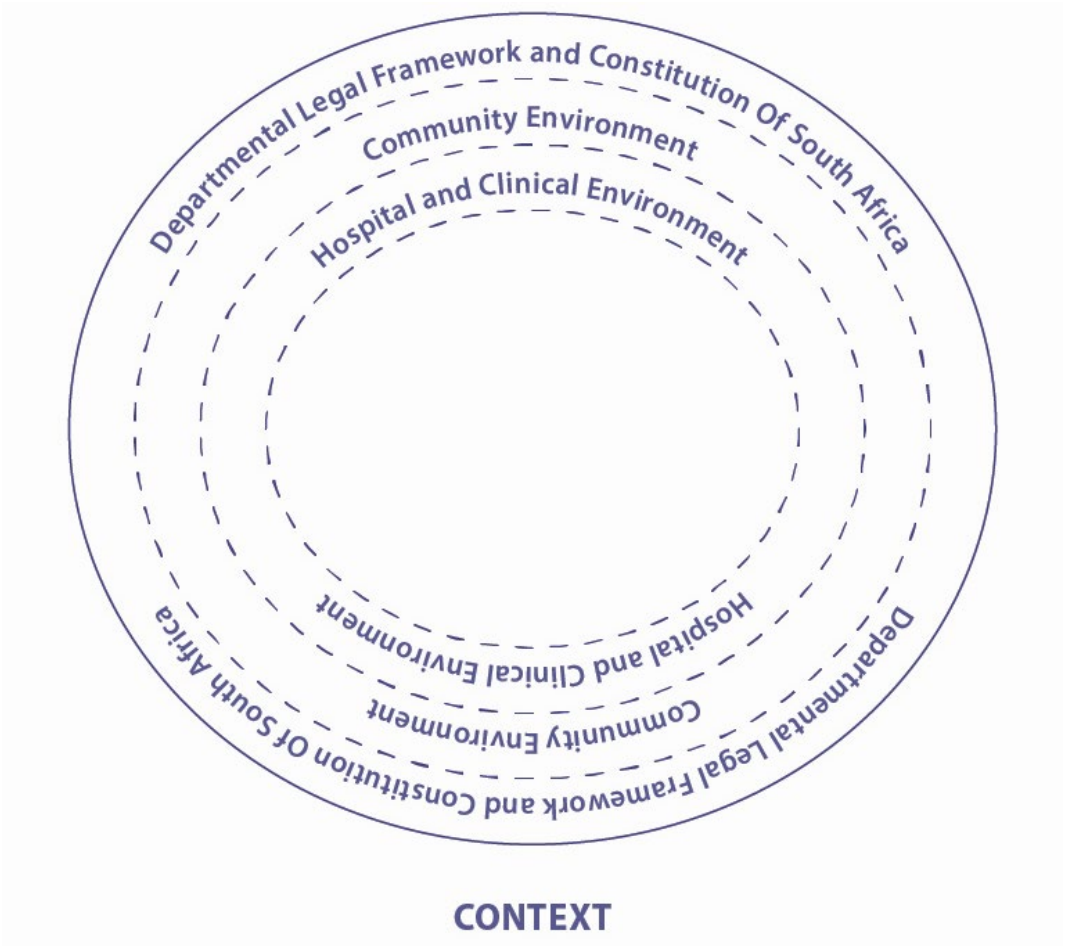

Figure 5.1: The context

The existence of the context, as part of the conceptual framework, is supported by the theoretical framework and assumes people construct concepts about the world that reflect their social environment (Charmaz 2014:12). Thus, the theoretical framework is applicable as social constructions occur in a social context where agents engage in fulfilling their roles at the optimum level, with the aim of offering social support to MHCUs. This view is supported by the constructivist approach, the paradigm that guided this study. Its focus is on constructions and relativism that characterise the researcher's endeavour (Charmaz 2014:13).

a) Departmental legal framework or guidelines

Organisational administration and mental healthcare services operate under the influence of guidelines gazetted by the Department of Health under the auspices of the WHO, developed in line with the South African Constitution. The MHCA (South Africa 2017:s40) and management guidelines for mental disorders serve as guidelines and could assist MHCPs in supporting MHCUs as it offers a directive on mental healthcare provision.

In this study, the position of the first layer, that is, the outer border, signifies that the mental health facilities, PHC facilities, and community environment operate under the auspices of departmental legal frameworks or regulations. MHCPs are guided by the MHCA and management guidelines on mental disorders in the provision of mental health services. Hence, the outside border is solid while the middle and inner borders are dotted lines, allowing a flow of information from the main context; that is, departmental legal frameworks. Meanwhile, South African Police Service (SAPS) officers feature in the outside border as directed by the MHCA in managing mental health cases between the community and the hospital environment.

The findings revealed inadequate mental health service provision due to a lack of mental health coordinators and follow-up teams. Thus, there is a need for improved coordination efforts. In support of the study's findings, Khoury and Ruelland (2020:96) explored community mental health programmes' impact on MHCUs' mobility around the city to seek mental health services; they reported the availability of mental health teams created change. Therefore, mental health service coordination by mental health coordinators (in

the form of quarterly meetings or other forms of engagement) will consequently ensure the availability and monitoring of the application of the MHCA and guidelines for mental disorders in mental health facilities.

Additionally, according to the MHCA (South Africa 2017:s40), the SAPS has permission to apprehend any person who may cause injury to themselves or others. This also applies to aggressive MHCUs who are difficult to handle, and this assistance brings relief to the family, community members and MHCPs who may need help in that regard. Mental healthcare coordinators should collaborate with the SAPS on MHCU transportation matters, thereby providing social support.

b) Community, cultural, and religious environment

Culture refers to the constantly changing patterns and products of acquired behaviour, including attitudes, values, knowledge and beliefs shared by members of a society and transmitted to others (Du Toit & Le Roux 2019:21). This concept encompasses the people's practices in a community that influence individuals to behave in a particular manner.

In this study, the second layer, that is, the middle border, represents the community's cultural and religious environment that shapes MHCUs' belief systems. The departmental legal framework, regulations, and mental health and PHC facilities influence the community's cultural and religious background. The dotted middle border means there is a flow of information among the three parts of the context to and from the departmental framework to the community and hospital environment and back to the community.

Generally, culture influences individuals' reactions toward mental health challenges, especially when they are confronted with mental illness. Moreover, individuals' religious background also plays a role. Findings revealed that some individuals stopped taking their medication, alleging a religious healer did not allow them to use Western medicine while under spiritual guidance. Moreover, the study's findings indicated that, irrespective of people's acknowledgement of the benefits of Western medicine, some individuals engaged in dual consultation; that is, taking medication from a health establishment and medication from a traditional healer at the same time. In support of the study's findings,

Knobi and Swartz (2018:8), whose study focused on examining faith healing for mental disorders from a neo-prophetic Ghanaian Christian perspective, concurred that MHCUs often consult faith healers.

Culture is learned from the community through language inherent in traditional practices, which implies that it can be modified and unlearned. This view is supported by Charmaz (2014:9), who professed society, reality and the self are constructed through interactions and thus rely on language and communication. This notion reflects the interrelatedness of this study and its theoretical framework, which embraces social constructivism (Burr 2015:4) and views reality (including social support and the self) as social constructions. This perspective is based on the assumption that people construct concepts about the world that reflect their social context (Charmaz 2014:12). This implies that in situations where cultural and religious practices are detrimental to the health of the MHCU, healthy practices can be enforced to create social change in the community or society. Therefore, ideal actions by different stakeholders must be established to improve social support for MHCUs and families or guardians within the cultural context.

Some MHCUs' mental health belief systems may be deeply rooted in cultural or religious backgrounds, and social support may be jeopardised and appear to be ineffective as MHCUs may stop taking their medication due to a traditional or religious healer's influence. In some cases, MHCUs may mix traditional medication with Western medication, resulting in complications or relapse followed by readmission. Thus, it is imperative to consider the MHCU's cultural and religious background. Empowerment and education in the community may also ensure people are informed of the benefits of mental health while not undermining their cultural and religious backgrounds. There should be an ongoing relationship between health establishments and traditional and religious healers, with clear roles to be played by each member in socially supporting MHCUs.

c) Hospital and clinical environment

The hospital and the clinical environment context refer to the actual physical environment where mental health services are provided. It is a place occupied by management and other staff members who ensure the realisation of daily activities at managerial and

operative levels, respectively. Hospital and clinical environments constitute the third layer of the context, in the innermost border with a square shape symbolising the institution's strength, efficiency, professionalism and practicality. These are centres of care and guide healthcare providers' actions in terms of mental health provision. Guidelines from the health facilities also direct families on interactions with MHCUs based on their environmental background.

- **Organisational policies and procedures**

The functionality of the health establishment is dependent upon healthcare administration and services that ensure the overall functioning of the healthcare facility, guided by a vision, mission, values, standards, policies, and procedures. In hospital settings, the vision, mission, and values serve as a vehicle for the realisation of quality care and mirror the organisation's movement towards its goals through strategic planning and management as per the organisation's vision. However, the organisation's effective and efficient outcomes depend on the layout of its structure, often planned according to the community's healthcare needs, which may be challenging.

This study's findings revealed a shortage of MDT members in the mental health institution based on the number of wards. Some participants attributed staff shortages to sick staff members and a lack of replacements for those who retired. Consistent with these findings, Madlala et al. (2020:3) reported a similar lack of trained professional nurses to implement additional programmes. Moreover, Santos (2020:11) indicated that participants in their study claimed they did not have practical skills and understanding to establish a public health, social work or psychological counselling service-related centre due to limited resources, unlike in other countries.

Hospital and clinical management ultimately observe leadership roles. Social support for MHCUs, from a contextual perspective (hospital and clinical environment), should be based on standardised operational procedures, as well as authority and coordination of health services as the essential basic elements of organisational structures. This approach should extend from hospital and PHC managers to MHCPs under the auspices of organisational policies and procedures.

- **Health service operational procedures' standardisation**

The standardisation of operational procedures across health establishments, including PHC settings, is of paramount importance. Guiding documents such as protocols and legal frameworks like the MHCA are currently not equally distributed among health establishments, especially in the PHC settings. Mental health service provision is based on the MHCA, which lays the foundation for supporting MHCUs by observing MHCUs' rights and establishing review boards that oversee MHCUs' interests (South Africa 2017:s19). The availability of mental health coordinators will strengthen MHCUs' social support as they distribute guiding documents and ensure that it is constantly referred to. Ongoing workshops and in-service training could also lead to adherence to the guiding documents. However, findings revealed a lack of clear guidelines on the management of various conditions, and participants were unsure of their practices as protocols might have changed. For instance, the handover reports of discharged MHCUs during transfer are often not properly completed, and information is frequently missing. Yin and Feng (2022:130) reported on COVID-19 safety protocols' effect on hospital workers' mental health, and they concur that workers felt safer working in an environment where clear protocols were in place, which reduced their anxiety. Similarly, Dlamini and Shongwe (2019:5) emphasised the need for institutions' management to establish strategies to deal with drug stockouts.

- **Authority and coordination of services**

Hospital and PHC management teams have the authority and power to allocate resources and delegate staff, but a lot depends on the availability of personnel and material resources. In this study, MHCPs indicated the extent to which the unavailability of resources, such as a shortage of transport, affects mental healthcare service delivery in the community. They mentioned a lack of home visits is one of the resultant factors, and community outreach activities, such as campaigns, are neglected. In support, Mulaudzi et al. (2020:4) outlined how a shortage of resources and staff, mainly psychiatrists and mental health-trained nurses, impacts the health system.

A coordination of mental health services by mental health coordinators and mental health teams under the supervision of hospital management from the provincial to local level will strengthen MHCUs' social support and ensure the smooth running of mental health services. They will also oversee the even distribution of resources.

5.2.1.2 The agents

Figure 5.2: The agents

Figure 5.2 presents a visual image of the agents of the framework. The agents are individuals who undertake an activity (Dickoff et al. 1968:468). The colour for the agents is blue, signifying a source of knowledge and tranquillity, resulting in collaborative stakeholders as well-informed teams who function to their best ability. The structure is round and formed by two circles intersecting at the centre. It denotes unity and interrelatedness of the formal and informal agents that the framework encourages for the realisation of social support (Colour Psychology 2022).

The agents who promote MHCUs' continuity of care through social support are divided into two: formal and informal. Each category of agents has an imperative role to play in supporting MHCUs. Agents' actions, one of Dickoff et al.'s (1968) elements, are supported by the social constructivist perspective, which formed the basis of this study. Social-cognitive views of social support are concerned primarily with support. This theory recognises stakeholders' interaction as a major step in the provision of support. It emphasises that for MCHUs to receive social support, which is a major premise of social cognition, people have to adopt a wide range of different professional roles, hence the description below.

a) Formal agents

Formal agents refer to individuals who underwent formal mental health training and whose provision of mental health care is grounded in the training they received. In this study, formal agents comprised the MDT members (social workers, occupational therapists, psychologists, psychiatrists, general practitioners, psychiatric and professional nurses) and CHWs, as depicted in Table 5.1. The MDT members play different roles in ensuring MHCUs' mental stability.

In this study, findings revealed that MDT members were available in different mental health institutions as part of staff establishments. Still, the service rendered was inadequate, thus hampering the smooth running of mental health services as planned.

- **Professional nurses, social workers and CHWs**

As part of the MDT, professional nurses play a major role in supporting MHCUs. Nurses should facilitate collaboration among the MDT members since they are nearest to the MHCUs and render a 24-hour service through observation. They review adherence to treatment and report on MHCUs' condition to colleagues in the hospital setting and community. Collaboration is also promoted by auditing MHCUs' files so that MDT members contribute meaningfully during MDT meetings since MHCPs know MHCUs better than any member of the MDT. Additionally, bilateral meetings involving the hospital's mental health team and PHC staff should be initiated by nurses ensuring that all stakeholders are involved to build a successful support system. The nurse's responsibility should be to advocate for MHCUs to ensure fitness during discharge and

leaves of absence. The provision of education, both in formal and informal settings, is another responsibility for nurses, as education can promote change and strengthen the support system.

While professional nurses are aware of nursing actions to be rendered to MHCUs, findings revealed inadequate support from MHCPs in terms of home visits, follow-ups and reviews, suggesting a lack of supervision. Additionally, findings revealed that in some institutions, staff members lose contact with the MHCU immediately after discharge and may only be in contact again during their next admission. Consistent with these findings, Turker and Weber (2021:552) also reported on barriers such as the inability to establish links and a scarcity of resources pointing to inadequate MHCU monitoring.

Meanwhile, social workers' support extends from holding formal and informal meetings with MHCUs' families to organising community mental health activities. Family meetings or gatherings at health establishments or the homes of MHCUs play an important role in supporting this population. During this forum, communication, the main tool of interaction, plays an important role in finding hidden information that can be used to promote social support. The social worker also organises mental health activities such as family days, mental health awareness and other mental health campaigns.

In this study, participants indicated that awareness campaigns were not conducted due to COVID-19, and MHCUs did not engage in support groups due to the fear of infection and could not be visited by family members. Furthermore, due to many restrictions, MHCPs could not deliver health services. Simon et al. (2021:1) recommend that public health policy planners consider lockdown matters such as restrictions and improve social support levels to increase public resilience. Additionally, social support is a strong resilience factor despite restrictive health measures. Thus, there is a need for future policies to consider the strong association between mental health institutions' capabilities, current mental health and social support levels to minimise long-term health, social and emotional issues (Simon et al. 2021:10).

Likewise, Meijer et al. (2019:464) determined mental health activities are beneficial because family group conferences ensure accessibility to information and create a learning platform for professionals, MHCUs and families. Campaigns also inform the

community of the importance of observing mental health as an important aspect of everyday life. Education, as part of campaigns, emphasises the importance of recognising MHCUs in the community and the support they require.

The social worker also plays a role in engaging with tribal authority figures on matters related to mental health to encourage their participation in supporting MHCUs. Generally, the community will listen to tribal authority leaders more readily than any other organisation or authority due to the proximity between the community members and traditional leadership. Therefore, traditional leaders play an important role in supporting MHCUs even in situations where the community disowns an MHCU due to property damage.

Another social worker's role entails enforcing networking between the hospital and the area social workers in the clinics and other parts of the community. Networking between the social workers will assist in promoting follow-ups on cases in need of a social worker's attention. The area social worker will be able to continue assisting with cases referred from the hospital, thereby rendering support since MHCUs' monitoring will be covered in the process. Strengthened relationships between the hospital and area social worker are also of utmost importance to alleviate the burden of tracing, assisting with grants, and assessing family structures and households; these tasks will be fast-tracked, thereby encouraging social support.

CHWs render mental health services in the community by monitoring medication adherence, checking on individuals' condition, and referring and educating MHCUs and family members. Generally, CHWs collaborate with PHC staff to care for chronic patients in the community. MHCUs discharged into the community form part of chronic patients and are thus supervised by CHWs. PHC staff thus notify CHWs of MHCUs in the community and their need for mental health services and home visits.

This study's findings confirmed that CHWs are the staff members who most often conduct MHCU home visits. However, home visits by CHWs may not suffice for appropriate mental health services to be rendered in the community, given the CHWs' level of education and the processes involved in taking care of MHCUs. Connolly et al. (2021:579) similarly alluded that the use of trained CHWs could benefit mental health

services, especially in underserved communities, but the approach had weaknesses and strengths. This implies stakeholders cannot rely on trained CHWs to execute their planned psychiatric services as their contribution is a partial solution to the gap in mental healthcare provision.

Generally, home visits, follow-ups and reviews are the duty of any MDT member, professional nurse, social worker or CHW who engages and networks with others in the quest to socially support MHCUs and families or guardians.

- **Occupational therapists, clinical psychologists, psychiatrists and religious leaders (chaplains)**

Occupational therapists work with MHCUs to re-establish any work-related capabilities that were disrupted by episodes of mental illness in preparation for their return to work. This strategy can mainly apply to professionals and other labour market employees, like factory workers. However, the findings revealed that knowledgeable MHCUs' skills were still overlooked in the workplace, allegedly due to their mental status, suggesting a lack of employers' and colleagues' recognition that they are capable employees.

Consistent with these findings, Alhamidi and Ayosef (2020:905) agree that people experiencing mental health problems face daily challenges and constraints. Inadequate rehabilitative services, one of the challenges, could later delay MHCUs' return to work and even affect their functioning.

Conversely, in cases where MHCUs never had an opportunity to experience a working environment, the occupational therapist assists with the development of vocational skills in a sheltered workshop environment. Additionally, MHCUs should be assisted in gaining independence in performing activities of daily living. Rehabilitation and vocational training thus focus on building a productive MHCU, thereby enhancing their self-esteem. The occupational therapist uses creative and therapeutic skills to rehabilitate MHCUs (Townsend & Morgan 2018:228).

The clinical psychologist also intervenes and specifically focuses on MHCUs' psychological challenges. The intervention can be in the form of individual, group or family therapy. Individuals (MHCUs) admitted due to abuse and other psychological

problems receive individual therapy, while families with psychological challenges attributed to the presence of an uncooperative MHCU receive family therapy as a means of support (Townsend & Morgan 2018:227).

The psychiatrist leads the MDT members' activities as an individual who diagnoses and treats mental disorders. MHCUs' discharge is also their responsibility, along with engaging in their leadership role, especially during informal meetings such as ward conferences or formal MDT meetings. The psychiatrist works closely with the psychiatric nurse to offer social support, prescribe medication to target symptoms, and refer MHCUs to appropriate MDT members (Townsend & Morgan 2018:227).

MHCUs and families are referred to the social worker for social problems, a psychologist to deal with psychological problems, an occupational therapist for rehabilitation, and a religious leader to deal with their spiritual needs. Families and MHCUs with spiritual needs are referred to chaplains who offer support by attending to their spiritual requirements. The chaplain thus provides support and religious-related counselling as needed by the family and MHCU (Townsend & Morgan 2018:228).

Under the leadership of the psychiatrist who recommends care, treatment and rehabilitation, the rehabilitative team is important in ensuring MHCUs' reintegration into the community because this action serves the MHCA's (South Africa: s3) main objective, which is care, treatment and rehabilitation. Therefore, a facilitative team spirit among the rehabilitative team ensures success.

The formal agents collaborate to ensure the main goal in this study (social support) is achieved, as indicated by participants. In this study, participants alluded to individuals with different roles working together in providing adequate social support. However, the study's findings also revealed inadequate communication among the healthcare workers involved in caring for MHCU. Some MHCP participants indicated that they use phones to communicate with MHCUs and families, which limits their interaction. Other MHCPs indicated that there is no interaction at all post-discharge.

In support of the study's findings, Leung et al. (2020:558) determined services provided by different professionals and sectors, such as community services and clinics, are

fragmented and without clear communication channels. Furthermore, this study revealed an inadequacy in mental health service provision due to a lack of mental health coordinators and follow-up teams. This view is supported by Martens et al. (2023:2), who emphasise the need for intensive care coordination or network-based community care for people with severe mental illness.

Thus, stakeholders' empowerment and education are emphasised as strategies to strengthen social support. Grant et al. (2022:7) concur, stating that low mental health literacy, lack of knowledge about service availability, stigma and misinformation about treatment pose barriers to help-seeking behaviour. Thus, to ensure successful social support, stakeholders' collaboration, empowerment and education need to be considered. This will benefit and promote change in mental healthcare services.

b) Informal agents

Informal agents refer to individuals who did not receive any formal training but are empowered informally about mental health issues. They are identified as traditional healers, religious healers and traditional authorities, as depicted in Table 5.1.

- **Traditional, religious healers and traditional authorities**

Traditional, religious healers and traditional authorities are informal agents rendering mental health services to MHCUs whose main belief is based on their cultural and religious backgrounds. This category of agents also has a vital role in supporting MHCUs and families, given the interaction that occurs, especially due to individuals' strong beliefs and proximity to traditional practices. Incorporating them into mental health activities could improve communities' mental health outcomes and create a change in the current picture, as some MHCUs and families engage in dual consultation due to cultural beliefs. Therefore, they receive mental health services at the hospital or clinic while simultaneously consulting with traditional or religious healers.

Furthermore, the traditional authority has a ruling power over communities under their control. Community members are attuned to the existing authority, and it is easier to access the community through this office than by any other means. MDT members mainly contact traditional leaders to gain entrance into a community in cases where mental

health education is to be given and to negotiate with communities when an MHCU is disowned due to their poor behaviour, such as property destruction.

In relation to informal agents, findings revealed that MHCPs access community members through traditional leaders to offer mental health information. Knobi and Swartz (2018:8) also reported that MHCUs consult with faith healers and are exposed to prayer and prayer aids such as holy water, fasting, speaking in tongues, and counselling as a form of diagnosis and treatment.

This category of agents contributes meaningfully to individuals' mental health and consequently reduces relapses and readmissions. The relationship between the MDT, traditional and religious healers as well as traditional authority should thus be strengthened to ensure effective social support for MHCUs. Thus, collaboration between these agents should be encouraged and adhered to. This collaboration will greatly assist as traditional and religious healers can also offer support by referring MHCUs to the hospital and PHC settings when needed. Likewise, the traditional authority will be able to commit community members to caring for MHCUs.

5.2.1.3 The recipient

Figure 5.3 presents the visual image of the recipients of the framework. The recipients refer to individuals who receive a service after executing a particular activity. The colour green symbolises life and denotes positivity, signifying the maturity of the MHCU, family or guardian and community in terms of their behaviours and actions, guided by the knowledge they received through empowerment and education (Colour Psychology 2022).

Empowerment and education yield harmony as the community becomes knowledgeable and understands the behaviour of the MHCU; hence, the structure is round and denotes life that will be added due to acquired knowledge. This study revealed the possibility of banning MHCUs from the community in cases where they destroy property. Thus, it is essential to educate communities to establish peace.

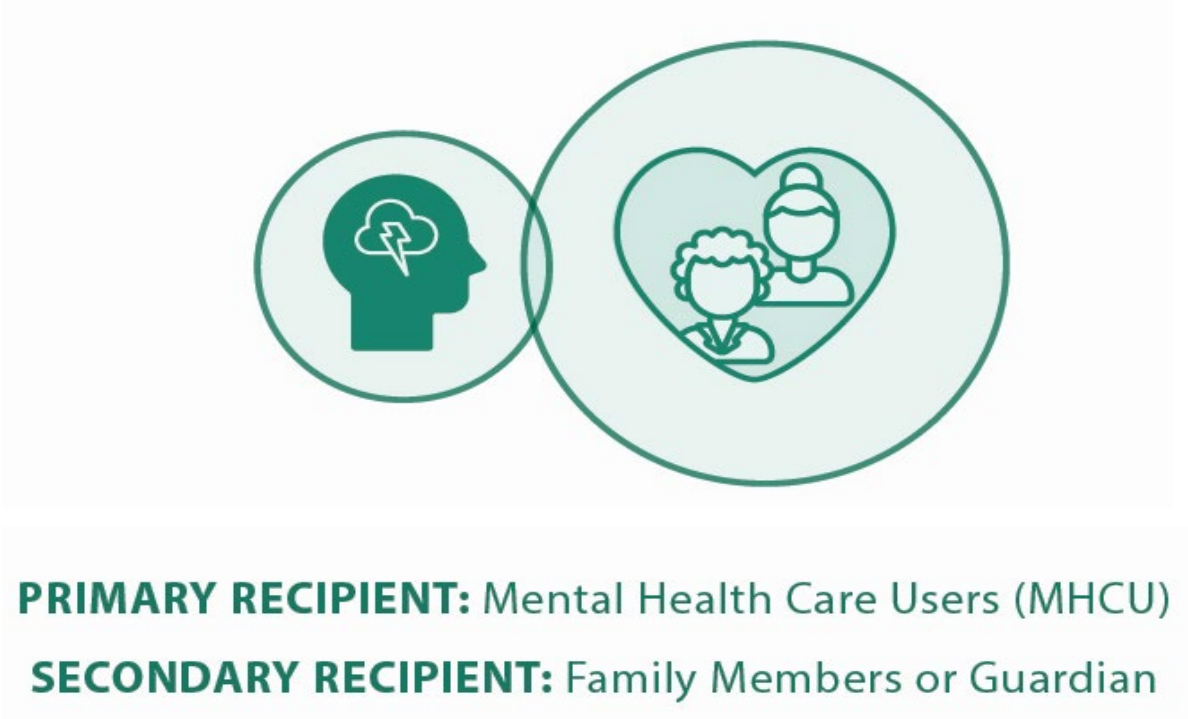

Figure 5.3: The recipient

Currently, social support structures are not well-established, but the stakeholders are doing their best to socially support MHCUs. Hence, the picture of both the formal and informal agents' hands with medication suspended in the air symbolises that the medication being given is ineffective. Additionally, the picture in the illustration of an MHCU depicts a clouded mind, indicating instability in thoughts and actions.

In this study, there are two categories of recipients; the primary recipient is the MHCU, and the secondary is their family or guardian. These are individuals who need social support from different stakeholders.

a) The primary recipient

The MHCU is the principal recipient of social support and mental healthcare services from stakeholders, as well as their families or guardians. Hence, the pictorial presentation of the MHCU coloured in blue depicts a circle intersecting with the secondary recipient and the agents.

The MHCU is at the centre of social support and requires assistance from all stakeholders on the road to recovery. Meanwhile, it is the MCHUs' responsibility to avail themselves to receiving care that will lead to expected social support. MHCPs must also lay a good foundation for effective communication and interaction with MHCUs. Symbolic interactionism, a constructivist perspective that focuses on dynamic relationships between meanings and actions, supports the notions of communication and interaction. It outlines the latter as an active system through which people create and mediate meanings (Charmaz 2014:266).

Building a sound provider-MHCU relationship requires specific conditions that are essential for the development of a therapeutic relationship, encompassing rapport, trust, respect, and being genuine and empathetic towards the MHCU, facilitating communication and interaction (Townsend & Morgan 2018:139). Building a sound relationship will be part of education as this is the basis of successful relationships.

In this study, findings revealed social support for MHCUs is currently inadequate. In this study, MHCUs were not the only category affected by stigma; their families and MHCPs also suffered stigmatisation and discrimination by community members and colleagues in the workplace, respectively. Relapse, readmission, and a lack of friends were some areas where social support gaps were identified.

MHCUs' experiences of stigma were also cited by Soeker et al. (2021:409), who postulated that stigma remains a major issue for MHCUs. Furthermore, Hana et al. (2022:9) reported similar findings that MHCUs were concerned about stigma from community members who openly displayed stigmatising actions.

b) The secondary recipient

The family or guardian is of secondary importance in receiving mental healthcare services from stakeholders, signifying the reason for their consideration as recipients based on their proximity to the MHCU. The family comes first in support and is considered part of the MHCU's support system. Hence, the pictorial presentation of the family or guardian is coloured in blue, depicting a circle intersecting with the primary recipient and the agents.

The recipient is at the core or centre of the social support framework as all the activities are directed towards the MHCU and their families or guardians. However, family conferences or family days, as well as individual and family therapy and education on caring for MHCUs are sometimes not attended due to family or guardian unavailability. A well-staffed and equipped organisation will combat this challenge by conducting home visits, since these activities may occur in a family setting.

Attending meetings and gaining an understanding of the importance of treatment adherence and the actions to be taken in case of a crisis all serve as determinants of social support success since the family is the support system nearest to the MHCU. A guardian may take care of the MHCU when family members are unavailable or absent from the MHCU's life. Secondary recipients typically reside with the MHCU and could provide pertinent information. However, findings revealed the absence of families' support in MHCUs' lives; instead, rejection or abandonment by family members were prevalent. MHCPs emphasised this view, and they indicated that relatives often want the Department of Health to keep MHCUs admitted as there may be no one to take care of them upon their discharge.

In a study by Moorkath et al. (2019:308), families similarly abandoned and rejected mentally ill persons due to social or religious customs rooted in shame, a cultural belief upheld by the ethnic group. Furthermore, Dlamini and Shongwe (2019:4) determined that MHCUs often default treatment and are readmitted due to inadequate support from relatives.

Treatment compliance is thus dependent on family or guardian support. In this study, participants' views highlighted a need for supervision and family involvement concerning matters surrounding mental health, such as the collection and taking of medication. In support, Cameron et al.'s (2021:14) review of literature regarding MHCUs' views of family involvement in their engagement with services and care reflected a need for increased family involvement.

In this instance, the formal agents, MHCPs and other stakeholders need to build a sound relationship so they can relate to the family or guardian. A well-established relationship will help the family to be open and transparent regarding issues attached to the MHCU.

However, some families may not open up and disclose information given their attitude towards the MHCU, which will hamper their potential to provide social support. The MHCP thus employs various mechanisms to win the family or guardian over and use the MHCU's openness and transparency to guide them in providing appropriate social support. Moreover, the formal agents empower and educate the MHCU and family or guardians on mental health matters to encourage social support.

5.2.1.4 The dynamic

Figure 5.4 depicts the dynamic of the framework, the energy source or force required in the execution of an activity (Dickoff et al. 1968). The colour red signifies strength, suggesting the power of the dynamic over the process. Therefore, irrespective of the energy that may be channelled towards successful social support, there will be forces that create disturbances; hence, the two vertical lines anchored with an arrow, which symbolise strength and progress (Colour Psychology 2022).

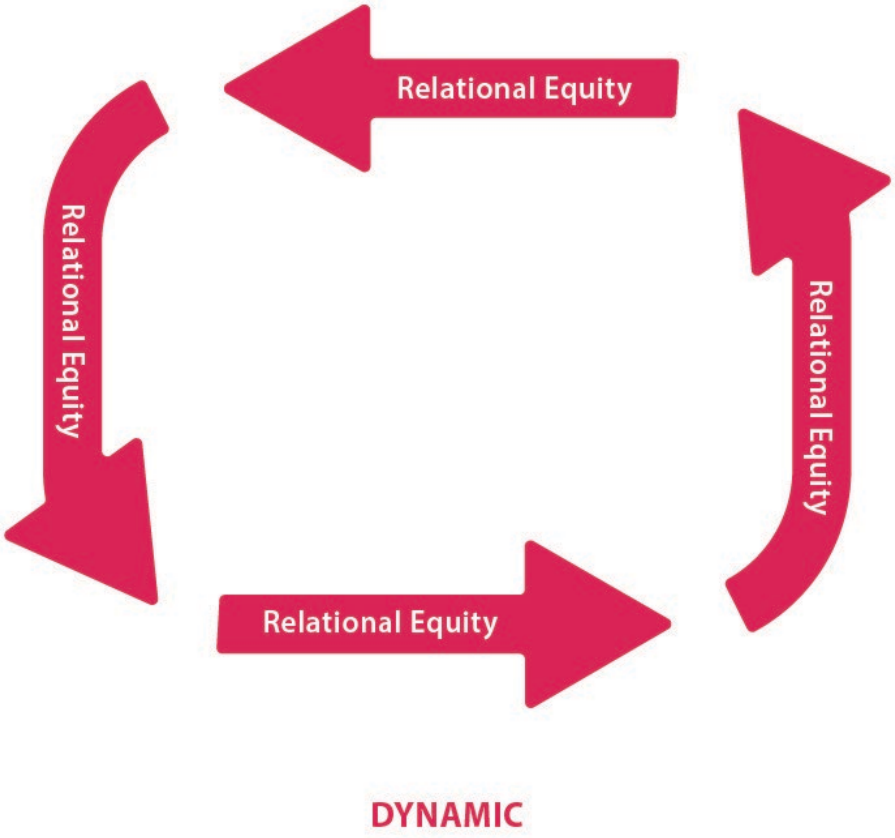

Figure 5.4: The dynamic

The theoretical framework underpinning this study recognises a dynamic as the force that must be considered to counteract any negative effect that may occur. It advocates for social justice and requires analytic tools to probe how events, processes and outcomes are constructed. It is a method that provides a means of studying power, inequality and marginality (Charmaz 2017:39), and the negative forces that can alter positive results.

The dynamic in this study refers to forces that steer the process (procedure) to yield the desired outcome. In this study, relational equity encompasses power equality, honesty, mutual trust, and reciprocal participation, as discussed below.

a) Relational equity

Relational equity entails understanding and learning about someone's reality through repeated interactions. In this study, repeated interaction and the delivery of mental health services are likely to yield the best outcomes in promoting MHCUs' social support. Additionally, stakeholders need to consider that equity entails prioritising those most in need of services, suggesting the whole procedure (process), from quality leadership to the monitoring of mental health services, should strike a balance in addressing the needs of MHCUs rooted in equity. In this way, effective outcomes will be achieved that will be recognisable as all MHCUs will finally receive attention as needed.

Moreover, issues such as inadequate support by MHCPs' employers, as evidenced by the shortage of human and material resources like transport, equipment and supplies, can give rise to a lack of relational equity, suggesting poor interaction among MDT members, MHCUs, families or guardians. Additionally, MHCPs indicated that the unavailability of resources, such as a shortage of transport, affects mental healthcare service delivery in the community. Home visits and community outreach activities, such as campaigns, are often cancelled as a result.

Consistent with these findings, Mulaudzi et al. (2020:4) affirmed staff shortages lead to an unbearable workload and consequently result in work-related stress and burnout. Additionally, strategies to deal with the high workload were not in place, especially in the PHC setting. Mulaudzi et al. (2020:4) further outlined how the shortage of resources and staff, mainly psychiatrists and mental health-trained nurses, impacts the health system.

Therefore, to curb the issue of inadequate relational equity, management must play a leadership role while MHCPs assume responsibility for observing the principle of equity. Power equality, as part of relational equity, is one aspect that can assist in ensuring effective social support.

In this study, relational equity could be observed by creating a balanced, respectful, and inclusive environment where the needs and voices of all parties are acknowledged and valued. An observation of relational equity as a dynamic in this sense will ensure continuity of care among MHCUs, the multidisciplinary team, and other stakeholders in mental health.

Furthermore, the practise of relational equity by stakeholders will ensure recognition of MHCUs' unique experiences, needs, and perspectives, thereby assisting MHCPs to recognise the MHCUs' potential. Additionally, MHCUs will be treated with dignity and respect. MHCUs will be actively involved in decision-making processes related to their care and receive personalised support that acknowledges their individual circumstances. This approach is imperative to socially support MHCUs as it helps build trust and a sense of agency among MCHUs, which is crucial for effective treatment and recovery.

Moreover, relational equity will assist in acknowledging and valuing the diverse expertise of each MDT member, thus fostering open communication, collaborative decision-making and mutual respect among psychiatrists, psychologists, nurses, social workers, and other healthcare professionals. Such an environment not only enhances team dynamics but also ensures a more holistic and integrated approach to patient care.

Meanwhile, family members, caregivers, community organisations, and policymakers also play a vital role in the mental healthcare continuum. Relational equity will ensure that MHCPs engage the aforementioned stakeholders in meaningful ways, respect their contributions, and consider their insights in care planning and policy formulation. This inclusive approach ensures that the care provided is not only clinically effective but also socially and culturally responsive.

- **Power equality**

Power is defined in Du Toit and Le Roux (2019:111) as a person's ability to impose their will on others despite resistance. In this study, power inequality implies an imbalance in actions and behaviours between the MHCP and MHCU. The MHCP is expected to identify problems, assess, plan, organise and implement the MHCU's care in a therapeutic atmosphere. However, when the MHCP displays power through untoward behaviour, the MHCU may feel threatened, affecting their reception of mental healthcare services. The MHCU may interpret the MHCP's actions negatively due to their demonstration of power as a knowledgeable individual, which may hamper social support. Therefore, an environment of equal power that fights a spirit of inferiority between MHCPs, MHCUs and families or guardians should be created. An atmosphere of power equality combined with mutual trust will encourage communication and interaction among individuals.

- **Mutual Trust**

Trust is an essential element in the development of a therapeutic relationship between an MDT and MHCUs. Trust cannot be presumed but is earned, and to trust another, one needs to feel confident in that person's presence, reliability, integrity, veracity and desire to provide help when requested; hence, a need for MHCPs to perfect skills that ensure the development of trust (Townsend & Morgan 2018:139). Townsend and Morgan (2018:139) further emphasise trust is an element that forms the basis of a therapeutic relationship. They warn that a lack of trust in an MHCP may be detrimental as the MHCU may not believe in the nurse's actions, thereby hampering social support. Consequently, compliance with treatment and the provision of mental health education and care, such as home visits, may add no value to the MHCU, thereby hampering social support. Additionally, trust is essential in a provider-MHCU relationship and should extend beyond normal care to the creation of a therapeutic environment.

Doblyte (2022:1) considers trust a critical mechanism for managing ambiguous situations. Furthermore, the author admits its influence on healthcare practices and objectives. Trust is an innate trait that determines human beings' responses or actions in any situation, which impacts the mental health actions delivered by healthcare providers. Trust comprises competency, consistency, integrity and compassion since these are elements whose nature and originality are reflected in the manner human beings behave. Thus,

these elements of trust depend on people's behaviour, and a lack thereof could destroy relationships and lead to mistrust.

Doblyte (2022:7) explored the degree to which trust dynamics between the state, the MHCP, and the MHCU shape the functioning of mental healthcare. Their findings revealed distrust's impact on mental health institutions and emphasised the need to build trusting relationships. Trust and distrust both have the potential to influence the truster's practices and, in turn, fortify and strengthen or undermine the goals of healthcare.

- Competency in mental healthcare provision

As an element of trust, competency comprises imperative attributes essential in mental healthcare provision. The success of executed activities depends on an individual's abilities in the following attributes: decisiveness, conscientiousness, adaptability and self-efficacy.

The healthcare provider is expected to make decisions quickly and efficiently depending on the situation at hand. In this study, findings revealed that some MHCUs were nearly banned from their community because of untoward behaviour such as arson. In such cases, the MHCP has to make a quick decision upon receiving such information because if the situation is appropriately addressed, communities' social support for MHCUs may be retained.

Social support for MHCUs goes beyond an ordinary action of mental health provision and requires the ability and inner drive to work hard and be diligent and reliable. In this study, social support required some stakeholders to render care, attend meetings, be involved in community activities such as awareness campaigns, and engage in home visits, activities that can be strenuous but require perseverance, denoting external forces that can disturb an activity. Similarly, healthcare providers may be required to adjust to changing situations depending on emerging challenges. Engaging in home visits may pose difficulties due to poor weather conditions or reception by family members in different households. In such circumstances, the healthcare provider should persevere and move towards a self-fulfilment of their plan, irrespective of their difficulties and uncertainties.

- Integrity in the fulfilment of stakeholders' roles

MHCPs are expected to demonstrate relevant moral values and social and cultural norms and be ready to face the consequences of their actions. In this study, MHCPs remained courageous and were prepared to alter their views and be culturally sensitive towards MHCUs while maintaining their own moral values, for the benefit of the MHCUs.

- Compassion

MHCPs should demonstrate empathy, be selfless and open-minded while dealing with MHCUs to understand and accept any given situation. In this study, findings revealed non-compliance to treatment and a lack of commitment to mental health provision as a result of inadequate social support from family members and MHCPs. Therefore, MHCPs should be ready to face such pressures and deal with them amicably.

- **Honesty**

Honesty entails telling the truth at all times and strengthening a relationship between two or more parties. Honesty is a two-way process that requires mutual respect, appropriate behaviour, following rules and regulations, maintaining discipline, and being punctual, especially during meetings, attending to mental health issues, and community gatherings. Dishonesty between an MHCP, MHCU and a family member may weaken the relationship and have negative consequences for MHCPs socially supporting the MHCU and their family.

MHCPs should lead by example, stay focused on the goal to be achieved and involve MHCUs and family members or guardians in planning activities required to promote successful social support, irrespective of possible challenges. Additionally, they must be the anchor point that MHCUs and family members or guardians can always count on. Transparency, truthfulness, respect and integrity are attributes of an honest individual and help build relationships essential for achieving set goals.

Transparency and honesty are the building blocks of a strong team. Meanwhile, honesty should also be demonstrated in dealing with the MHCU and family or guardian. Each stakeholder's action is imperative and calls upon commitment and cooperation among team members, which could be challenging.

Truthfulness should also be maintained at all times as a solid foundation for genuine relationships relies on this attribute. Truthfulness calls for loyalty among MHCPs to their employer and the recipient of care because without it, the relationship between the three parties collapses, and there will be no fulfilment of any promises by the healthcare providers, straining social support.

Honesty further implies a demonstration of respect; without it, healthcare instructions for recipients will not have an impact, which may strain the social support outcome. Honesty calls for an observation of the recipients' culture. In some cultures, respect remains a stronghold in relationships, and mental health services will not have any impact in its absence. Hence, integrity is essential as moral standards mean an individual is being honest in all actions. Where there is no integrity, honesty is not upheld, jeopardising the relationship between the healthcare provider and the MHCU.

A study by Weziak-Bialowol and Bialowolski (2021:1) examined whether the strength of honesty and integrity was prospectively associated with physical health, depression and daily functioning outcomes. Their findings revealed positive associations as evidenced by participants' improved longevity and reduced risks of physical ailments and mental disorders; suggesting dishonesty can increase mental health risks such as relapse. In this study, the aspects of readmission and relapse were cited several times and were considered contributory factors towards inadequate social support.

- **Reciprocal participation**

Reciprocal participation entails engaging in a particular action together. Positive regard for reciprocal participation yields favourable results. A negative provider-MHCU relationship is likely to awaken a lack of commitment and cooperation by the MHCU, as evidenced in this study. MHCPs pointed out that they followed up with MHCUs and conducted home visits, but this action did not yield the anticipated positive results, as reflected by the high readmission rate. The MHCPs should present themselves therapeutically to avoid imposing their actions on recipients. Mutual respect ensures both parties are satisfied in the relationship and encourages positive engagement. Positive reciprocal behaviours and attitudes from both parties are thus essential in fostering positive outcomes in the provider-MHCU relationship. This view is supported by Hickey, Pryjmachack and Waterman (2020:106), who determined that reciprocity is essential for

recovery in mental health. These findings suggest a lack of reciprocal participation causes negative outcomes in promoting social support for MHCUs.

Vygotsky's social-historical theory of cognitive development is applied in this context to emphasise that contributions by both the MHCP and MHCU are important, none is greater than the other (reciprocal participation). Meanwhile MHCPs are well vested with theory, the MHCU culture plays a role in daily life. Therefore, it is considered important in social support of MHCU.

According to Crain (1914:238), Vygotsky's social-historical theory of cognitive development professes that a child's development in the area of cognition goes beyond abstraction and includes the culture learned from society. Therefore, as an individual continues to grow, the behaviour they acquire from society and behaviour as a product of the mind form part of cognitive development. However, to support this notion, Vygotsky (as cited in Crain 1914:239) engaged in a study to examine whether abstract thinking is a product of relatively advanced levels of social-historical development. Findings revealed that the mind is a product of social and historical change, suggesting that contributions from both the MHCP and MHCU are equally important; none is greater than the other. Therefore, in their quest to attain a desired outcome, the MHCP should function as an agent of change and foster a positive relationship. This is done to counteract their own behaviours and actions that may reflect the more knowledgeable individual (MHCPs) in the relationship and create a balance in the process, thereby avoiding linear contributions in socially supporting the MHCU and family or guardians, leading to passive participation.

In this study, findings reflected inadequate reciprocal participation, as most actions between the MHCPs and MHCUs were MHCP-initiated and MHCP-focused, suggesting less participation by the recipient. The danger of such a situation is the possibility of awakening the MHCU's negative thoughts, resulting in their unreceptiveness to care. This implies strengthening the provider-MHCU relationship. Thus, gatherings such as family meetings, home visits, individual and family therapy as well as ward conferences should be intensified to foster interaction and engagement between families, MHCUs, MHCPs and the community. An opportunity for one-on-one social support will be created, and this could benefit MHCUs and their families or guardians.

5.2.1.5 The procedure

Figure 5.5: The procedure

Figure 5.5 depicts the procedure of the framework. The procedure entails a step-by-step process of executing an activity (Dickoff et al. 1968). The chosen colour is purple, signifying harmony in the mind and emotions of the MHCU and family or guardian, leading to balance and stability in families and among individuals. Furthermore, it reflects peace of mind, a link between the spiritual and the physical worlds, suggesting successful social support because of stakeholders' collaboration and quality management (Colour Psychology 2022).

As reflected in the study's findings, an effective social support system requires an observation of factors such as quality leadership, stakeholder collaboration, provision of

resources, empowerment and education, and monitoring of mental health services. The aforementioned aspects are described below.

a) Quality leadership

Support is linked to quality care. Healthcare professionals' leaders function under the auspices of the provincial government. The Provincial government reports to the National Department of Health. Therefore, through incorporated visionary leadership and quality management, which will also apply in the provision of mental health services, healthcare services will flourish due to well-coordinated activities (Du Toit & Le Roux 2019:156). The success of a quality management programme is dependent on the commitment and loyalty of employees, and this can only occur in an environment with openness, transparency and support.

In this study, findings reflected a need for climate change by management, as indicated by the inadequate infrastructural services available, such as rehabilitation centres and a need to fund mental health activities. This view is supported by Wannasewok et al. (2022:108), who agreed that community rehabilitation service facilities for MHCUs with severe mental illness are lacking and is a significant challenge in providing mental health care. Furthermore, a study by Arriola-Vigo et al. (2022:716) revealed a scarcity of financial and logistical resources to undertake home visits or psychosocial club activities. Financial burdens related to extramural activities and a lack of transportation were identified as additional hindrances to undertaking community engagement events.

It is imperative to note that effective social support starts with visionary leadership, whose main focus is on rendering quality care to yield the required outcomes. For change to take place, a productive leader provides direction, coaches, delegates and supports staff members. In this study, the manager of the health establishment set a good personal example of engagement and interaction and created an environment open to communication to facilitate collaboration among stakeholders. Additionally, stakeholders' capabilities should be realised and channelled to provide the best social support for MHCUs and their families or guardians. Meanwhile, it is essential for healthcare leaders to possess political skills so they understand others' attitudes, behaviours and actions. Additionally, adjustments in their behaviour in accordance with the situation are essential

to achieve favourable results. Therefore, healthcare leaders should network with local government leaders to exert their influence on mental healthcare service delivery. Collaboration with the local government forms part of this study's framework.

Within the local government (the municipality), there is a health section where the Department of Health is represented. Therefore, the local government should be involved in validating the framework to keep abreast of local mental health issues. This study recognises that the current mental healthcare legal framework is being reviewed, and the municipality's health desk will thus be part of such an activity and workshops will be conducted to offer updates on mental health issues.

b) Stakeholders' collaboration

Collaboration among stakeholders is an integral part of mental health service provision. Effective social support stems from stakeholders' collaboration at both interdepartmental and interdisciplinary levels.

- **Interdepartmental stakeholders' collaboration**

Mental illness may be associated with a lack of resources in the community. Findings alluded to the availability of recreational and mental health facilities such as sports fields and shelter workshops in the community to combat some of the contributory factors to mental illness; this requires interdepartmental collaboration, especially at the managerial level. The Department of Sports and Recreation, the Department of Local Government and Housing, the Department of Social Development, and the Department of Health should work together, each providing services to ensure MHCUs are socially supported.

- **Interdisciplinary stakeholders' collaboration**

Stakeholders include the Department of Health, MDT members, MHCUs and their families, CHWs, traditional and religious healers, as well as traditional authorities. In this study, collaboration among stakeholders requires communication and interaction, commitment, networking and engagement.

The communication and interaction process starts with the MDT member's interaction in a health establishment (hospital). The psychiatrist, who is the leader of the team, initiates

and secures meetings to discuss matters related to the provision of mental health services for MHCUs, families, and the entire community. Meetings are held provincially, at the district level, locally (at the health establishment), and at a community level. This strategy promotes the dissemination of information, thereby encouraging social support for MHCUs and families.

While these meetings can result in a change in mental healthcare service provision, this study's findings revealed inadequate mental health service provision due to a lack of mental health coordinators and follow-up teams. Participants emphasised a need for a focal person to deal with mental health issues, the establishment of district and institutional coordinators, as well as mental health teams to go around the villages and check on MHCUs. This view is supported by Martens et al. (2023:2), who emphasised a need for intensive care coordination or network-based community care for people with severe mental illness.

The developed framework recommends that stakeholders should be encouraged to commit and be ready to network and engage to facilitate the smooth running of mental health services. Networking and engagement will take place between managers at the upper, middle, and operational levels. Additionally, engagement should occur between MDT members, CHWs, police officers and community policing forums, as well as traditional authorities and healers. The developed framework further recommends that engagement be in the form of meetings and involve mental health coordinators as the disseminators of information among health establishments. Networking among stakeholders involves handing over and receiving reports on MHCUs among the stakeholders. This will prevent the fragmentation of services, a loss of information, and MHCUs' treatment-defaulting tendencies. Communication and interaction, commitment, networking and engagement will be well-facilitated among the stakeholders to enhance social support for MHCUs and families. As reflected in the findings, the aforementioned aspects appeared inadequate, hence the need for intensification.

c) Provision of resources

The health establishment's management team oversees the organisation's administrative matters and health service provision. One of the major functions of healthcare facilities'

management functions is ensuring the availability of resources. A well-equipped organisation promotes quality care. Well-staffed healthcare establishments and the availability of material resources ultimately contribute meaningfully to MHCUs' social support.

There should be mental health coordinators at the provincial, district, and local health establishment levels. Mental health teams help to ensure the success of mental health service provision. Mental health coordinators should engage with management from the provincial level and cascade all information down to the local level by networking among themselves. The developed framework also recommends that mental health activities be coordinated between health establishments. Meanwhile, mental health teams should be interacting with staff at the PHC setting, CHWs, MHCUs and families.

CHWs should collaborate with the mental healthcare team and the PHC staff, in line with the execution of mental health activities in the community. However, this will take place under the supervision of the health establishment's mental health coordinator.

d) Stakeholders' empowerment and education

Individuals' empowerment has many benefits. Productivity and changed attitudes towards a particular issue are some of the aspects that can be observed in an individual or group of people who went through a capacitation process. Empowerment entails giving power to individuals to undertake a particular activity. Therefore, in this study, empowerment encompassed the promotion of mental health by training healthcare providers and other stakeholders to engage in road shows, awareness campaigns, mental health education in formal settings, and community engagement.

- **Promotion of mental health**

Mental health promotion is essential to create change among individuals or communities whenever there is a gap in knowledge. Communication media, road shows, campaigns and training are some strategies that can be employed to bridge a gap in inadequate social support, as was the case in this study.

- Communication media

Communication media plays a vital role in the dissemination of information. MHCPs should be responsible for disseminating mental health information through local newspapers, radio and social media platforms, such as Facebook, Twitter and WhatsApp, to update, educate and remind MHCUs and family members or guardians about mental health issues. They should inform communities how to report mental health conditions, medication use and follow-up care. A blog should also be created where mental health messages can be posted.

In this study, findings revealed that broadcasting through the radio or television, where a slot is given to an MHCP to inform others about mental health matters, could be better than engaging in a campaign, as more people access the information. Local newspapers and pamphlets were also cited as media sources that could be used to disseminate mental health information to the community. Social media platforms, such as Facebook and Twitter, are even more beneficial because adults and youths use smartphones, and it will be easy for them to access mental health information as they browse these platforms on their phones. Furthermore, a blog could be created so that individuals can access mental health information through their cell phones.

Consistent with the study's findings, Liu (2022:9) concurred that media (cell phones, computers, newspapers or radio) could help in the dissemination of mental health information. In support of these findings, Duara et al. (2022:1940) also asserted pamphlets are an effective medium to disseminate information as youths and the general public reacted positively to this medium in their study.

Thus, the Department of Health and the Department of Communication and Digital Technologies should collaborate and ensure appropriate communication networks are created. Furthermore, collaboration between mental healthcare coordinators and the Department of Health will help ensure effective communication through media sources.

- Roadshows and awareness campaigns

Roadshows and awareness campaigns are some strategies that can be used to reach the community and inform them about the delivery of mental health services. The whole process of promoting mental health through roadshows and campaigns begins with an

assessment of the need for the event, followed by planning and implementation, which involve participation by stakeholders. This process requires self-confidence and interpersonal and communication skills. In the future, the distribution of pamphlets during roadshows or campaigns will form part of the event as an additional means of disseminating mental health information to the community.

Participants identified self-help skills and other mental health activities as mechanisms that could contribute to the continuity of care and consequently promote mental health. Furthermore, findings revealed that participants supported the importance of mental health activities by indicating that families and communities received support during family day meetings and changed their views of mental illness. Family conferences, open days and mental health awareness days are events that could be used to promote mental health.

This view is supported by Meijer et al. (2019:464), who profess mental health activities are beneficial since various family groups get involved to ensure the accessibility of information and create learning platforms for professionals, MHCUs and families. Therefore, the Department of Health, together with management, should ensure social support by funding activities that promote individuals' knowledge about mental health.

- Mental health education

Mental health education is essential as a source of information and changes individuals, families and communities; insights regarding mental health issues (Uys & Middleton 2014:246). Furthermore, the prevention of mental illness is emphasised, and education enhances individuals' understanding, knowledge and ability to manage daily problems effectively. Meanwhile, families and communities manage challenges related to mental illness responsibly based on the mental health education they receive (Uys & Middleton 2014:247).

A lack of mental health knowledge among fellow MHCPs, MHCUs, families and the community was cited several times by MHCPs in this study. Misconceptions about mental health issues and non-compliance were identified as the main factors signifying a need for improved mental health education.

In line with these findings, Gonzalez and Benuto (2022:852), whose study aimed at minimising stigma and increasing knowledge about mental health issues, noted that older adults attributed mental health challenges to witchcraft or bewitchment. In a study conducted by Perez-Florez and Cabasa (2021:437) to examine the effectiveness of mental health literacy and stigma interventions, findings revealed that interventions such as mental health education improved knowledge of mental disorders among mentally ill individuals. Hence, mental health education is one of the strategies that could promote social support for afflicted individuals.

Meanwhile, education at this juncture requires advocacy for services, where the MHCU and family or guardians are recognised as being more than recipients and are involved in decision-making. According to Charmaz (2014:96), a proponent of grounded theory, being attentive to an individual's language and meaning is of paramount importance. Hence, in terms of mental health education, clarity in terms of terminology is crucial, as in Western language, the meaning of a particular concept may be different from the African perspective or other points of origin (context). Thus, language should be contextualised depending on MHCUs' place of origin or location to achieve objectives.

The approaches that should be used to deliver mental health education are total population, milestone, gatekeeper, community and high-risk approaches. The benefit of these approaches is that people belonging to a particular group receive mental health education concerning their needs. In this study, varied approaches to mental health education assisted healthcare providers in planning and targeting relevant groups. Teaching strategies such as lectures, presentations, demonstrations and social talks could also be used to deliver mental healthcare messages.

- **Capacity-building**

Capacity-building is used to improve an individual or organisation's capability, aiming to yield better results. Adequate support, mentoring and teaching lead to a skilled and knowledgeable individual with clear direction in handling areas that require development. Training and in-service education are capacity-building strategies and are discussed below. In this study, findings revealed that for MHCPs and CHWs to provide mental health education as a mechanism to promote MHCUs' social support, they should also be capacitated themselves; hence, the introduction of training in relation to mental health.

These findings resonate with existing research; Smith et al. (2019:200) revealed a lack of training, exposure to issues tailored to the LGBT community and readiness to learn about the provision of care for the LGBT community among care providers. Additionally, Willems et al. (2021:6) concur a gap in mental health service provision exists, and they recommend that CHWs undergo training to increase their basic knowledge and ability to recognise mental health problems.

- Training and in-service education

Ongoing staff development is an essential organisational element and symbolises growth and maturity. It ensures employees are kept abreast of new developments. In this study, training and in-service education for mental health staff members expanded their knowledge and thus strengthened the social support structures that were already in place. Additionally, police officers should also undergo training through workshops on how to handle MHCUs, as stipulated in section 40 of the MHCA.

- Formal training

In order to execute this activity, some MHCPs receive training on mental health from experts and then train MHCUs, CHWs and police officers at all health establishments and local police stations attached to the hospital. Training for MHCPs, in accordance with the developed framework, shall mean mental health information has been received, and information has been internalised. Thus, trained MHCPs are competent and ready to empower informal agents such as traditional and religious healers, traditional authorities, and other community leaders.

Formal education and training success depends on the efficacy of the facilitation; hence, individuals who facilitate learning require facilitation skills such as the ability to set goals, neutrality, encouragement, preparedness, flexibility, and time management. The individual should possess personal attributes such as experience in writing and delivering training, excellent communication skills, presentation, interpersonal and management skills in order to be an effective facilitator. Meanwhile, the Department of Health's focus on supporting MHCUs relates to the allocation of an appropriate budget for MHCPs to ensure effective social support is provided.

In-service education should be used to revive and emphasise the mental health information received. Meanwhile, ongoing training, especially in the form of workshops, could ensure that MHCPs are kept abreast of new developments, such as reviewed mental health policies and procedures.

- Informal training

In this study, informal training entails imparting facilitation skills to the key figures who are in a position to educate MHCUs, families, guardians and the community on mental health issues. Training on mental health conditions that are tailored to informal agents' level will benefit MHCUs, families, and communities as MHCPs may not be in a position to reach all community members. Some MHCUs and families also consult traditional healers; therefore, mental health education could be provided during such consultations. Moreover, the mutual contribution of mental health information is recognised in this study; therefore, the two-way principle should be applied, suggesting the traditional healer's knowledge should be recognised. However, awareness regarding traditional medicine dosages and some traditional actions, especially tools used during some rituals that may be detrimental to the health of the MHCU, must be highlighted. Mental health education should be provided during tribal authority meetings and at political, church, and other community gatherings, as the majority of key figures at these events would have received training.

- **Community engagement**

According to Uys and Middleton (2014:247), behavioural change seldom occurs if people do not have an opportunity to participate in related discussions. Community members understand their challenges better than primary care providers and healthcare providers from external institutions. Therefore, information regarding the status of the community can be readily found from community members through community assessments and other forms of engagement. Therefore, while the main goal of this study was to encourage social support for MHCUs and families or guardians, community engagement is also of great importance. A rehabilitated MHCU who is integrated back into the community, usually called a mental health ambassador, could help steer the community engagement process.

Community engagement is of utmost importance, given the findings of the study. Participants raised concerns regarding communities' mental health knowledge, indicating that there is a lack of understanding regarding mental health, which calls for health education. In line with these findings, Arriola-Vigo et al. (2019:715) found workshops and campaigns yielded positive results and were essential to educate MHCUs and the community about the promotion and prevention of mental health disorders.

The success of activities executed in the community depends largely on community members' involvement. Generally, one person or a particularly defined group cannot create social change. In this study, the developed framework will be used to identify key figures from the community and incorporate them as stakeholders to encourage social support for MHCUs. However, community participation also extends further to include ordinary members of the community. Therefore, key figures will include stakeholders and other community members involved in promoting mental health activities such as roadshows and awareness campaigns. The inclusion of ordinary members of the community will assist in uncovering hidden issues about communities' perceptions concerning MHCUs, thereby encouraging social support.

In support of the aforementioned statement, the community's involvement in caring for MHCUs was identified as an essential feature in mental health by participants, emphasising that they should try and understand that MHCUs (as others) may not be dangerous. Community members should partner with families and take responsibility for offering MHCUs employment and supervising their treatment compliance. Arriola-Vigo et al. (2019:720) similarly affirmed that community involvement in mental health (in the form of community engagement activities) automatically results in consistent and standardised services for MHCUs. This involvement also generates positive outcomes, improves efficacy and reduces mental health provision costs. Additionally, the availability of community mental health models in healthcare institutions has the potential to fight stigma and increase community involvement.

Furthermore, other forms of engaging the community include community dialogue. An opportunity to exchange information, clarify views and develop solutions for community issues needing attention among individuals from sections of the community should be created. In this study, the developed framework will encourage community dialogue,

which will allow a plan to be employed to involve community members in caring for MHCUs.

In this study, the developed framework encourages agents to be the scaffold because of their theoretical knowledge, thus offering the community members an opportunity to explore unknown mental health issues through reflection and the construction of positive attitudes and new ideas, as emphasised in constructivism (Charmaz 2014:13). The MHCP should also learn from the community members and avoid imposing their views onto the community members as mutual trust is encouraged.

- **Monitoring of mental healthcare services**

Services being delivered require monitoring to ensure activities are successfully executed. Mental health coordinators should network, engage and monitor the efficacy of activities rendered across health establishments while the mental healthcare team, in collaboration with the CHWs, monitor MHCUs' compliance with treatment and attendance of mental health services. The mental healthcare team should also follow up with newly discharged MHCUs and take care of referrals in collaboration with the CHWs.

Mental healthcare services must be monitored. The findings revealed that in some institutions, staff members lose contact with the MHCU immediately after discharge and may only be in contact again during a readmission. In support, Reid et al. (2020:56) also emphasised a need for ongoing monitoring and coordination between providers and across sectors. Participants also indicated that the systems of care were unable to provide resources and coordination (Reid et al. 2020:56). Hence, the introduction of mental health coordinators from provincial to local levels, as well as mental health teams, is vital. This category of mental health providers will facilitate communication and interaction, among other duties, in the quest to ensure stakeholders assume and fulfil their responsibilities.

Social workers from the hospitals should also network with area social workers based in the community to review social problems and conduct home visits. Home visits are not the sole responsibility of social workers, and the mental healthcare team and CHWs will also conduct home visits. Home visits allow the team and the social workers to assess the family and home environment, interfamily and neighbourhood relations, as well as

relationships within the community. Additionally, the establishment of one-on-one relationships to ensure close monitoring of the MHCU occurs during home visits, depending on the family members' availability and structure. Audits, mental health team visits and performance management systems are measures to employ while monitoring mental health services.

- Conducting audits

Mental health services should be audited following the peer-review approach to ensure suggested strategies to improve social support are effective and improve the delivery of services. Documents and stakeholders' contributions are some aspects that could be checked during audits. Planning and preparations for audits are ultimately crucial for the success of the whole activity, and an audit tool can include a rating scale or a checklist. Additionally, standard operational procedures should be made available across districts; that is, in hospitals and PHC settings, so that audits can be gauged, and the people concerned can work towards achieving set goals based on the audit outcomes.

External and internal audits can be employed, but internal audits can be biased as they may be subject to conflicts of interest. However, it can also be beneficial as the individuals concerned can quickly identify challenging areas. External audits are conducted by officials not attached to the institution and could be even more beneficial based on these officials' neutrality.

- Mental health team visits

Support visits by the mental health team to informally evaluate mental healthcare provision in institutions and the homes of the MHCUs could improve social support for MHCUs. Although the visits may be informal, individuals and institutions visited may comply better than those not visited. Mental health teams could also exchange among districts. Informal evaluations by different health team officials could promote MHCUs' social support.

- Performance management system

A performance management system is used in institutions to assess employees' performance. The aim is to identify gaps in the delivery of services and create an improvement plan in case an individual does not perform well. This type of system can

improve individuals' performance as identified challenges can be addressed by engaging the individual in a workshop. Incentives in the form of bonuses and salary increases could also be implemented and encourage employees to improve their performance since the reward is based on their score.

5.2.1.6 The outcome

Figure 5.6 depicts the outcome of the framework. According to Dickoff and James (1968a:202), a terminus, also known as an outcome, refers to the endpoint of the activity. Polit and Beck (2021:233) further describe an outcome as the results of individual patients or organisations, such as the community or society, receiving care. Additionally, Polit and Beck (2021:233) emphasise an outcome as the consequences of individual actions and behaviours, suggesting the occurrence of an activity is based on the involvement of various stakeholders to achieve a particular goal.

Figure 5.6 represents increased knowledge, divinity, life force, brightness and overall splendour (Merced Union School). This is illustrated by the yellow colour, signifying cheerfulness, awareness and energy (Colour Psychology 2022). It suggests success because of the stakeholders' collaboration and quality management based on the knowledge they acquired through empowerment and education, as indicated in the procedure (process). Additionally, with subsequent perseverance and endurance through the stakeholders' and community's hard work and persistence in the execution of mental health activities, effective social support will ensue, resulting in MHCUs (primary recipients) and families or guardians (secondary recipients) feeling well supported. Consequently, continuity of care is promoted.

Figure 5.6: Outcome

In this study, an interplay of stakeholders and other agents is required to ensure appropriate social support for MHCUs. The aspects described below serve as evidence of an effective and efficient social support system to promote continuity of care for MHCUs:

Findings revealed fragmented mental health services across institutions. Some participants indicated a lack of continuity in reports, especially during discharge. Others raised concerns regarding the inability to trace MHCUs and indicated that they only learn about an MHCU's whereabouts after readmission. Therefore, efforts by management, stakeholders and the community, as suggested in the framework's procedure (process), will result in a well-coordinated mental health service.

The empowerment of stakeholders (MDT members, PHC staff, CHW, traditional and religious healers, and traditional authority) and the community will lead to effective collaboration once they are more knowledgeable about mental health conditions. This attribute can contribute to an activity's efficiency and efficacy. The engagement of traditional and religious healers and authority figures will also contribute to successful social support for MHCUs to promote continuity of care. If appropriately facilitated, empowerment will result in a well-informed community. Consequently, community members' positive attitude towards MHCUs will ensue due to their acquired knowledge as well as an observation of culture that can be a hindrance if not observed by MHCPs.

Based on the above recommendations, the provision of social support could be improved and result in MHCUs and family or guardians feeling supported. This phenomenon will lead to MHCUs' commitment and willingness to comply with treatment and improve the availability of other mental health services, thus promoting continuity of care (see Figure 5.7).

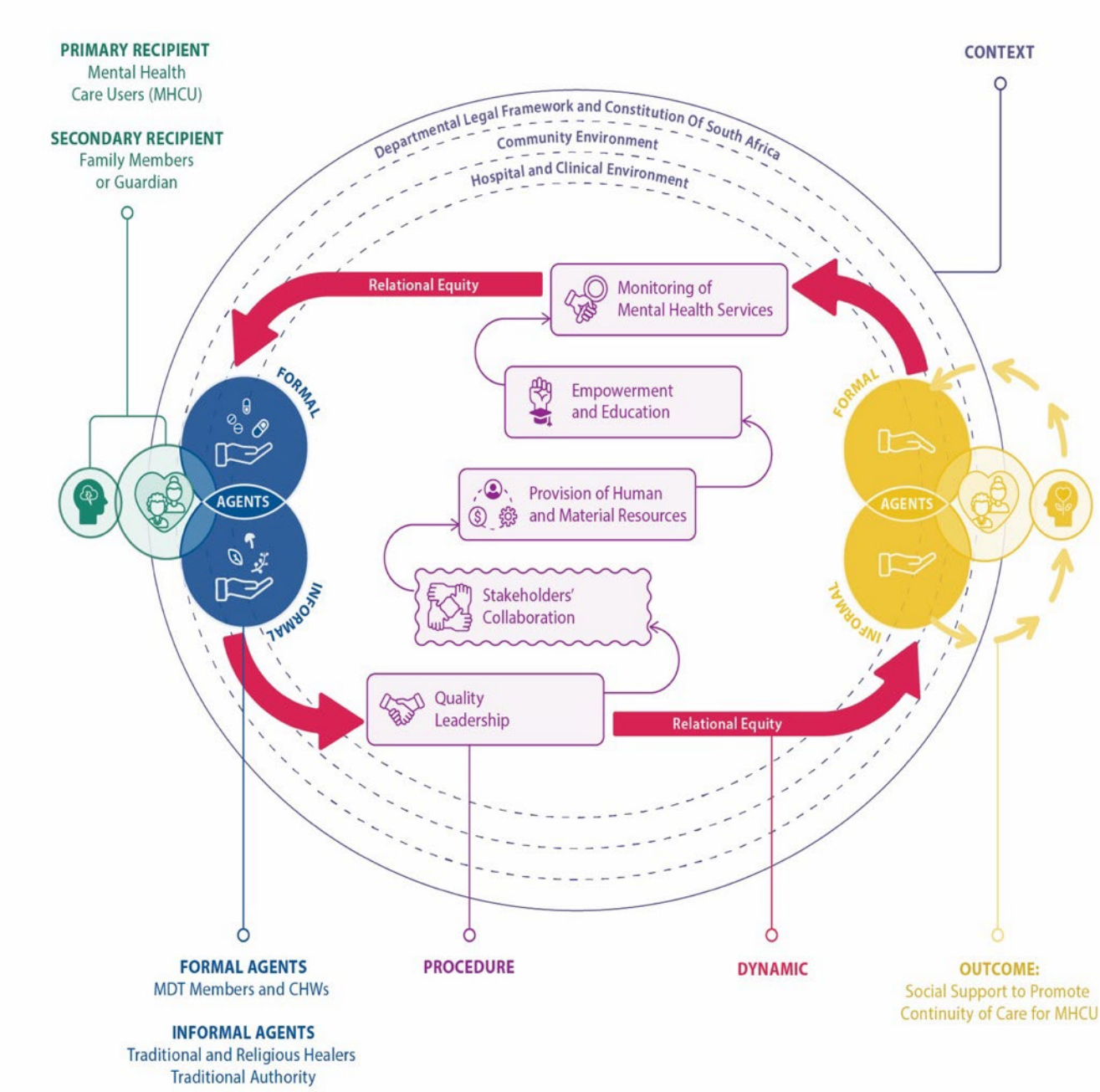

Figure 5.7: A social support framework for MHCUs to promote continuity of care

5.3 SUMMARY

This chapter outlined the conceptual framework that was developed based on the research findings. Activities were categorised using the six elements described by Dickoff et al. (1968). This discussion was followed by a description of the framework and its structures. Social support was viewed as the primary research phenomenon, and the

main aim of social support is to improve the quality of mental health services when caring for MHCUs. The next chapter discusses the framework's validation.

CHAPTER 6
VALIDATION OF THE CONCEPTUAL FRAMEWORK

6.1 INTRODUCTION

The previous chapter outlined a conceptual framework using Dickoff et al.'s (1968) six elements to describe the model and its structures. This chapter discusses the framework's validation to achieve the study's objectives, as outlined in Chapter 1. The validation process explored how the conceptual framework was structured, the various concepts, and their relatedness. A justification for the study is also provided.

6.2 VALIDATION OF THE FRAMEWORK

Validation entails evaluating a framework's appropriateness in accordance with what is known about the system of the framework, and sufficient results can serve as a solid basis for decision-making (Vemer, Ramos, Van Voom & Feenstra 2016). Creswell and Poth (2018:254) explain validation as a broad understanding of traditional and contemporary perspectives essential for informing a researcher's work. Furthermore, it encourages the researcher to provide an opportunity for other voices to reflect on the work done in an unmediated way.

Additionally, ethically, validation allows the researcher to question underlying moral assumptions related to the framework, political and ethical implications, and the equitable treatment of diverse voices (Creswell & Poth 2018:257). Validation in qualitative research (including frameworks) promotes the emergence of new possibilities, opens up new questions and stimulates new dialogue, thereby adding transformative value, leading to action and change. To that end, the researcher engaged experts and stakeholders in validating this study's framework. As Creswell and Poth (2018:258) profess, written accounts of a document resonate with intended audiences and must be compelling, powerful and convincing. The researcher thus exposed the framework to critical reflection of the concepts in terms of relationships and structure.

Chinn and Kramer (2022:170) state that exposure to critical reflection assists researchers in determining how well their framework relates to practice, research or educational activities. Furthermore, they emphasise the importance of critically reflecting on a framework and explain that, during this period, associates form ideas about questions to ask and responses that are generally acceptable and valuable for the discipline. The rationale for validation entails recognising problems about future use and promoting engagement in corrections, especially when the source of the concept's clarity is understood.

According to Risjord (2018:1), theories are central to scientific understanding as they unravel comprehensive patterns in an attempt to explain them. This process assists researchers in seeing relationships among phenomena that might seem disconnected and also assists in developing effective interventions. Thus, it becomes crucial to understand what a given theory attempts to explain about the way things work and how it might be clinically useful. Therefore, with this background knowledge, a new phenomenon comes with questions trying to position itself in theories. In order to respond to the questions, criteria that evaluate or validate the framework are then applied.

For this study, the conceptual framework was presented to experts and stakeholders for evaluation and validation. Experts and stakeholders included a deputy director (mental health coordinator), nurse managers, operational managers, psychiatric nurses, social workers, occupational therapists, clinical psychologists, a psychiatric nursing science lecturer from a university, and psychiatric nursing science lecturers from a college. Generally, frameworks are evaluated or validated to identify concepts the framework consists of, the relationship among them, and its structural form. However, for this study, the panel also focused on identifying problems concerning the framework's future use. This was followed by the researcher engaging in corrections, where applicable.

Pragmatic and epistemic criteria were applied. Pragmatic criteria are concerned with the model or framework, content, and the researcher, whereas epistemic criteria evaluate a model based on scientific knowledge (Risjord 2018:7).

6.2.1 The pragmatic criteria of evaluation

According to Risjord (2018:7), the pragmatic criteria seek to explore whether a model is good for the research field based on its usefulness, abstraction and values.

6.2.1.1 Usefulness

The framework's evaluation is preceded by getting clarity concerning what the researcher is trying to address with the developed conceptual framework (Risjord 2018:7). Thus, the conceptual framework in this study attempted to respond to the research question that concerns social support for MHCUs to promote continuity of care, as outlined in Chapter 1. To respond to the question, the conceptual framework outlined stakeholders (both formal and informal) and activities that should be executed. The clarity of activities outlined in the conceptual framework will likely create change as it directs stakeholders to the type of activity to be performed, when to execute it, and how.

6.2.1.2 Abstraction

The criterion of usefulness concerns the manner in which the conceptual framework answers the research question and gives rise to two further pragmatic evaluation criteria: the criterion of abstraction and value (Risjord 2018:8). The criterion of abstraction focuses on whether the conceptual framework ignores something important; it entails checking whether all parts of the developed conceptual framework are considered. However, because abstraction is a criterion discussed under usefulness, the whole process of checking for any tendencies of ignorance occurs as the researcher attempts to answer the research question, as outlined under the usefulness criterion. Therefore, the framework is not good for the research field if abstraction exists. In this case, other frameworks must supplement the framework to cover any missing dimensions (Risjord 2018:8).

For this study, the developed conceptual framework covered all essential features that address the research purpose (the context and situations, where useful), the concepts, definitions, relationships and the structure (Chinn & Kramer 2022:160). Experts and

stakeholders confirmed that the conceptual framework did not ignore any essential features.

6.2.1.3 Values

This criterion attempts to rationalise the value embedded in a framework. In support of the criterion's application, Risjord (2018:8) emphasises that researchers do not choose values in a vacuum, isolated from criticism. Instead, presenters raise questions in an attempt to defend the credibility of the information presented, reasons to substantiate the value in question, and the root of originality, which means they follow the path shared by fellow researchers in the field, healthcare providers or even the community, trying to fit the findings into the body of knowledge already in existence. In this study, experts and stakeholders concluded the framework adds value to all spheres since the concepts, definitions, and purposes were empirically accessible (Chinn & Kramer 2022:176).

6.2.2 Epistemic criteria of evaluation

The epistemic criteria focus on the accuracy and reliability of a framework, attempting to assess the existence of the elements in relation to the phenomenon as depicted in the structure and their interactions. This entails understanding how testable the framework is and considering its usefulness. Furthermore, the extent of robust interventions, a characteristic of accuracy in terms of measurement, is invited during the application of the criteria to determine credibility. Comparison is also considered during the process of checking accuracy and reliability. Some form of operationalisation should exist for a particular attribute to be accurate.

6.2.2.1 Operationalisation

Accuracy and reliability are a result of a tested framework, indicating whether the elements postulated exist and whether they interact in the way proposed by the framework (Risjord2018:8). Risjord (2018:8) states that, in order to make a clear observation that a framework is inaccurate, there should be some form of operationalisation. Operationalisation entails finding something observable that correlates with the elements in the framework and their properties (Risjord 2018:8). In

this study, the concepts used in the development of the conceptual framework were observable. Also, the elements were assessed using a questionnaire and were found to be measurable.

6.2.2.2 Precision

Precision refers to predictions about how a change in one element will correlate with a change in another. When a framework is tested, the evaluator will determine whether the modelled phenomenon behaves as the model says it does. This explains the model's support of predictions about how changes in the elements cause changes in the larger whole of the framework (Risjord 2018:8). The elements, as depicted and outlined in the framework, correlate well with one another, and a change in one element is likely to affect the others, and then the framework as a whole. Thus, the framework can be tested with expectant results; no vagueness has been noted.

6.2.2.3 Empirical support

Empirical support entails that when a framework has been operationalised and is precise, a relevant test would measure or observe whether the elements change in the way the framework predicts. Thus, empirical support entails exposing a framework to a direct test. However, an intervention inspired by the framework is typically not a direct test and offers only weak, indirect support (Risjord 2018:8). Thus, an intervention is considered a direct test only if it is capable of manipulating elements postulated by the framework and is used to determine whether the phenomenon changed in the way predicted (Risjord 2018:8). In this study, the framework has not been subjected to testing; therefore, it is difficult if not impossible to describe its relevancy to empirical support.

6.2.2.4 Theoretical support

The epistemic support of a framework is also drawn from scientific knowledge. Researchers believe that the scientific knowledge added by their contributions will fit together into a perfect whole. Moreover, accuracy is confirmed when evidence from other domains shows that the elements and relationships exist. This is considered theoretical support for the model or framework (Risjord 2018:9). For this study, the framework drew

epistemic support from current scientific knowledge. Concepts were described based on recent literature and descriptive data outlined in Chapter 5.

The pragmatic and epistemic criteria attempted to outline the framework's detailed theoretical relevance. These criteria explicitly explained concepts in the framework based on their usefulness, abstraction, values, operationalisation, precision, and empirical and theoretical support, presenting an understanding of the framework based on broad scientific knowledge.

Risjord's (2018) aforementioned criteria assisted in analysing and evaluating the phenomenon. Chinn and Kramer (2022:170) focused mainly on the structure of a framework; hence, the researcher further exposed the framework to their criteria to validate it by posing the following questions:

How clear is the framework?
How simple is the framework?
How general is the framework?
How accessible is the framework?
How important is the framework?

6.2.3 How clear is the framework?

According to Chinn and Kramer (2022:171), clarity entails how well the theory can be understood and how consistently ideas are conceptualised. Clarity encompasses semantic clarity and semantic consistency, which entail an understanding of concepts' theoretical meaning. Conversely, structural clarity and structural consistency address the clarity of the concepts in a theory or framework but attempt to reflect connectedness within a theory or the whole of a theory. In this study, semantic clarity, semantic consistency, structural clarity and structural consistency were considered determinants of clarity and applied to understanding the framework (Chinn & Kramer 2022:171).

6.2.3.1 Semantic clarity

Semantic clarity refers to explicitly defining concepts within a theory (Chinn & Kramer 2022:171). Definitions of concepts are important aspects of semantic clarity as empiric meaning within a theory is established, suggesting less defined or unidentified concepts result in empiric indicators becoming less clear. Clarity further implies when two individuals read the theory, similar empiric images should emerge (Chinn & Kramer 2022:171).

The use of common language often leads to concepts' clarity being obscured. Hence, in this study, the researcher used concepts with a common meaning in the profession, thereby avoiding ambiguity. Furthermore, diagrams are simple, suggesting clarity of ideas in the framework that enhances understanding (Chinn & Kramer 2022:172).

6.2.3.2 Semantic consistency

Semantic consistency refers to clarity in terms of the concepts used based on their definitions. A theory with inconsistently defined concepts gives competing messages about its meaning (Chinn & Kramer 2022:172). Sometimes concepts are well stated, but the original meaning from the theory is conveyed differently, suggesting inexplicitly defined concepts lead to alterations of meaning and give rise to inconsistency from one instance of use to the next (Chinn & Kramer 2022:172). In this study, the researcher used concepts in a way that is consistent with their definitions to combat alterations of meaning while in use (Chinn & Kramer 2022:172).

6.2.3.3 Structural clarity

Structural clarity refers to how identifiable and apparent the connections and reasonings are within a theory (Chinn & Kramer 2022:173). In this study, conceptual linkages were used so that the descriptive elements of the structure and relationships provide important information on addressing the dimensions of clarity. Thus, coherency in the interconnection and organisation of concepts is apparent, resulting in a framework whose conceptual network is readily identifiable and recognisable (Chinn & Kramer 2022:173).

6.2.3.4 Structural consistency

Structural consistency entails consistency in a structural form's use in a theory. A theory can be built around one main structural form, such as a form that differentiates concepts, structures concepts linearly, or structures concepts in a hierarchy. Sometimes, one form applies to the overall general profile for major relationships, while minor components of a theory take a different form (Chinn & Kramer 2022:173). In this study, the structures used to link concepts and relationships were consistently applied throughout the framework to serve as a structural map that enhances clarity (Chinn & Kramer 2022:173).

6.2.4 How simple is the framework?

Simplicity relates to the number of elements presented within a descriptive category, the concepts, and their interrelatedness (Chinn & Kramer 2022:174). Complexity relates to conveying many theoretic relationships between and among numerous concepts. In this study, the framework serves as a structural representation of a theory's evolvement from a state of complexity to simplicity, as is the case in grounded theory (Chinn & Kramer 2022:174; Charmaz 2014:1). The specific number of concepts was used with caution to counteract theoretical complexity and simplify the theory, thereby reducing the chances of confusion (Chinn & Kramer 2022:174).

6.2.5 How general is the framework?

A theory's generality entails the breadth of scope and purpose covered by the theory (Chinn & Kramer 2022:174). A general theory can be applied to many situations, but specific theories have limitations. In this study, the scope of concepts and purposes within the framework provided clues concerning its generality and thus encompassed more empirical indicators. The broad scope and purpose of the framework enabled the concept of social support to be understood from a broader perspective (Chinn & Kramer 2022:174). In essence, the conceptual framework that was developed can be transferable to other areas with similar contextual backgrounds.

6.2.6 How accessible is the framework?

Accessibility addresses the extent to which the empirical indicators of the concepts can be identified, and the purpose of the theory can be accomplished. The extent of the relationship, coupled with the connectivity between empirical indicators and concepts, as well as the clarity of the theory's purpose, indicates the concepts' practicality in clinical practice. A theory with concepts that lack empirical dimension tends to be ideas that cannot be understood empirically, suggesting the theory is inaccessible in practice (Chinn & Kramer 2022:175).

In this study, the concepts are empirically accessible, thus serving as a basis for validating conceptual relationships and making use of the framework in practice. Additionally, the framework's purpose is to enhance social support by addressing present mental health practices, so the concepts are applicable in the clinical area (Chinn & Kramer 2022:175).

6.2.7 How important is this framework?

The importance of a theory in nursing relates to its clinical significance or the value it adds. An important theory anticipates the best results, is usable in practice, education and research, and is valuable for creating a desired future (Chinn & Kramer 2022:176). In this study, the framework consists of concepts, definitions and purpose rooted in practice as evidenced by the empirical dimension. Hence, it serves as a guide in practice, education, and research (Chinn & Kramer 2022:176).

6.3 METHODOLOGY FOR THE VALIDATION PROCESS

6.3.1 Sampling

A qualitative non-probability convenience sampling method was used to sample validation participants, a technique that involves readily available participants (Brink et al. 2018:125). Of the 20 (100%) participants, 16 (80%) were professional nurses and constituted a deputy manager (mental health coordinator), nurse managers, operational managers and psychiatric nurses. Other participants included allied health professionals (social workers, occupational therapists, and psychologists). These professionals are in

constant contact with MHCUs, families or guardians and community members, reflecting their suitability to validate the framework. Health professionals were appropriate to include in the validation process as the framework concerns their area of expertise. This view is supported by Chinn and Kramer (2022:177), who claim a theory needs to be examined based on its use, and this approach requires an understanding of the area of expertise (practice), processes of description, and critical reflection.

6.3.2 Data collection

According to Brink et al. (2018:31), the ethical principles of voluntary participation and protecting the participants from harm are formalised in informed consent. Additionally, voluntary consent is obtained when the participants understand the informed consent form. Thus, after reading it and confirming they understood the content, the researcher invited the participants to sign the consent form. None of the participants was coerced to participate in the framework's validation.

The background information on validation, including the reasons thereof, was presented to the experts and stakeholders using PowerPoint. A brief explanation of the components was also outlined, emphasising the concepts and their interrelatedness. This was followed by a presentation of the framework's structure in its original form without any influence from the researcher.

The conceptual framework was presented to the panel of experts as well as stakeholders to validate based on its simplicity, exactitude, suitability and applicability. The participants had an opportunity to seek clarity about the framework. A questionnaire comprising two sections (demographic data and data distribution; see Annexure E) was distributed for the framework's validation.

Chinn and Kramer (2022:194) explain that theoretical and conceptual relationships are validated by creating a mapped design that verifies the descriptive and explanatory powers of the designated relationship. Participants were advised to complete the questionnaire without discussing it with each other. Twenty questionnaires were completed and submitted to the researcher.

6.3.3 Results of the framework's validation

Table 6.1: Demographic profile of the experts and stakeholders who validated the framework

Participant details	Number of participants	Number of participants in percentage (%)	Qualifications
Deputy director (Mental health coordinator)	1	5	- M (Cur)
Nurse managers	2	11	- M (Cur), - Diploma in Nursing (General, Psychiatric, Community) and Midwifery)
Operational Managers	9	47	- M(Cur) in mental health nursing, - B(Cur) - Diploma in Nursing (General, Psychiatric, Community) and Midwifery)
Psychiatric nurses	2	11	- Diploma in Nursing (General, Psychiatric, Community) and Midwifery
Social workers	2	11	- Master of Public Management -BSW (Social worker)
Occupational therapist	1	5	- BSC Occupational Therapy, P. Diploma in Public Health
Clinical Psychologist	1	5	MSc Psychology
Psychiatric nursing science lecturer (university)	1	5	D (Cur)
Psychiatric nursing science lecturers (college)	2	11	-P. Diploma in Public Health -Diploma in Nursing (General, Psychiatric, Community) and Midwifery

Table 6.2: Section B: Data distribution

	AGREE		DISAGREE		COMMENTS
	F	%	F	%	
1. Did the framework trigger something in your mind when you first saw it?	20	100	-	-	Well presented
2. Is the framework easy to understand?	20	100	-	-	Well presented
3. Are there parts that confuse you?	3	15	17	85	Misinterpretation of pictures
4. Can the framework be made clearer?	6	30	14	70	Pictures not clear
5. Do you think the framework does a good job of showing what it is supposed to?	20	100	-	-	Well presented
6. Is there anything important missing or not given enough attention?	1	5	19	95	Add interdepartmental stakeholders' collaboration
7. Do you think the framework clearly shows the important parts and how they relate to each other?	20	100	-	-	Well presented
8. Are there parts that need more detail?	5	25	15	75	Add evaluation to monitoring as well as interdepartmental collaboration to the process
9. Do you think this framework can be used easily in real-world situations?	20	100	-	-	Well presented
10. Do you think problems can arise while the framework is in use?	1	5	19	95	Add interdepartmental to stakeholder collaboration to

	AGREE		DISAGREE		COMMENTS
	F	%	F	%	
					deal with challenges relating to those departments

In addition, three open-ended questions were added:

- How can we make it easier to use?
- What are the top three changes you would make to improve the framework?
- Is there anything else you would like to say about it?

6.3.4 Responses to the framework's validation

Table 6.2 shows responses to the framework's validation questionnaire. Of the 20 (100%) participants in this study, one (5%) was a deputy director (mental health coordinator), two (11%) were nurse managers, nine (47%) were operational managers, two (11%) were psychiatric nurses, two (11%) were social workers, one (5%) was an occupational therapist, one (5%) was a clinical psychologist, one (5%) a psychiatric nursing science lecturer from a university, and two (11%) were psychiatric nursing science lecturers from a college.

Moreover, the majority of the participants (n=17; 85%) were professional nurses (psychiatric trained), some with advanced psychiatric nursing as an additional clinical qualification, while others held an additional academic qualification within the health sector. Fourteen (70%) held a managerial position within the health sector, and four (15%) were allied professionals.

The participants' feedback on the developed framework indicated that 15 (75%) agreed on its clarity; however, five (25%) were not satisfied with visibility, alluding to an increase in font size to make pictures clearer, thereby preventing misinterpretation.

The researcher acknowledges their feedback and recognises the importance of clarity in the framework's presentation, as well as the diverse perspectives of the audience. This step is crucial in refining academic discourses, ensuring that frameworks are communicated effectively and resonate with varied audiences.

The researcher accepted the inherent limitations posed by PowerPoint slides. This constraint significantly impacted the amount of information that could be presented without compromising the design's integrity and readability. While increasing the font size could enhance visibility, it would have necessitated a reduction in content or an alteration in the design's layout. Such changes could potentially lead to a more cluttered and less effective presentation.

The researcher also reflected on the challenge of presenting complex information in a visually clear and uncluttered manner, especially when confined to a standard paper size. The researcher had to prioritise the most critical elements of the framework for inclusion in the design, striving to strike a balance between being informative and maintaining visual clarity.

In future, the researcher will also consider alternative formats and supplementary materials to address the visibility issue. Explorations into the use of digital formats, larger posters, or additional handouts were suggested as potential ways to circumvent the limitations of an A4 layout.

All the participants (n=20; 100%) agreed on the simplicity of the framework, indicating that the framework is easy to understand; 17 (85%) agreed on the breadth of the scope and purpose of the concepts in terms of social support, alluding to the generality of the framework, while three (15%) disagreed. In terms of accessibility, 20 (100%) indicated the framework is accessible, alluding to empirical accessibility (practicality); 19 (95%) agreed that the framework is important and will add value to the promotion of mental health, while one (5%) disagreed.

Generally, one participant suggested an algorithmic form to make the framework easier to read and recommended that stakeholders' collaboration be divided into two, that is,

interdepartmental and interdisciplinary. The use of technology to allow changes for improvement in the future was also advised.

In answer to the question of whether respondents had any additional comments about the framework, they indicated that the framework was good, well presented, and easy to understand, with adequate information to improve service delivery. Additionally, the framework will encourage the government to provide human and material resources and take mental health services seriously.

Moreover, all the respondents (n=20; 100%) agreed on the framework's implementation and indicated it would contribute to improved social support for MHCUs. As a result, continuity of care will be promoted, thereby enhancing mental healthcare services in terms of care, treatment and rehabilitation. Therefore, it can be concluded that professional nurses and allied health professionals accepted the developed framework. The professional nurses' and allied health professionals' responses revealed that the social support framework for MHCUs to promote continuity of care could be implemented in mental health institutions and PHC settings. Therefore, the study's assumption is that this newly developed framework could provide substantial insight to improve mental healthcare services.

6.4 JUSTIFICATION OF THE ORIGINAL CONTRIBUTION OF THE STUDY TO THE BODY OF KNOWLEDGE

The study's findings point to a current inadequacy of social support for MHCUs. A conceptual framework was developed to inform the community about MHCUs' needs and encourage social support. Evidence that this study is an original contribution to the body of knowledge follows.

The context draws a distinction between this study and other studies that focused on the same phenomenon. Thus, any other frameworks addressing this phenomenon do not represent the study's findings because the study is grounded in social constructivism, which is rooted in context. The setting (context) where the study took place is rural areas in a province situated in South Africa, a developing country, suggesting the findings are not limited to Limpopo province but can apply to other provinces as the country's rural

population is estimated at 31.67% (Global Economy.com 2022). Furthermore, this is the first study to follow the grounded theory approach in conducting research in rural areas, which adds to the findings' credibility in terms of context.

Communities' cultural and religious environments form part of the context, suggesting the community is not solely defined in terms of the recipient; rather, it is contextualised, meaning the community forms part of the context. Generally, the hospital and PHC settings would be considered the context as these areas are relative to the phenomenon in terms of data collection. However, the findings revealed that the community is not a subsection of a particular component, but a component in itself, prompting the researcher to consider it part of the context. The traditional authority was identified as an important community influencer (stakeholder) in promoting social support for MHCUs in addition to the known traditional and religious healers researched in terms of social support. Community engagement, a concept evolving from research engagement, is another aspect that literature has not recognised in changing societal perspectives about social support. Community engagement entails involving the community in MHCU activities, a powerful tool to win community participation in mental health provision.

The study's findings alerted the researcher to view the notion of a recipient differently. Initially, the participants and researcher considered the family or guardian a support system for the MHCU. However, it became evident that the family is also a recipient of mental health services, meaning the two parties influence one another and are at the same level, since both lack theoretical knowledge regarding mental health issues and are dependent on MHCPs for this information.

Constructivism, the paradigm underpinning this study, emphasises that people from the same context have more influence on one another, meaning a change in one person will influence another (that is, MHCUs and families or guardians); hence, both were considered recipients. A need for the application of one-on-one engagement as a strategy to encourage support emerged during the study and is endorsed by the framework, suggesting this strategy should be established and considered one of the key support systems. Traditional stakeholders' roles were clarified and endorsed by experts during the framework's validation after a gap was identified in previous research studies on social support, thereby minimising confusion about the care of an MHCU. Traditional

healers thus help discern whether the MHCU should settle for Western or traditional medicine.

6.5 SUMMARY

This chapter discussed the validation of a social support framework that was developed. Participants responded to questions after critically reflecting on the process of developing a framework. The chapter also presented the participants' comments, since the questionnaire was presented to experts in the subject matter and stakeholders. The next chapter offers a summary of key findings, limitations of the study, conclusion, recommendations and the researcher's personal reflections.

CHAPTER 7
SUMMARY OF KEY FINDINGS, LIMITATIONS, CONCLUSION, RECOMMENDATIONS AND PERSONAL REFLECTIONS

7.1 INTRODUCTION

The previous chapter discussed the framework's validation by experts and stakeholders. This chapter summarises the key findings, limitations, conclusion, recommendations and the researcher's reflections.

7.2 RESEARCH DESIGN AND METHODS

A constructivist, grounded theory approach was used in this study. The approach allowed the researcher to move beyond explanations and develop a theory grounded in data from the participants' experiences. Furthermore, the grounded theory entails various systematic yet flexible steps guiding the researcher in collecting and analysing data; this strategy assisted the researcher in staying focused (Charmaz 2014:3). Consequently, the findings from the collected and conceptualised data, as described in Chapters 4 and 5, helped the researcher remain immersed in the data. Additionally, grounded theory offers tools for conducting successful research (Charmaz 2014:3). In this study, the approach allowed the researcher to delve deeply into the subject matter and present the information required to offer adequate social support to MHCUs and families or guardians. Data were collected from professional nurses, social workers and MHCUs using face-to-face semi-structured interviews. A thematic analysis was used to analyse the collected data. The researcher strived for excellence by ensuring rigour throughout the study.

7.3 SUMMARY OF KEY FINDINGS

As an introduction and orientation to the study, Chapter 1 gave an overview of the study, its aims and objectives, and the employed research methods. The framework's development and validation were also highlighted. However, detailed information on the study's research design and methods was outlined in Chapter 3. Moreover, the literature review (Chapter 2) served as a basis guiding the study.

The qualitative findings indicated that mental health services were being offered, but the level of execution could not yield effective social support to sustain mental health services at the expected level. Service provision fragmentation characterised mental health services. Daily mental health activities were highlighted by participants, including strategies that were employed to offer social support to MHCUs; however, due to the inadequate use of established guidelines and inadequate supervision, continuity of care was unintentionally jeopardised.

The key findings are summarised and discussed based on the study's objectives.

7.3.1 Phase one – Conduct a situation analysis

Phase one of this study was a situational analysis. The objective was to explore and describe operational managers', MHCPs' (professional nurses and social workers), and MHCUs' experiences regarding social support and continuity of care.

In Chapter 4, four themes emerged from the findings, and these were further classified into categories and codes. These themes focused on support, mental healthcare services, contemporary issues in healthcare, and moving forward to support MHCUs.

In this study, MHCPs (nurses and social workers) indicated that home visits, periodic reviews and follow-ups were conducted; CHWs were the category of service providers that most often conducted home visits. The study's findings revealed inadequate social support by MHCPs for MHCUs and families or guardians in this area. As a result, the majority of MHCUs performed mental health activities on their own, suggesting inadequate supervision and family involvement. Some were rejected, neglected, abandoned, or not accepted, as evidenced by MHCUs residing alone or with a minor; one lived with a school-going child. Consequently, relapses and readmissions ensued.

These challenges occurred due to inadequate home visits and appropriate follow-up care. Therefore, mental health services should be audited following the peer-review approach. Mental health teams' informal or formal visits should also be reviewed to informally evaluate mental healthcare provision in the institutions and MHCUs' homes. These

evaluations could ensure that the suggested strategies to improve social support are effective and improve the delivery of mental health services.

Furthermore, findings highlighted that stigmatisation and discrimination against MHCUs, family members or guardians was attributed to a lack of support from community members, who had insufficient knowledge regarding mental health. This phenomenon resulted in isolation, compounded by a lack of relationships with friends. These findings suggest a lack of community involvement in socially supporting MHCUs. Meanwhile, traditional and religious healers' involvement was evident, though relapses and readmissions were still noticed, suggesting inadequate social support.

A lack of community involvement was a significant issue contributing to inadequate social support. The cause is a knowledge deficit regarding mental health, as evidenced by misconceptions about mental health and non-compliance with treatment. Community empowerment and education form part of the procedure (process) for delivering mental health services. Therefore, mental health education should be provided to community members using roadshows, awareness campaigns, social media and community outreach programmes. Community engagement should also be employed to empower and educate fellow community members.

Additionally, findings revealed a need to address the educational gap identified among MHCPs, suggesting their inadequate empowerment in health education matters. The notion of empowerment and education thus impact formal and informal agents' level of knowledge. Therefore, all agents should undergo formal and informal training.

MHCUs' and families/guardians' lack of social support was based on inadequate rehabilitation programmes, compounded by a lack of rehabilitation centres, communication and interaction, consequently contributing to stigmatisation and discrimination in the workplace. Employers and colleagues lacked knowledge regarding mental health. Meanwhile, COVID-19, a contemporary issue in global health, also impacted mental healthcare provision. Appropriate infrastructure (by the Department of Health) for rehabilitation centres, such as halfway houses for MHCUs, will combat the rehabilitation challenge. Empowering MHCPs, MHCUs and families or guardians with

mental health information will also address the problem of stigmatisation and discrimination in the workplace, as findings indicated a need to educate all stakeholders. Findings also revealed leadership-related challenges. A shortage of human and material resources prevented MHCPs from conducting home visits and follow-ups to ensure MHCUs' progress was reviewed. Inadequate service delivery was identified as a challenge evidenced by a shortage of treatment and financial support for mental health activities and services. Inadequate support for MHCPs (from mental health coordinators and follow-up teams), availability of transfer and discharge protocols, as well as the provision of infrastructural support services were discussed. In addition, inadequate stakeholder collaboration also contributed to inadequate social support.

Quality leadership supported by the Department of Health will ensure mental health services receive the attention needed. The availability of human and material resources will address the majority of leadership-related challenges. Increased communication channels and interaction, the core of mental health coordination, should also be addressed by increasing the availability of mental health coordinators at all levels.

7.3.2 Phase two – Develop a social support framework

The objective of the second phase was to develop a social support framework for MHCUs to promote continuity of care based on the findings of the situation analysis. The attainment of the objective delineated in Chapter 5 was facilitated using the practice survey list of Dickoff et al. (1968); it served as an instrumental cognitive device in formulating a preliminary conceptual social support framework for MHCUs. This framework was instrumental in providing foundational principles and strategies that offered further insights and fostered the development of nuanced ideas on support mechanisms for MHCUs.

The constructed conceptual framework comprised six fundamental elements: the context, which encapsulates the overarching milieu within which mental health activities are situated; the Departmental of Health and the Constitution of South Africa, which provide the statutory and regulatory underpinnings for mental health practices; community environment, which represents the societal backdrop that influences and is influenced by

mental health initiatives; and the hospital and the clinical environment, which are the primary settings for the delivery of mental health services.

The activities related to mental health are housed within these environments, signifying the sites of mental health interventions. The agents of these activities are formal and informal entities, including stakeholders responsible for providing mental health services. The recipients of these efforts are the MHCUs, along with their families or guardians, who are the individuals who benefit from the social support extended by various stakeholders.

The framework's activities must be executed with procedural diligence for the recipients to benefit from mental health services. The provision of quality and ethical leadership characterises the procedure, the collaboration of stakeholders, and the allocation of both human and material resources. Notwithstanding the concerted efforts among stakeholders to provide care, the dynamic of relational equity needs attention. If neglected, there is a risk of the collapse of mental health services, which could precipitate undesired outcomes and adversely impact the quality of social support being provided to MHCUs.

A visual representation was provided to explain the conceptual framework's structure. This included a detailed description of the framework's building blocks, complemented by the presentation of a comprehensive framework diagram, thereby providing a visual synthesis of the theoretical constructs underpinning MHCUs' social support.

7.3.3 Phase three – Validate the social support framework

The objective of phase three was for experts and stakeholders to validate the social support framework. Chinn and Kramer (2022:176) advocate that after a framework's articulation, the researcher should pose incisive questions to glean insight into the framework's applicability for its designated purposes. In alignment with this recommendation, the researcher employed the evaluative criteria outlined by Chinn and Kramer (2022:176), specifically the five questions assessing clarity, simplicity, generality, accessibility and importance, to validate the framework.

The conceptual framework was scrutinised by a panel comprising experts and stakeholders. The validation process centred on the framework's structural representation, particularly emphasising its simplicity, precision, suitability, and applicability. Twenty questionnaires were disseminated among a diverse group of respondents, which included a district mental health coordinator, nurse managers, operational managers from mental health facilities, an operational manager serving as a quality assurer, advanced psychiatric nurses, psychiatric nurses, social workers, an occupational therapist, and a psychologist.

The feedback from all stakeholders was overwhelmingly positive, with unanimous agreement on the value of the framework's structural presentation. Evaluators affirmed the framework's potential to significantly bolster the social support provided to MHCUs, enhancing the continuity and quality of care. This collective endorsement by the panel of experts and stakeholders is a testament to the framework's robustness and capacity to effect meaningful improvements in the scope of mental health services.

7.4 LIMITATIONS OF THE STUDY

The Limpopo province is demarcated into five distinct districts. The scope of this study was confined to three districts, a limitation dictated by the geographical placement of mental health institutions. The research was conducted exclusively within the Limpopo province, and the sample was not extended to private hospitals that house mental healthcare units. Furthermore, the study encountered procedural delays as the acquisition of approvals from mental health institutions was protracted, necessitating the researcher to make additional follow-ups to obtain the requisite permissions, consequently impeding the study's progress.

The expansive distances between Limpopo province's districts and the separation of mental health facilities and clinics further slowed the study's advancement. During the framework's validation process, traditional stakeholders, who the researcher thought would have offered substantial contributions, were not included. Their absence was attributed to their unavailability within the timeframe allocated for the validation process. As a result, the validation exercise was circumscribed to a selection of experts and

stakeholders, thus not fully encompassing the wider spectrum of potential contributors. Some further limitations are discussed below:

7.4.1 Impact limitations

The following discussion is based on specific limitations.

7.4.1.1 COVID-19

During the data collection phase, there was a relaxation of the national lockdown restrictions, attributed to a temporary reduction in COVID-19 cases. Despite adherence to the prescribed precautionary measures against COVID-19, including wearing masks, observing social distancing, and regular sanitisation, a sense of unease persisted among participants. The interviews reflected this unease, with a pronounced focus on the pandemic.

Participants frequently cited COVID-19 as a significant impediment to effective engagement with MHCUs and their families or guardians, suggesting that the pandemic's pervasiveness was a barrier to access. Consequently, this preoccupation with the pandemic and its associated challenges may have inadvertently influenced the study's outcomes. The heightened concern over COVID-19 and its impact on the study's processes raise the possibility that the findings were, to some extent, shaped by the extraordinary circumstances imposed by the pandemic.

7.4.1.2 Access to health facilities

Access to health facilities varied significantly. The reception from nurse managers in mental health facilities and PHC settings also ranged from welcoming to sceptical. Data collection was scheduled during participants' free hours to avoid disruptions. Despite this, one nurse manager convened a lengthy meeting, delaying the participation of eager individuals, even though an appointment had been scheduled. This delay caused disappointment among participants, which may have influenced their responses and, subsequently, the study's findings.

The data collection period was intentionally brief to minimise the impact on patient care, relying solely on participants' available time. Additionally, some data collection environments were noisy due to the MHCUs' behaviour despite having a designated office for interviews. This noise could have affected the quality of the collected data.

7.4.2 Grounded theory

Grounded theory, by its nature, is an intricate and time-intensive methodology. It demands meticulous attention to numerous facets, particularly during the data collection phase. For a researcher embarking on a qualitative approach for the first time, adopting grounded theory presented an additional layer of complexity. There is a risk that certain elements may have been inadvertently overlooked or addressed only superficially due to the researcher's inexperience.

Moreover, the potential for unintentional bias is heightened when the researcher holds preconceived notions about the subject of study. Such biases could subtly steer the development of the framework (unintentionally). Recognising this, the researcher adhered to Charmaz's (2014) guidelines to uphold the integrity and quality of the research. To enhance the credibility of the finding, a core tenet of grounded theory, the following methodological practices were employed:

- Allowing the inquiry process to be guided by participant engagement, ensuring that the research remained grounded in the empirical data.
- Cross-referencing the emergent theoretical constructs with the participants' own interpretations and understandings of the phenomenon under study.
- Incorporating participants' verbatim language within the theoretical framework to preserve the authenticity of their experiences.
- Conducting a reflexive exploration of the researcher's own perspectives and insights, acknowledging their influence on the interpretation of the phenomenon.

In addition to these practices, the researcher took several procedural steps to fortify the research process. Interviews were audio-recorded to capture the full breadth of participant responses accurately. Analysis commenced concurrently with the first

interview, and reflective memos were composed following each interview session. The constant comparative analysis method was used to facilitate the generation of a conceptual framework. Finally, to ensure the framework's validity, it was presented to stakeholders for validation. These measures collectively mitigated the challenges associated with grounded theory and ensured a rigorous and reflective research process.

7.4.3 Ethical limitations

The principle of beneficence, which requires observation concerning psychological harm and other spheres of personal being, might have been contracted irrespective of the researcher's consideration of the principle indicated in Chapter 1. During data collection, some participants' colleagues and relatives survived or succumbed to the pandemic (COVID-19), and most of the participants kept referring to COVID-19 as a hindrance to the provision of mental health services, especially in the community. Commenting on COVID-19 might have affected some participants psychologically due to their proximity to those affected by the pandemic. Culturally, some individuals may not display hurt emotions; however, information on counselling was available and brought to the participants' attention during the debriefing.

Limitations and biases may affect the quality of a study. However, limitations, such as the possibility of psychological harm caused by COVID-19, were unavoidable. Moreover, despite the limitations and biases mentioned, the study's findings are consistent with global research about the need to socially support MHCUs to promote continuity of care. The framework thus adds value to the body of knowledge.

7.5 CONCLUSION

This study explored the social support phenomenon for MHCUs in three specialised mental health institutions. The study aimed to develop a social support framework to assist in optimising social support for MHCUs and promote continuity of care. Social support for MHCUs is not a new concept among stakeholders, yet the study's findings indicated inadequacy, suggesting a need for a social support framework for MHCUs to strengthen existing strategies. Additionally, most activities essential for continuity of care were either partly performed or not at all. All this prompted the researcher to develop a

social support framework to offer some direction on the execution of activities to promote MHCUs' social support.

Defaulting treatment leading to relapses and a high rate of readmissions served as a landmark for inadequacy, indicating the relevance of social support for MHCUs. The conceptual framework aims to mould the mental health system by providing additional insights regarding MHCUs' social support needs, thereby attempting to change the current social climate. Hence, the researcher's introduction of the procedure or process: quality leadership, stakeholder collaboration, the provision of human and material resources, empowerment and education, and monitoring of mental health services should direct agents in executing mental health activities. Consequently, the recipients will receive social support that will create change and subsequently promote continuity of care.

Given the process, change requires interdepartmental collaboration, especially at the managerial level. The Department of Sports and Recreation, Department of Local Government and Housing, Department of Social Development and Department of Health work together, each providing specific services to ensure MHCUs are socially supported. However, the findings revealed that a lack of social support persists, irrespective of the current strategies in place. MHCUs, family members or guardians and MHCPs were also stigmatised and discriminated against by community members and colleagues in the workplace due to their status.

This challenge might affect the MHCUs' road to recovery and can cause the MHCU to default treatment, leading to family instability, relapse and later readmission. The impact of stigmatisation and discrimination on MHCPs can also cause MHCPs to avoid working in mental health facilities, thereby compounding the shortage of human resources already in existence; hence, the researcher emphasised training for professional nurses on mental health. Moreover, participants explained mental health education was given, but a gap in knowledge was identified as evidenced by a lack of prepared lessons before educating MHCUs and engaging in initiatives to provide ongoing mental health education.

A lack of support from the MHCUs' workplace was also revealed in the study's findings. Some may have a desire to work, yet employers and colleagues may not be ready to

welcome the individual back into the work environment given their condition, and this is a serious challenge. Without gainful employment, the Department of Social Development will be forced to give MHCUs a disability grant despite their ability to work and address their daily needs. Thus, this calls for the education of MHCUs' employers and colleagues. Generally, community members and health facilities expect family members or guardians to support MHCUs. Conversely, the study's findings reflected family members or guardians were also recipients in need of social support; this responsibility was ascribed to MHCPs, with the support of hospital management. The family or guardian remains a support system due to their proximity to the MHCU. Healthcare providers, other stakeholders and community members should thus support the MHCU and their family or guardian. The mental health institutions' management should also ensure the success of mental health service provision by promoting mental health, capacity-building, communication media, community engagement, empowerment, and education for all stakeholders. The developed framework reflects interrelated concepts to help stakeholders move in the right direction towards achieving this goal.

While the political and economic background of the country may affect the delivery of mental health services, the Department of Health's directors, together with associated departments, should engage and establish better ways of delivering mental healthcare services to improve the current state of affairs. In essence, the Department of Health is a source of support with the power to run all health programmes. Thus, gaps identified in this study, such as inadequate reporting, transfer and discharge systems, call for the development and revision of protocols, procedures, and standard operating procedures related to mental health service provision. The developed social support framework for MHCUs ensured the study's objectives were met.

7.6 RECOMMENDATIONS

Social support is fundamental in the MHCUs' journey to recovery; however, it depends on the stakeholders' effective collaboration, especially in terms of communication and interaction. The main goal of social support is to ensure care, treatment and rehabilitation, which leads to recovery. Social support also indirectly influences MHCUs' quest to seek mental health services promptly, thereby preventing relapse and readmission.

In this study, findings revealed different mental health aspects were poorly executed and addressed, resulting in the inadequate provision of mental health services to MHCUs. The study unravelled issues of concern and challenges that require change in the existing system. Based on the conclusion, recommendations are provided to address the described challenges. Two main areas are considered, namely nursing practice and future research.

7.6.1 Recommendations for nursing practice

The study's findings indicated a need for improvements in mental health service provision. Therefore, recommendations are made based on the main aspects that impacted social support, including quality leadership, stakeholder collaboration, the provision of human and material resources, empowerment and education, and monitoring of mental health services. Table 7.1 outlines recommendations related to nursing practice.

Table 7.1: Recommendations related to nursing practice

ITEM	CHALLENGE	RECOMMENDATIONS
Stakeholders' collaboration	Inadequacy in terms of teamwork, engagement and networking leads to poor communication and interaction	- The mental health section at the provincial level should ensure mental health services are well-coordinated. - The availability of mental health coordinators at the provincial and district levels and local areas should be increased. - The availability of mental health teams to deal with mental health issues at the community level should be increased. - The relationship between mental health institutions and the SAPS should be strengthened. - Regular meetings should be scheduled among stakeholders and

ITEM	CHALLENGE	RECOMMENDATIONS
		between colleagues to strengthen teamwork and networking.
Provision of human and material resources	Shortage of human and material resources	- Recruit and hire relevant staff based on current health needs to ensure the smooth running of mental health services. - Ensure the availability of transport to assist healthcare providers in terms of conducting home visits, attending meetings and engaging in other mental health activities.
Empowerment and education	Inadequate staff capacitation	- Nursing education departments in mental health facilities should spearhead and promote mental health and capacity-building, as well as engage in research concerning mental health issues.
Minoring mental health services	Relapses and readmissions due to a lack of follow-up care	- Conduct audits of clinics and ensure mental health teams' visits to clinics and MHCUs' homes are evaluated.

7.6.2 Recommendations for future research

The study's outcomes underscore the imperative for further research in several key areas to enhance the efficacy of mental health service provision. These areas include:

- A rigorous evaluation of the developed social support framework to pinpoint potential enhancements that could elevate the quality of mental health services. Such an appraisal would aim to refine the framework, ensuring it is robust, responsive, and capable of meeting MHCUs' evolving needs.
- An in-depth analysis of the communication dynamics and collaborative interactions between formal and informal stakeholders. Given the delineation of roles within these

two cohorts, it is crucial to understand how these interactions can be optimised to facilitate a more cohesive and integrated approach to mental health care.

- Investigative work on the impact of empowerment and educational initiatives on the social support available to MHCUs and their families or guardians. This research would seek to determine how effectively disseminated mental health information can raise awareness and understanding of mental illness within the community.
- An evaluation of the engagement strategies and networking practices among healthcare providers, focusing on the continuity of care for MHCUs. The study's findings have highlighted service fragmentation, marked by inadequate handovers and a tendency to lose contact with MHCUs between admissions or entirely. Addressing this gap is essential for ensuring consistent and coherent care pathways.
- An exploration into contemporary communication methods to provide social support to MHCUs. Social media platforms' (such as Facebook and Twitter) potential to facilitate support for MHCUs and their families warrants investigation, considering the ubiquity and reach of these digital tools.

Each of these proposed avenues for future research holds the promise of contributing valuable insights and practical improvements to the field of mental health care, ultimately aiming to foster a more integrated, informed, and supportive environment for MHCUs and their networks.

7.7 PERSONAL REFLECTION

The study addressed the phenomenon of social support for MHCUs. Writing a proposal was challenging yet motivating as there was progress. However, the outlay of the proposal, especially the objectives across the phases, reflected the journey I was about to embark on, meaning what I had started would not be finished tomorrow. It became apparent that I was moving from the unknown to the known, and I wasn't sure I would reach this goal since I had to pave my way through till the end.

The grounded theory approach encouraged me to delve into data collection and analysis. Interviews were unique, differed from what I am used to, and the subsequent steps subscribed to the approach. Similarly, data analysis taught me a lot, and I felt compelled

to move forward. Developing a framework was a tedious yet interesting part of my study as it became apparent that I was about to reach my main objective.

My attitude during this journey was that of a finisher. However, it was not easy as I had to adjust to a new level of thinking and behaviour, especially when confronted with newly discovered research concepts or a different approach toward certain aspects. My experience in terms of my supervisor is that of a motivator to discover and learn new things that will take you to new heights depending on your availability and readiness to learn. At this juncture, I do not doubt that I was taught “how to fish and not given a fish”. I believe that all this was done to build me up as an independent researcher. My arrival at my destiny was also inspired by a desire to be a knowledgeable academician since I work in an academic field.

The study adds to the existing body of knowledge on social support and offers a new social support framework for MHCUs. In conclusion, I want to acknowledge the path I walked was unique and accomplished through the support of my supervisor, who did not solely concentrate on my academic work but also cared about my psychological health and advised me on coping strategies throughout this journey. I managed to reach my destiny.

7.8 SUMMARY

The study attempted to explore MHCUs’ social support in Limpopo province, a previously under-researched phenomenon. Findings indicated a need to socially support MHCUs exists in the area. This chapter briefly described the study’s design, methods, and findings. The process involved in developing a framework was discussed, and an outline of the validation procedure was presented. Concluding remarks and limitations of the study were drawn. Based on the findings, recommendations were provided concerning future research and nursing practice.

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ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES

REC-012714-039 (NHERC)

6 December 2017

HSHDC/820/2017
Lenny Tina Mushwana

Student No.:3162-245-3
Supervisor: Prof JE Maritz
Qualification: D Cur
Joint Supervisor:

Dear Lenny Tina Mushwana

Decision: Ethics Approval

Name: Lenny Tina Mushwana

Proposal: A social support framework for mental health care users to promote continuity of care

Qualification: **DPCHS04**

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted from 6 December 2017 to 6 December 2022

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on. 6 December 2017

The proposed research may now commence with the proviso that:

1) *The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*

2) *Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the Research Ethics Review Committee, Department of Health Studies. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150

3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

Note:
The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.

Kind regards,

Prof L.H. Roos

Prof JE Maritz
CHAIRPERSON
maritje@unisa.ac.za

Prof MM Moleki
ACADEMIC CHAIRPERSON
molekmm@unisa.ac.za

Prof A Phillips
DEAN COLLEGE OF HUMAN SCIENCES

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE B: PERMISSION REQUEST FROM DEPARTMENT OF HEALTH: LIMPOPO PROVINCE

The Head of Department
Limpopo Department of Health
Polokwane
0700

Dear Sir / Madam

Permission to collect data from selected hospitals and clinics in Limpopo Province

I am Lenny Tina Phakula; a PhD student at the University of South Africa (UNISA) conducting research entitled "A social support framework for mental health care users to promote continuity of care" under the supervision of Prof J E Maritz. I hereby request permission to collect data for my study at selected hospitals and clinics in the Limpopo Province. The aim of the study is firstly to explore the experiences of operational managers, mental health care providers, social workers and mental health care users regarding a social support for mental health care users within the context of the Limpopo province and secondly to develop a framework to promote social support and continuity of care for mental health care users. The central question that will guide the study will be: "What are the experiences of operational managers, mental health care providers, social workers and mental health care users regarding the social support of mental health care users?

Semi-structured individual interviews will be conducted with the prospective participants. Appointment will be made in advance with prospective participants who will be required to give informed consent to participate. Data from semi-structured interviews will be audio-taped and transcribed verbatim in preparation of data analysis.

I will respect the rights of participants and will inform them of their right to:
 Give informed consent in writing to participate in this study. Withdraw from the study at any time if they so wished.

 Confidentiality and anonymity and privacy.

 Ask questions and clarification from the researcher

I will respect all human rights enshrined in the constitution of this country. Participants may experience some discomfort in relation to questions asked, hence the researcher will arrange counsellors to offer counselling if the need arises. The study will benefit the province to assist in social support of mental health care users and continuity of care. I have obtained and attached an ethical clearance from the registered Ethics committee of the Department of Health Studies at UNISA.

I shall execute the study in strict accordance with the approved proposal requirements of the ethics policy of UNISA. I undertake to provide the Department with a report on completion of the study.

I trust that my application will be favourably considered.

Yours faithfully

Ms Mushwana Lenny Tina
Student Number: 3162-245-3
Cell: 083 420 5317
E-mail: phakulalt@webmail.co.za

ANNEXURE C: APPROVAL FOR THE RESEARCH – DEPARTMENT OF HEALTH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stander SS (015 293 6650)

Ref:LP_201804_009

Mushwana LT
UNISA

Greetings,

RE: A social support framework for mental health users to promote continuity of care

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 th District Executive Manager.
   - In the course of your study there should be no action that disrupts the services, or incur an cost on the Department.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

Date 23/05/2018

Fidel Castro Ruz House, 18 College Street, Polokwane Private Bag X9302 Polokwane

ANNEXURE D: PERMISSION REQUEST FROM DEPARTMENT OF HEALTH DISTRICTS: LIMPOPO PROVINCE

The District Executive Managers (Mopani and Vhembe Districts)
Limpopo Department of Health
Polokwane
0700

Dear Sir / Madam

Permission to collect data from selected hospitals and clinics in Limpopo Province

I am Lenny Tina Phakula; a PhD student at the University of South Africa (UNISA) conducting research entitled "A social support framework for mental health care users to promote continuity of care" under the supervision of Prof J E Maritz. I hereby request permission to collect data for my study at selected hospitals and clinics in the Limpopo Province. The aim of the study is firstly to explore the experiences of operational managers, mental health care providers, social workers and mental health care users regarding a social support for mental health care users within the context of the Limpopo province and secondly to develop a framework to promote social support and continuity of care for mental health care users. The central question that will guide the study will be: "What are the experiences of operational managers, mental health care providers, social workers and mental health care users regarding the social support of mental health care users?

Semi-structured individual interviews will be conducted with the prospective participants. Appointment will be made in advance with prospective participants who will be required to give informed consent to participate. Data from semi-structured interviews will be audio-taped and transcribed verbatim in preparation of data analysis.

I will respect the rights of participants and will inform them of their right to:

 Give informed consent in writing to participate in this study. Withdraw from the study at any time if they so wished.

 Confidentiality and anonymity and privacy.

 Ask questions and clarification from the researcher

I will respect all human rights enshrined in the constitution of this country. Participants may experience some discomfort in relation to questions asked, hence the researcher will arrange counsellors to offer counselling if the need arises. The study will benefit the province to assist in social support of mental health care users and continuity of care. I have obtained and attached an ethical clearance from the registered Ethics committee of the Department of Health Studies at UNISA.

I shall execute the study in strict accordance with the approved proposal requirements of the ethics policy of UNISA. I undertake to provide the Department with a report on completion of the study.

I trust that my application will be favourably considered.

Yours faithfully

Ms Mushwana Lenny Tina
Student Number: 3162-245-3
Cell: 083 420 5317
E-mail: phakulalt@webmail.co.za

ANNEXURE E: APPROVAL FROM MOPANI DISTRICT

The District Executive Managers
Department of Health (Mopani and Vhembe Districts)

Dear Sir / Madam

Permission to collect data from your institutions

I am Lenny Tina Phakula; a PhD student at the University of South Africa (UNISA) conducting research entitled "A social support framework for mental health care users to promote continuity of care" under the supervision of Prof J E Maritz. I hereby request permission to collect data for my study at your institutions. The aim of the study is firstly to explore the experiences of operational managers, mental health care providers, social workers and mental health care users regarding a social support for mental health care users within the context of the Limpopo province and secondly to develop a framework to promote social support and continuity of care for mental health care users. The central question that will guide the study will be: "What are the experiences of operational managers, mental health care providers, social workers and mental health care users regarding the social support of mental health care users?

Semi-structured individual interviews will be conducted with the prospective participants. Appointment will be made in advance with prospective participants who will be required to give informed consent to participate. Data from semi-structured interviews will be audio-taped and transcribed verbatim in preparation of data analysis.

I will respect the rights of participants and will inform them of their right to:
 Give informed consent in writing to participate in this study. Withdraw from the study at any time if they so wished.

 Confidentiality and anonymity and privacy.

 Ask questions and clarification from the researcher

I will respect all human rights enshrined in the constitution of this country. Participants may experience some discomfort in relation to questions asked, hence the researcher will arrange counsellors to offer counselling if the need arises. The study will benefit the province to assist in social support of mental health care users and continuity of care. I have obtained and attached an ethical clearance from the registered Ethics committee of the Department of Health Studies at UNISA.

I shall execute the study in strict accordance with the approved proposal requirements of the ethics policy of UNISA. I undertake to provide the Department with a report on completion of the study.

Attached find ethical clearance certificate from the university and permission letter from Department of health

I trust that my application will be favourably considered.

Yours faithfully

Ms Phakula Lenny Tina
Student Number: 3162-245-3
Cell: 083 420 5317
E-mail: phakulalt@webmail.co.za

ANNEXURE F: DEPARTMENT OF HEALTH APPROVAL – VHEMBE DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 20.11.2020

Dear Sir/Madam. MUSWANA L T

Permission to conduct a research on the
"A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH ...".

1. The above matter refers.

2. Your letter received on the 20.11.2020 requesting for permission to conduct a research is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the study to be conducted within Vhembe District. You are expected to submit the results to the District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavors.

..... 23/11/2020
CHIEF DIRECTOR: DISTRICT HEALTH DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

"he heartland of Southern Africa – development is about people!

ANNEXURE G: PERMISSION REQUEST FROM DEPARTMENT OF HEALTH HOSPITALS: LIMPOPO PROVINCE

The District Executive Managers (Mopani and Vhembe Districts)
Limpopo Department of Health
Polokwane
0700

Dear Sir / Madam

Permission to collect data from selected hospitals and clinics in Limpopo Province

I am Lenny Tina Phakula; a PhD student at the University of South Africa (UNISA) conducting research entitled "A social support framework for mental health care users to promote continuity of care" under the supervision of Prof J E Maritz. I hereby request permission to collect data for my study at selected hospitals and clinics in the Limpopo Province. The aim of the study is firstly to explore the experiences of operational managers, mental health care providers, social workers and mental health care users regarding a social support for mental health care users within the context of the Limpopo province and secondly to develop a framework to promote social support and continuity of care for mental health care users. The central question that will guide the study will be: "What are the experiences of operational managers, mental health care providers, social workers and mental health care users regarding the social support of mental health care users?

Semi-structured individual interviews will be conducted with the prospective participants. Appointment will be made in advance with prospective participants who will be required to give informed consent to participate. Data from semi-structured interviews will be audio-taped and transcribed verbatim in preparation of data analysis.

I will respect the rights of participants and will inform them of their right to:

 Give informed consent in writing to participate in this study. Withdraw from the study at any time if they so wished.

 Confidentiality and anonymity and privacy.

 Ask questions and clarification from the researcher

I will respect all human rights enshrined in the constitution of this country. Participants may experience some discomfort in relation to questions asked, hence the researcher will arrange counsellors to offer counselling if the need arises. The study will benefit the province to assist in social support of mental health care users and continuity of care. I have obtained and attached an ethical clearance from the registered Ethics committee of the Department of Health Studies at UNISA.

I shall execute the study in strict accordance with the approved proposal requirements of the ethics policy of UNISA. I undertake to provide the Department with a report on completion of the study.

I trust that my application will be favourably considered.

Yours faithfully

Ms Mushwana Lenny Tina
Student Number: 3162-245-3
Cell: 083 420 5317
E-mail: phakulalt@webmail.co.za

ANNEXURE H: APPROVAL FROM DONAL FRASER HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
DONALD FRASER HOSPITAL

LIMPOPO PROVINCE
DONALD FRASER HOSPITAL
2020 -12- 0 8
PRIVATE BAG X1172
0971 VHUFULI
DEPARTMENT OF HEALTH

Ref: 4/2/2
Enquiries: Neluheni T/ Mphephu V.F
Ext. 9306 Cell no. 0721880436
07/12/2020

TO: Ms Phhakula Lenny Tina
UNISA
PO BOX 392
UNISA 003

RE: A SOCIAL FRAMEWORK FOR MENTAL HEALTH CARE USERS TO PROMOTE CONTINUITY OF CARE

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
   - Kindly be informed that In the course of your study there should be no action that disrupts the services.
   - You are to give report to quality assurance manager of Donald Fraser Hospital after completion of research study at Donald Fraser Hospital.
   - After completion of the study, a copy should be submitted to our institution to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - You are therefore requested to contact nursing administration office number 7, OPD basement for logistic arrangements.

3. Please bring along the following documents:

   - Permission letter granted from department of health.
   - Permission letter granted from educational institution.
   - This letter.

Hoping you will find this in order

SIGNED.....Date.....08/12/2020

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 I: APPROVAL FROM THABAMOOPO HOSPITAL

CONFIDENTIAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
THABAMOOPO HOSPITAL

Ref : S5/3/1/2
Enquiries : Mrs Shivitl M.P
Tel : 015 632 9000 (9003)
Email : mamere.shivitl@dhsd.limpopo.gov.za
Date : 14/12/2020

THABAMOOPO HOSPITAL
CEO
14 DEC 2020
TEL: 015 632 9000
FAX: 015 632 5205
PRIVATE BAG X37, CHUENESPOORT, 0745

RE-PERMISSION TO CONDUCT RESEARCH AT THABAMOOPO HOSPITAL

STUDY TOPIC: A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH USERS TO PROMOTE CONTINUITY OF CARE.

RESEARCHER: LENNY TINA PHAKULA

1. Permission to conduct research study as per your research topic is hereby granted
2. In the course of your study, there should be no action to disrupt the routine services in the institution.
3. In conducting the study, adhere to the principles of ethical considerations i.e. anonymity, privacy and confidentiality; addressing harm etc.
4. Present a copy of the research findings to the institution upon completion of your study.
5. As the researcher you should be able to assist with the interpretation and implementation of the study recommendation where possible.
6. The above approval is valid for a one year period.
7. Amendments on the proposal should be communication accordingly.

Your cooperation will be highly appreciated.

14/12/2020

ACEO

THABAMOOPO HOSPITAL
CEO
14 DEC 2020
TEL: 015 632 9000
FAX: 015 632 5205
PRIVATE BAG X37, CHUENE

DATE

Private Bag X37, CHUENESPOORT 0745
Tel: (015) 632 9000 Fax: (015) 632 5205

ANNEXURE J: PERMISSION LETTER EVUXAKENI

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
EVUXAKENI HOSPITAL

Ref: S5/3/1/2
Enquiries: Rikhotso M.J

Date: 27/11/2020
To: Phakula ~~H~~ L.T.

SUBJECT: PERMISSION TO CONDUCT RESEARCH: PHAKULA L.T

The above matter refers:

1. The request to conduct the research as indicated through your application, has been approved by the department.
2. The approval to conduct the above-mentioned shall for a one year period as stated in par 2(e) of the department's approval letter as attached herein.
3. Wishing the best in your research work.

Hoping you will find this in order.

CHIEF EXECUTIVE OFFICER

30/11/2020
DATE

Received by: Phakula LT

Signature: Phakula

Date: 30.11.2020

Private Bag X9661, GIYANI, 0826. Site 2177 Section A, GIYANI, 0826
Tel: +27 15 812 1138 · Fax: +27 15 812 1139, Website: http:limpopo.gov.za

The heartland of South Africa – Development is about people!

ANNEXURE K: INFORMED CONSENT FORM

To be completed by operational managers, mental health care providers, social workers and mental health care users

A social support framework for mental health care users to promote continuity of care

Dear Research Participant,

My name is **Lenny Phakula**, and I am studying towards a doctoral degree in Health Studies at the University of South Africa (UNISA). As a requirement for the degree, I am doing research on social support for mental health care users. In order to do this, I need to look at effective ways of promoting social support for mental health care users. For this reason, I would like to invite you to participate in this research project as it is hoped that your participation may assist in bridging the gap that currently exist regarding social support of mental health care users.

Participation in study: You will be asked to respond to questions about you and your experiences in an interview that will take between 45-60 minutes. Your participation is voluntary, which means that you do not have to participate if you do not want to. If you say no, this will not affect you negatively in any way whatsoever. The information that you provide is confidential. This means that your information will be kept private and will not be shared with any other person, except researchers involved in the study, who also will not know that the information came from you, as your name will not be recorded on any of the documents.

I will audio-record the interview so that I accurately capture what you say, but I will not capture any information that might identify you. I will switch the audio recorder ON after brief introductions to start the recording and, as we proceed with the interview, we will not use any names. You many request that the recording be paused at any time.

If you agree to participate, it is important to take note of the following information presented below:

Aim of the study: A substantial number of research studies have been conducted regarding support of mental health care users. However, social support of mental health care users seem not to be adequate as evidenced by frequent readmissions. This study seeks to develop a tailored social support framework for mental health care users to promote continuity of care.

Reason for your invitation: You have been asked to join in this study because you are believed to be familiar and experienced on the topic under study.

Study benefits and risks: There is no direct benefit to participation in this study; however, the

answers you provide may help to improve social support of mental health care users. The risks of participating in this study are minimal. As we mentioned, you can refuse to answer any question or withdraw from the study at any time.

Rights: If you have any further questions about this study or about your rights as a study participant, you can contact me, Lenny Mushwana, at 0834205317.

Should you have any concerns regarding ethical matters pertaining to this research, you may contact the Chair of the University of South Africa, Department of Health Studies, Research Ethics Committee, Prof J E Maritz, maritje@unisa.ac.za.

If you agree to participate in this study, please sign below to indicate that you have understood what the study is about and what your role is. You will be given a copy of the signed consent form.

Consent sheet

I have been informed of the study purpose and of my rights as a study participant. The investigator has offered to answer my questions concerning this study. I hereby:

- consent to participate in the | Yes | No | study:
- allow the researcher to audio record the interview | Yes | No | proceedings:

Participant's Name: _____ Researcher's Name: _____

_____ _____

Signature Signature

_____ _____

Date Date

ANNEXURE L: INTERVIEW GUIDE FOR MCHUS

TITLE: A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH CARE USERS TO PROMOTE CONTINUITY OF CARE

Dear Sir/Madam

Thank you for agreeing to participate in this study. My name is Lenny Mushwana. I am studying towards a doctoral degree in Health Studies at the University of South Africa (UNISA), and I am conducting a study on: A social support framework for mental health care users to promote continuity of care. The information you provide will be treated with utmost confidentiality and will only be used for the purpose of this study. You will be asked to respond to questions about you and your experiences. The interview will take approximately 45-60 minutes.

Thanking you in advance.

Lenny Mushwana : 0834205317/ phakulalt@webmail.co.za

1. What help did you receive from the hospital or clinic after your discharge?
    a. If needed prompt for informational support e.g. advice or referrals to support groups, mental health education,
    b. Emotional support as in the offering of empathy, concern, trust, acceptance, encouragement, caring,
    c. Tangible support (e.g., financial assistance),
    d. Intangible support (e.g., personal advice).

2. What help did you receive from family, friends, or neighbours after your discharge?
    a. Prompts for emotional support as in the offering of empathy, concern, affection, love, trust, acceptance, intimacy, encouragement, caring or companionship
    b. Tangible support (e.g., financial assistance, housing, transport),
    c. Intangible support (e.g., personal advice).

3. What can the hospital or clinic staff do to help you after your discharge?
4. What can your family, friends, or neighbours do to help you after your discharge?
5. What can you do to get the help you need after discharge?
6. Would you like to add anything related to providing or receiving support?

Facilitative communication techniques will be used such as active listening, reflections, summaries, and clarification.

Specific probes: Action and processes related to all questions and answers

ANNEXURE M: INTERVIEW GUIDE OPM NURSES

TITLE: A social support framework for mental health care users to promote continuity of care

Dear Sir/Madam

Thank you for agreeing to participate in this study. My name is Lenny Mushwana. I am studying towards a doctoral degree in Health Studies at the University of South Africa (UNISA), and I am conducting a study on: A social support framework for mental health care users (MHCUs) to promote continuity of care. The information you provide will be treated with utmost confidentiality and will only be used for the purpose of this study. You will be asked to respond to questions about you and your experiences. The interview will take approximately 45-60 minutes.

Thanking you in advance.

Lenny Mushwana : 0834205317/ phakulalt@webmail.co.za

1. How is social support of MHCUs important to you?
2. How do you provide social support to MHCUs after discharge?
3. How does what you do during discharge have implications for social support of MHCUs?
4. What actions do you take to ensure successful continuity of care during discharge of MHCUs?
5. What can be done to provide social support and continuity of care to MHCUs?

Facilitative communication techniques will be used in order to probe, prompt or clarify statements.

Specific probes: <u>Action and processes</u> related to all questions and answers

ANNEXURE N: PARTICIPANT INFORMATION LEAFLET

Title: A model to promote positive attitude among nurses in Limpopo Province South Africa.

Purpose: To develop a model that will promote positive attitude among nurses in Limpopo Province.

Objectives:

- To explore t/he perceptions of patients on the behaviour of nurses.
- To explore the views of patients regarding the behaviour of nurses
- To identify and assess knowledge of nurses regarding positive attitude
- To develop a model that will promote positive attitude among nurses in Limpopo Province

Significance of the study

The findings of the study may help nurses to develop strategies that will promote positive attitude among nurses *in Limpopo Province. There will be changes in the practice of nurses and avoid long stay of patients in the hospital and costs will be reduced. The relationship between the employees and the employer may be improved and be strengthened and the morals, values, and behaviours will be taken into consideration. The findings of the study may assist policy makers in formulating new policies on* positive attitude among nurses*. It may assist researchers to do more research on* positive attitude among nurses

What are the risks?

There are no risks anticipated except some tiredness during interviews. You may experience some temporary discomfort from sharing your experience**.**

What are the benefits?

Participation is voluntary and you may end participation at any time without any penalties or loss of benefits which you are entitled. Patients will also benefit from your participation.

Whom you should contact

Your participation in this project is appreciated, if you have queries, please contact the researchers at the numbers listed below:

Promoter: _____ Cell number:_____

Co-promoter_____Cell number: _____

Researcher: _____Cell number: _____

ANNEXURE O: SAMPLE INTERVIEW TRANSCRIPT

Interview sample (Nurse)

Participant No. 11

R: The first question is: How is social support of mental health care users (MHCUs) important to you?

P: It's very important because those people are regarded as people and they are neglected in the community. (lack of community support)

R: Mmm, they are neglected in the community. In response to the question posed, you indicated that they are very important and that they are people as well but are neglected in the community. Why do you say they are neglected in the community?

P: They are neglected by community members, they don't regard them as people, they don't consider them. (stigmatised by community members) I can give an example like in the meeting like "Xivijo". Again they are neglected by their own family members. They don't teach them on personal hygiene or giving them food, taking care of them like giving them treatment.(lack of family support).

R: They don't give food, no personal hygiene and they don't give them treatment. Okay, if I have to dig more on the importance of social support, you just indicated that it is very important because people neglect them, so, how best can you support them?

P: Is to teach their family members on how to manage MHCUs, how they must teach them mmm… like personal hygiene and domestic work, how to develop themselves. (education to the family members) They must get it from home. (family involvement)

R: Okay, how to develop themselves. And then they must also teach them domestic work, okay. What else?

P: Uh, develop themselves, (engage in self-help skills) engage them in meetings, community gatherings. (community involvement)

R: Okay, in community gatherings. When you say develop themselves, what do you mean?

P: Some of them they are able to… they can sew, and sell the product. They can do hand work. , (engage in self-help skills)

R: Okay, they can do handwork. So, if they are able to do handwork, how best can the family be involved?

P: The family can be involved by giving them support. (family involvement)

R: Okay, family can be involved by giving them support, how?

P: They can give them support financially, how to manage their finances because they are getting their grant. (family involvement in financial management) They can start there with their grant. (family involvement)

R: Okay, they can start with their grant, okay, I get you. So, you said supporting them is very important because they turn to be neglected by the community, okay. What is it that you can do to the community to show them, that MHCUs are people just like us?

P: We can do awareness on mental health, teach the community how to engage those people and how to help them in every area, like the one that I said, hand working) everything and to inform them on, to educate the community so that they can understand mental illness. (education to the community

R: So who should inform the community that they be aware of mental health?

P: The Department of health, obvious. Awareness can be done here at the clinic or health talk during morning sessions. Mental health (education done by the MHCPs)

R: Okay, awareness can be done and even health talks.

P: Mmm.

R: Okay, in the morning. So, you said this can be done through health talks and awareness to the community.

P: Uh… and even if during the funerals you can get a slot and educate the people, during gatherings, community gatherings., funerals, parties, you can get a slot and talk about mental illness .(education to the community)

R: You can get a slot okay, and talk about mental illness. You said gatherings such as funerals and parties..

P: Family gatherings or parties, where we can be involved. (education to the family)

R: Okay. When you say, you can get a slot and talk about mental illness, what do you exactly mean?

P: We can talk about the signs and symptoms of mental illness and how they can get help (contents of mental health education) and considering those people as people. (avoiding stigmatising MHCUs)In fact we can try to educate them so that they can understand that mental illness is like any other illness like Hypertension, it can be treated, it can be controlled. (awareness on mental health issues)

R: Okay, it can be treated and it can controlled, Okay, tell me more about importance of social support.

P: If a person is not getting a social support, he or her, she can, the illness can become worse. (lack of financial support) She can even default treatment, because she don't get social support, she won't see that treatment important. (importance of financial support)

R: Okay, if there is no support, okay, hence you mentioned the ways in which you can support the MHCUs. You mentioned the health talks, health talks in gatherings, you also mentioned the issue of educating people; and also to ensure that they are developed, maybe through hand work; and be supported by the family. How best can the clinic, or the health care providers offer them support, let's say the MHCU is able to do hand work, how best can you assist?

P: We can find the stakeholders who are dealing with the work that he or she is interested in, so that they can help the patient on how to do it better, and develop him or her on the work that he or she is interested in. (stakeholders involvement) You can give information to the... and emphasise that even if you have mental illness still you can participate in anything like any other person who does not have mental illness. (education to the MHCUs)

R: Okay, what do you mean by stakeholders?

P: For example, there are community projects, where you find, women they sew and then maybe they are doing something, something like handwork, community projects that are funded. (stakeholders involvement)

R: Okay, I get you. They can join the community projects funded by…

P: …the Department

R: the Department. Okay. Firstly, we looked at how important is social support to you as a health care provider. Now our second question is: How do you provide social support to MHCUs after discharge?

P: The social support is to educate the family members on how they are going to deal with the MHCU after discharge at home, (education to the family) and then you are going to educate also the MHCUs on how to behave at home. How to take treatment, the importance of adhering to treatment, education to the MHCUs) and also to do the follow-ups (follow-ups engagement) by doing the home visits. (home visits engagement)

R: Who is supposed to do the follow-ups?

P: The follow-ups here because of the shortage, (shortage of staff) we are using the community health workers. We don't have the nurses who are doing home visits. (collaboration with community health workers)

R: Hmmm, because of shortage you are using the community health care workers.

P: Yes.

R: Okay, not nurses because of shortage. So, if you are using the community health care workers, remember now we are looking at the issue of mental health, mental health is a speciality, is not something that is general. So, now, how do you empower the home-based carers?

P The health care workers are getting the health talks, on mental health, how to treat the patient, how to take care. (empowering CHWs)

R: Who is doing the health talks?

P: We have got an OTL, their manager, he is an enrolled nurse. So he is the one who is educating them (OTL empowers CHWs) and where they need support, they ask a

professional nurse to go and give support at their meetings. (support of CHWs by MHCPs)

R: Okay, they do consult when they are stuck.

P: Mmm

R: Okay. I understand. What is it that they cover, when they go and do home visit?

P: When they go and do the home visit, (home visits engagement) they emphasise the adherence of the treatment and also to educate the family on the social support of the family. education to the family

R: Okay, they emphasise the issue of adherence of the treatment and also to educate the family on the social support of the family, okay. What involvement is there between you and the community health care workers, as you are the people in charge of the clinic or you just leave them with the enrolled nurse to take care of them?

P: We do get involved we go and teach them about uh…other chronic illnesses. (empowering CHWs)

R: Okay, you teach the home-based carers….

P: …mmm, home-based carers.

R: …about, other chronic illnesses, okay, that is your involvement, because, what I was trying to establish is: do you at times hold meetings, where you will have an agenda and discuss different issues with the home-based carers, bearing in mind that I still remember that you said that they under the supervision of the enrolled nurse, but do you as a clinic, because I believe that you are in charge of the institution, do you come together with the home based-carers for meetings or are they are on their own?

P: Usually here in clinic F, they are on their own. (inadequate support for CHWs by MHCPs)

R: Okay, you just teach them about chronic illnesses.

P: Uh… but the meetings they do it with the OTL. (communication between the OTL and CHWs)

R: Okay, do you have any interaction with the OTL as the owners of the clinic

P: Yes we do, we communicate with the OTL, even if we have problems at the community we communicate with the OTL that there is this patient, so and so we need help, so they go together with the OTL to the family. communication between the OTL and MHCPs)

R: Okay, I get you.

P: We communicate with the OTL, and then the OTL will send a message to the community home-based carers. (Interaction between the MHCPs, OTL and CHWs)

R: Okay, in other words, is very rare for you to get the information as to what is going on with the MHCUs at the community because they are not reporting to you, they are reporting to the OTL

P: They report to the OTL, “mara” if there is a problem, “nee” they come, uh, they come with the OTL and they report it themselves, not sending the OTL, they come personally that I came across this and that. (communication between the OTL and MHCPs)

R: Uhmm… okay, they come personally, okay I get you. What does OTL stand for?

P: OTL its outreach team leader.

R: But by profession this person is an enrolled nurse?

P: Yes she is an enrolled nurse. So, they have been trained for that, that is why they use that OTL, outreach trained label.

R: Okay, So, when the home-based carers, attend to a particular MHCU, what is it that they usually focus on, By now I am aware that they go out for all chronic patients, so, when they go to a MHCU, what is it that they focus on?

P: They focus on adherence to treatment. (adherence to treatment)

R: Is just adherence to treatment?

P: and hygiene, personal hygiene, (education to the family and MHCU)

R: Okay, what else?

P: and then the, the… social support, social support at home. (social support by family members)

R: What do you mean by social support at home?

P: Are there someone at home who is taking care specifically for the patient? because there must be someone assigned to take care at home, to be responsible for the person, to take care of the person, family support for instance, he or she is the one who is able to renew the grant, helping the patient to go and get the grant, (financial support by family members) helping the patient to come to the clinic. (follow-up care)

R: Okay, If we have to rate it, out of ten families, if we have to check, I know you are not in direct contact with the home-based carers, but you said there is an OTL who communicates with them. I want to believe the OTL is the one giving you the report; so, out of ten families will you say there is someone who is supervising the MHCU or what is it that is happening? I mean within your area is there anyone who is supporting the MHCU, in each and every family or what is the state of affairs?

P: Is not each and every family that has got a supporter for the users. (inadequate MHCUs supporters within families)

R: So, in that case, how do you deal with the situation if there is no supporter?

P: We try to trace the family and we talk to them about the importance of social support (education to the family)

R: Okay, you try to trace the family, so that at the end they can understand, how to support him. Okay. I get you. We were still looking at how to provide MHCUs with social support after discharge. Maybe to give you a summary of what we have covered so far is that you are educating the family and the user and then the MHCU is mostly educated on how to behave, treatment adherence and treatment follow-up. You also indicated that there are no nurses to do home visit because of the shortage; in that case you are using the home-based carers; and that when the home –based carers go to a particular family, they focus on treatment adherence, they focus on checking in how the user is being supported by a family member. What are the other things you do for the users who has been discharged from the hospital except for what you said?

P: The only thing is when the user come to the clinic but for home visits at home for support from nurses, we only support them when they come to the clinic. (MHCPs support)

R: You only support them when they come to the clinic, okay. There are different forms of supporting the MHCU. When you say you only support them when they come to the clinic what do you mean?

P: We support them on educating them more about mental illness and the importance of adherence with… with; we also teach them on how to take their treatment, to differentiate their treatment, to know their treatment how it works. (education to the MHCUs)

R: When you say to know their treatment what do you mean?

P: We teach them that when they don't take their treatment what is going to happen to their illnesses. (importance of taking treatment)

R: What is going to happen to them if they don't take their treatment, okay. Let's move to the third question. The next question is: What can be done to provide social support and continuity of care to MHCUs?

P: What can be done to show support?

R: Yeah, we just want to find out… you mentioned what you are doing, such as doing home visits through home-based carers and doing this and that; that is what you are doing as a clinic, so, now I just want to find out from you as an individual, what can be done to offer social support and continuity of care. In other words what is your view regarding these two issues, social support and continuity of care?

P: Okay what can be done, we can do the support groups; (forming support groups) we can gather them, the MHCUs and teach them as a group so that they can be able even to express themselves and to tell the other MHCUs how they can take care of themselves; they can educate themselves.(educate MHCUs to empower self)

R: Hmmm, okay, when they are together in that gathering.

P: Uh, when they are together.

R: Okay, what else?

P: Another thing, what we can do is to do the follow-ups, the home visits (engagement in home visits) and follow-up the patient who is discharged, (follow-up care) to see if the patient, if he or she is taking the treatment (adherence to treatment) and to monitor if the family is supporting the patient. (family support) We can do the follow-ups up until we see that the he or she is adhering (follow-up care) and also the family members, they are well educated, they are well informed, they can be able to deal with the patient. (family support by MHCPs)

R: Okay, with the education that you will be giving them.

P: Uh…

R: Okay, you will check if they are well educated to such an extent that they can be able to take care of the patient, okay. What else?

P: Another thing we can involve the patient on the activities here at the clinic. We can do activities, we can teach them even the garden, uh… they can do gardening…uh, they can do gardening here at the clinic, and sell the products. (engagement in self-help skills)

R: And sell the products. Okay, what are the other means that can be done to provide social support and continuity of care?

P: Again is to… if a patient is having a problem, you can refer the patient to the Psychologist or to the Social worker if they have social problems. (collaboration with MHCPs)

R: Social worker in terms of social problems and the Psychologist for counselling. What are the other things that you can do to ensure social support and continuity of care?

P: Mmm… another thing is to give them treatment and …to give them treatment (active involvement in giving of treatment) and to make sure that they come to the clinic for follow-up. (follow-up care)

R: Okay, give them treatment and make sure that they come for…

P: … follow-up (emphasis on follow-up)

R: They come for follow-up, okay, what else?

P: We can trace the patient if he or she is not coming to the clinic. (follow-up for defaulters)

R: Oho, we can also trace the patient if he or she is not coming to the clinic, okay. What are the other forms that you can think of regarding social support and continuity of care?

P: … (Laughing). I have exhausted all the the…

R: …the things that you can think of, you have exhausted the things that you can think of, okay. Thank you so much, we have come to the end of the interview. I thank you once again for availing yourself for this interview. Thank you.

Interview Sample (Mental health care user)

Participant No. 30

R : The first question is : What help did you get from the hospital or clinic after discharge?

P: The help I got at the clinic is that they supplied me with my monthly treatment, however at times they will take time to assist me.

R: Okay, they gave you your treatment but at times took time to attend to you.

P: They usually delay in helping us.

R: Okay, what is it that you brought along from the hospital that indicated that you must be supplied with treatment at the clinic?

P: I wasn't given anything on discharge, I did not bring anything from the hospital.

R: Okay, Except for supplying you with treatment, what other help did you receive at the clinic?

P: They have never given me anything except for treatment.

R: When you come across serious challenges, don't they step in and assist you?

P: They do assist me.

R: What type of challenge did you experience such that they decided to help you?

P: What made them to come to my assistance was because I was mentally disturbed.

R: So, it was when you were mentally disturbed?

P: Yes, I was really disturbed I even ran after my parents with "panga" in my hand. I caused confusion and they were afraid of me.

R: So, they made you sure that you made peace with your parents.

P: Yes, they did help me and calmed the situation, as of today I am able to socialise with other people.

R: Except for calming the situation between you and your parents, what are these other means they used to demonstrate love or things they did to you such that you could trust them?

P: My wife and parents are able to calm down when am angry and the help to manage my condition.

R: I suggest we focus on clinic staff for now.

P: Okay

R: How do you relate with the clinic staff during difficult times or when you meet serious challenges?

P: I believe that if I can approach them in times of challenges, they can assist me.

R: So, you are able to approach them when you have problems, okay.

P: I do seek their advise when challenged.

R: Except for what we looked at, that is help with regard to treatment, and assistance when challenged by certain situations, what other help did they offer you with, more especially financially related?

P: They assisted me by giving me disability grant.

R: How many children are you having?

P: I have three kids, two stepchildren and one biological child

R: Okay, you do receive grant, okay. How does this grant meet your needs since you indicated that you have a wife and three children?

P: The grant is of greater assistance. I even built a house because I am receiving a grant.

R: I understand you do receive a grant, what are the other ways you could pursue to add up to the grant that you receive, just for more income?

P: Yes, I think I should find other ways of increasing the income, at times we are advised to buy our treatment due to treatment shortage.

R: So, there are times where your treatment can not be found here at the clinic?

P: We are told we have to buy at the chemist.

R: Then you realise that you do not have money.

P: Yes, that is why am thinking of increasing the grant by doing other piece jobs.

R: How best can you add up to the grant that you already receiving?

P: I think those dealing with grant issues should come together and find ways of increasing the amount we are given. This will assist in buying of treatment as needed when not available at the clinic.

R: I get you; I understand that those concerned with grant issues should come together and find ways of increasing it, however personally, how best can you increase the amount that you receive through disability grant?

P: I think I should get piece jobs so that I can earn some money that can assist in this regard.

R: Okay, you spoke of piece jobs, so, does this imply that you do not want a full time job?

P: I do want a full time job, however it will be difficult for me to work full time because my body is painful.

R: Okay. At times we meet serious challenges and need help or even counselling, who assisted you in this regard?

P: Yes, I did come across a serious challenge some years ago and I was assisted by the hospital staff. They indicated that I need not worry about the issue and they even added up on my treatment to help me cope with the situation.

R: Okay, so, they assisted by giving you treatment?

P: I took the treatment and after that I felt much better.

R: Okay, you indicated that you are given your monthly supply of medication, and they do assist you when you meet challenges and that they offer you a grant on monthly basis. Okay, what are the other ways, the hospital or clinic staff can assist you with?

P: What I can say is that they do help when a need arises. They indicated that if someone does not hide whatever is a burden or challenge in his or her life, they can assist as needed.

R: Okay

P: They further indicated that what will help me is to continue doing what I am suppose to do or else listen to the instructions that am given

R: According to you, they do assist when there is a need, okay.

P: They do, however, when they are tired, they no longer render the service as expected.

R: Okay, Now let's look at our second question, and the question is: What help did you receive from family, friends and neighbours after discharge? Let's start with family.

P: My family does help me. They show me love and meet my other needs such as buying me food when I do not have money.

R: Except for what you just mentioned, how else does your help you?

P: They really support me; they give me whatever I want.

R: How is the support that you are given, can it be attributed to conditional support?

P: There are no conditions we are given support as required. They have been supporting us since we were young. Our parents passed on, since then they have been taking care of us.

R: Okay.

P: The person who looks after us is our grandmother, am afraid, she can pass on any time.

R: Oh, so, the person looking after you is your grandmother.

P: It is my grandmother, my mother and father divorced some time ago. We were left with my mother who passed on in 2015.

R: Umm.

P: My mother and father divorced in 1998.

R: What was your father's reaction towards you after your mother passed on, in relation to offering you support?

P: My father is married to another woman. So, whenever you present your problems, he will promise to do something about it, but later he will not attend to you, He will remind you that he is not working, he is receiving social grant, so, you better meet your own needs.

R: Okay

P: However, myself together with my siblings we do take our time and go and visit him and check how he is doing.

R: How is you relationship with your step-mother?

P: We have a good relationship with our step-mother, no problems

R: Umm

P: Even with my father, I relate well with him. At times he will give me R10.00 or R20.00, not more than that.

R: Okay, I get you. So, it means your grandmother is the one who does everything for you.

P: We put together whatever we have and in that manner continue with life.

R: Okay. By the way, how many siblings are you having?

P: Five (5)

R: Okay, so all in all you are six (6)

P: Yes.

R: Okay, how is your relationship with your siblings?

P: The relationship is good; they are able to respect me and they do recognise that I am their elder brother.

R: Okay, what type of home treatment do you get from your family together with your siblings

P: We are five (5) all in all. So, I and the second born we are mentally, but the other three are healthy. My siblings respects me as a brother. The second born becomes worried when I do not exercise. He reminds me that I must exercise because if not, the treatment won't be good for me.

R: Okay.

P: He will say to me, avoid frequent naps because that makes you to be fat, he is my friend, we share everything together. He advises me on many things. Sometimes I tell him that I have a problem with my wife. He will advise me not to be angry and take things light.

R: Umm

P: They all understand and respect me.

R: So, they respect you.

P: The fact that I am not well mentally does not make them to degrade me.

R: Okay, you indicated that your grandmother takes care of you and your siblings, we also looked at your father and your stepmother. You also indicated that your siblings does show you respect as their elder brother. You also indicated that the second born advises you and you share everything with him. He even advise you to exercise indicating that if not, the treatment may cause damage to you.

P: Umm

R: Okay. What type of support do you receive from your wife?

P: My wife is too supportive, when I remember her I feel good. She also lost her parents when she was nine (9) years old. She brought change in my life. She encouraged me to finish building my house which was halfway and it remained like that for years before I met her.

R: Umm...

P: My wife cannot be replaced by anyone. She came with two children but, I don't even think of marrying a young lady because of the manner in which takes care. She still takes care irrespective of my condition and does not listen to anyone who discourages her in this marriage because of my condition.

R: Umm...

P: She always tell people that am her husband irrespective of my condition. I am even thinking of serving some of my grant so that I can go and pay "lobola".

R: So you haven't done so

P: But I will save some of my grant so that I can go and pay "lobola"

R: Okay, So, there is no way that they can help you here at home?

P: Yes, my father and my step-mother, could not assist me when I built my house, my granny is the one who assisted me with building of the house. Even now we are preparing to build another house.

R: Oho. Who is working amongst your siblings?

P: The second born is the only one working. He transport learners to and from school. However he earns little, but he is able to look after his two children. He is married and stays in my mother's yard.

R: Okay, before I can pose question three (3), lets' look at what we covered. In your response to question one (1), you indicated that the clinic staff provide you with treatment and offer you help when you meet challenges. In question two (2), I enquired about your father, his wife, your granny and siblings. My question was based on the support they offer you as a family member and you responded to the question. Now our third question is: What can the hospital or clinic staff do to help you after discharge?

P: What I can say about the clinic staff is that they work hard, however after lunch they wok slowly. They should check their time. I would like the clinic staff to work the way they did before lunch that is my expectation from them.

R: I get you, but I would like to hear more about what you just said

P: What am referring to is that after lunch, they do not allow us in the consultation rooms, it is only after 30 minutes that they will call us.

R: So, okay, except for watching their time, what are the other expectations you envisage from them?

P: They should also take extra care when it comes to the elderly and the disabled, they should be prioritised.

R: Okay, I get you. Now let's focus on people with mental illness

P: I wish they list people who are mentally disturbed in one book

R: What are exactly referring to?

P: What am referring to is that we should be listed in one book, so that we can be one and they can call us to come together for exercises and even take us out for excursion where we can have an opportunity learn from other MHCUs, especially when we can be given an opportunity to visit other hospitals.

R: Umm...

P: That's what I want, a situation in which they will say to us: now, we do this, you do this as MHCUs.

R: Okay

P: They should give an opportunity to MHCUs to showcase their talents.

R: Okay, I get you

P: If they can hear us they will hate me.

R: You don’t have to worry you are just telling the truth. So, you want them to recognise you, and register you as MHCUs in your register only, so that you can come together as MHCUs.

P: Yes, we could exercise, and be taken to other hospitals to see what other MHCUs are doing with their own hands

R: Okay

P: I wish teams be formed, compete against one another and win prizes (laughing).

R: Okay, I get you.

P: (Laughing aloud).I also wish that there be a serious follow-up for MHCUs. especially pertaining taking of treatment. Some MHCUs they no longer take treatment. They sometimes skip treatment for the whole week. The danger for that you find that they become violent and engage in dangerous acts. You find that such people cannot be controlled and they chase community members on the streets.

R: Umm...

P: That is the reason I emphasise that they should do serious follow-up.

R: You emphasised a lot on the need for follow-up. How often do they pay you a visit as a MHCU?

P: I was once visited by a social worker that is where they found out that my younger brother is also suffering from mental illness but they did not find me at home. They indicated that they will visit us again but they didn’t. I made a follow-up and those accompanying the social workers indicated that they just wanted to check the environment, and also check if we are taking treatment as well as finding out if we well taken care of?

R: Except for social workers, who else has visited you from the clinic, be it nurses or other members?

P: The home-based carers are the ones who come and deliver treatment. We have never receive nurse’s visitation.

R: What is it that they do on arrival?

P: They check how you are doing health wise, complete forms, regarding taking of treatment, nutrition, check if you are taken care of. They also advise us to abstain from taking alcohol. They explain thoroughly.

R: Okay. How often do they visit you?

P: They used to come, but as of now, they no longer come for me, they only visit my granny since she is hypertensive.

R: Okay, you just indicated that, they don't pay you a visit, okay.

P: Yes, they indicated that as of now am in control, so I should come and collect my treatment at the clinic.

R: When did the home-based carers last visit you?

P: They last visited me three years ago.

R: You indicated that follow-up should be done to MHCUs who need attention. What about you?

P: I also need follow-up. If no one follow me up I may end up not behaving accordingly, maybe undressing in public and in that way I will become a laughing stock in the community.

R: Umm...

P: They should do a follow-up to everyone whether you are well or not well, they should check whether we are taking treatment and also check if the environment is well taken care of, including washing our clothes and staying clean.

R: Okay. You explained a lot regarding collection of treatment at the clinic. What is it that the nurses do on arrival when you visit the clinic to collect your treatment?

P: When I have to collect treatment there is no problem. If treatment is not available at the clinic, I collect it from hospital.

R: Okay, what type of questions are you asked when you come to the clinic to collect your treatment?

P: They usually ask if my treatment is available and also to check if I am taking my treatment. Then I will respond and tell them that I do take my treatment. If there are problems such as experiencing tremors, I do inform them and I also enquire as to the cause of the problem and they will indicate that it is because of the type of treatment i am taking. Usually I do not just take treatment, I first enquire and get details concerning my treatment.

R: Okay, Except for what you mentioned, what are the other questions that the clinic staff ask you when you come and collect your treatment?

P: They ask us questions related to behaviour only if it shows that you are not well. They usually focus on treatment. They will ask you if you are taking treatment and how do you take it. They also notice when am sad, and they usually ask why am I sad, they will then crack some jokes so that I can laugh.

R: Okay

P: They usually detect that I have a problem. Probably my treatment got finished and of late did not take it (laughing).

R: Okay, all along we were focusing on the nurses, trying to find out, that which you wish they could do for you. Now let's focus on your family and let's start with your granny. What is it that you wish your granny can do for you to show support?

P: I wish I and my granny can continue to be united and assist one another to ensure smooth running of the family.

R: Umm

P: I should contribute some amount whenever I receive money. I should not let her do everything, until she grumbles simply because I do not contribute towards household needs.

R: Umm, except for being united when it comes to finances, what else are you expecting your granny to help you with?

P: I also wish that she offer support to us her grandchildren. She does have moments with us. At times she will inform us that we must not focus on our parents' death rather think of the future. She also reminds us that one day she will pass on and we will be

remaining alone. There will be no one to take care about your future. As am speaking my granny is not well, she is sick, so my wish is that as long as she lives we should remain united and help one another to focus on the life.

R: Okay, what is your wish from your father's site and your step mother?

P: I think my father and step-mother should be open to us so that when we meet challenges, we may feel free to contact them and tell them that we are experiencing 1.2.3. Our granny tries her best to help us in all respects. If I happen to ask for R200.00 from my granny and she indicates that at the moment, she does not have that amount, my father should give me, in fact they should support us in all respects, so that we may not be afraid to tell them when we have problems.

R: Okay, I get you, the support you are expecting from your father is financial.

P: Umm

R: I would like to hear more about the support you expect from your father.

P: He should also buy us clothes. Now it is Festive season since it is Christmas time. He should give us shoes, clothes, in fact, he should surprise us during this season.

R: Umm, coming to your wife, what are your expectations in relation to the support that you need from your family members?

P: My wife should not follow what people say or have friends that may mislead her. She should always listen to what I say as a husband not her friends.

R: Umm.

P: I want her to be trustworthy to me and I trustworthy to me, that is what I want from her.

R: Okay, so you want her to be trustworthy.

P: Umm

R: Okay. Who is your friend?

P: I used to have a friend but I no longer have one.

R: You just said that you no longer have a friend?

P: Yes, I do not have a friend, when I meet someone as a friend is for that moment, not for life. In fact my friend is my wife. I share everything with her and she is able to keep my secrets in her heart.

R: Okay, according to you, how best can neighbours help you?

P: They can help me with material things, not everything. In terms of sharing private issues I may not need their help because, you tell this one your problems the next thing you will hear it from other people. I need temporary help from neighbours, something that I need for that moment, for example, I can borrow bath soap but at the same time I should return it as soon as I get it. Your neighbour can make friends with you, meanwhile he is your enemy on the other side.

R: So, according to you your neighbourhood assistance should not be taken to the next level, it should be temporary.

P: Because, you may find that if I rely more on them, they will even say that I gave birth to many children hoping that they will assist me when it is difficult. You can find that neighbours are just like friends.

R: Okay, in your case, now that you are not well mentally, how best can neighbours help you?

P: They should support me by reporting to my family, immediately they realise that I am not well.

R: Okay, in other words, you allow them to report to your family, behaviour that indicates that you are mentally disturbed at that moment. (MHCU appear tired) Okay, we are about to finish, we are left with two questions only. The next question is: What can you do to get the help you want after discharge?

P: For me to get the help I want I can just take my treatment.

R: So, is that the help you will need now that you are discharged?

P: I have to take my treatment as expected and also keep myself busy with other activities, because as I take this treatment, I feel better and boosted to such an extent that I can engage in activities that need strength.

R: Okay, so, for you is to take your treatment as expected and keeping yourself busy, okay except for what you just mentioned what are the other ways that you can employ to ensure that you gain support now that you are discharged?

P: Is to go to church and pray, just like other people do.

R: How will the church help you in this regard?

P: The church does help, since 2008, I have been taking treatment and going to church.

R: Umm

P: Since I have been to church and taking treatment, I see a great change. Some people don't even believe that I am a MHCU. I am able to feel that I will be disturbed not long and immediately I have that feeling, I am able to take action and do what they told me to do at church and immediately I do that I am able to overpower those spirits.

R: Okay, so you are able to follow church instructions.

P:I am able to overpower those spirits and I never stop to take my treatment (laughing).

R: Umm, I get you. So, you still feel okay when you use what you have been given at the church and treatment.

P: There is no problem, we were told not to mix treatment with some heavy staff, so I use light staff. Even at the church we are encouraged not to stop taking treatment. When you visit the headquarters of our church, you are given a letter as an indication that you are taking treatment and if you happen to experience problems while there at the headquarters they do take you to the hospital.

R: So, they do advise you not to take...

P: strong staff.

R: except for the water that you during from the church what are the other staff that you take from the church?

P: I also take light tea. I was told not to drink strong tea as am on treatment (laughing).

R: Okay, I get you, you take treatment and also keep yourself busy with spiritual things. What are the other things you do so that people may recognise you as a MHCU who needs support?

P: I also listen to the radio; it helps me to cope with this situation.

R: Okay, while the radio issue reminds me of the social media. How do you engage with social media?

P: I do not like those things, I know that there is Whatsapp and other forms of social media, I don't follow those things, you should note that my church does not recommend things that will make you lose your respect.

R: What happened with your interest to the social media?

P I realised that social media can ruin your future, as of now I am focusing in my future, I have had problems in the past, I no longer want to find myself in trouble. Now I am focusing on the church. Presently the church is closed but I cannot take an advantage and drink liquor and next thing when the church reopens, I put on my uniform and go to church, you see, the two does not mix (laughing).

R: So, in other words you do not engage yourself in social issues through social media?

P: You know what, even if I can learn today, I soon forget about it because I do not have an interest.

R: Lastly, Would you like to add anything related to providing or receiving support?

P: I recommend that more workers be hired in clinics and small hospitals to assist those who are already hired because they get tired.

R: Okay, more workers should be hired. What else?

P: I also recommend that the home-based carers assist nurses during busy days. You see on Monday, Tuesday and Wednesday, the clinic is too busy, so, the home-based carers should assist on those days.

R: Okay, what are the other things you would like to add?

P: (Laughing). The care should be of high standard.

R: What are you exactly referring to?

P: As we are here at the clinic for consultation, while others are being attended to inside that consultation rooms, there should be other workers attending to those who are on the queue.

R: Uhmm...

P: That is the way they should work. I wish they add more consultation rooms.

R: According to you the consultation rooms available are inadequate.

P: They are inadequate, the more the consultation rooms the faster will be the queue, and this will assist in those who are in a hurry, to leave the clinic earlier. People stay for a long time here at the clinic due to shortage of consultation rooms.

R: Okay, what are the other things you would like to add?

P: (Silent for some time, then laughed after some time)

R: There should be doctors at the clinic, people are bound to travel for long distances for doctor's review and they are unable to arrive at the hospital on time due to long distance.

R: Okay, what are the other things you would like to add?

P: I think now am at ten (10), that is I mentioned ten of them (laughing). However I would also like to see pregnant women receiving appropriate attention.

R: Okay, what you have indicated so far is more related to care, what about support that mostly concern MHCUs?

P: So, you also want me to mention something concerning support?

R: Yes

P: We should be given an opportunity to go out for trips. We should go out, visit other places and learn from others. We receive grant, they could take some of our grant and organise trips for us. Then we will return home when we are supposed to.

R: Okay, what are the other things you would like to add to what you have just mentioned?

P: They should not be impatient with us. Some of us we are seriously affected by this condition, therefore they should be patient with us.

R: We have come to the end of the interview. Thank you so much, unless you have some questions.

P: I think I contributed enough; I no longer have anything to say.

R: Thank you so much.

ANNEXURE P: EDITING CERTIFICATE

Between the lines editing

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Professional Copy Editor and Proofreader
(BA HONS)

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19 January 2024

To whom it may concern:

I hereby confirm that I edited the thesis titled: "A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH CARE USERS TO PROMOTE CONTINUITY OF CARE". Any amendments introduced by the author hereafter are not covered by this confirmation. Participants' verbatim quotes were not edited. The author ultimately decided whether to accept or decline any recommendations I made, and it remains the author's responsibility at all times to confirm the accuracy and originality of the completed work. The author is responsible for ensuring the accuracy of the references and its consistency based on the department's style guidelines.

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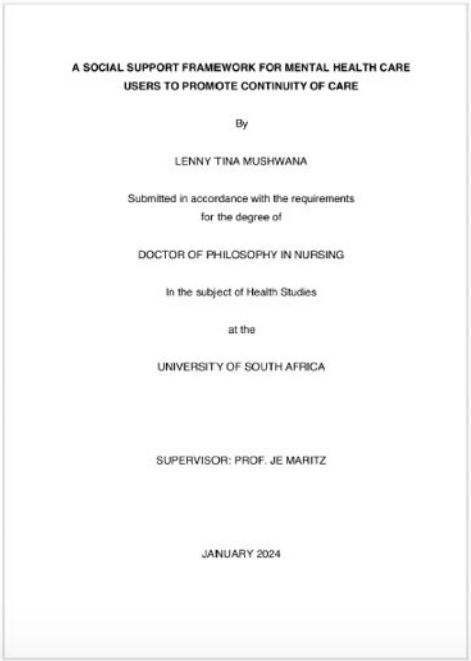

A SOCIAL SUPPORT FRAMEWORK FOR MENTAL HEALTH CARE USERS TO PROMOTE CONTINUITY OF CARE

By

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