A CLINICAL LEADERSHIP-MENTORING FRAMEWORK FOR NURSE MANAGERS IN MENTAL HEALTH CARE SETTINGS

by

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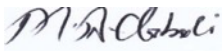
Signature:  **Date**: 30 June 2024

DEDICATION

I dedicate this work to:

My loving family who supported me with prayers and believed in my dream:

- My husband, my rock, Peter Chabedi
- My daughters Bonolo and Nthabiseng
- My grand-daughter Keratiloe

In loving memory of my late parents: Samuel Ndlovu Mathe and Mary Mamagolo Mathe.

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ABSTRACT

In the rapidly evolving landscape of the 21st century, leadership is recognised not merely as an art but as a value-driven imperative vital for transformation across all fields, including mental health care. The ongoing transition from traditional to modern leadership approaches presents fascinating challenges, particularly in nursing. Mentoring of upcoming nurse leaders is essential for a successful role transition.

The purpose of this study was to develop a clinical leadership-mentoring framework for nurse managers in mental health care settings to foster growth in mental health leadership. A qualitative approach and grounded theory design were used to explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders and clinical nurse leaders are faced with in mental health care settings.

Focus group interviews were used for data collection. The population consisted of assistant nursing managers and operational nursing managers working in two public mental health care institutions in Gauteng Province, as these individuals engaged in leading mental health care institutions. The total number of participants for the research study was twenty-seven (27). The sample consisted of assistant nursing managers (n = 12) and operational nursing managers (n = 15). Thematic data analysis was conducted.

The findings revealed that there are challenges experienced by the assistant managers and the operational managers for effective clinical leadership mentoring. The clinical leaders recounted their own experiences of being mentored and identified the factors and strategies that facilitated the mentorship of novice leaders. Institutional and professional challenges, as well as difficulties encountered when working with mentees, were outlined as aspects that impeded effective mentorship. Clinical nurse leaders reflected on opportunities, or a lack thereof, for promotion into leadership positions within a mental health care setting and indicated the importance of sound mentorship to facilitate the process. Dickoff and James' survey list of 1968 was used for the development of a clinical leadership-mentoring framework for managers in mental health clinical settings.

KEY CONCEPTS

Mentoring, clinical leadership, mental health care setting, nurse managers, framework.

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ASD:	Assistant Directors
DoH:	Department of Health
ICN:	International Council of Nurses
GDoH:	Gauteng Department of Health
GP:	Gauteng Province
NDoH:	National Department of Health
NHS:	National Health Service
NHSP:	National Health Strategic Plan
SA:	South Africa
SANC:	South African Nursing Council
SDL:	Self-directed learning
SLT:	Social Learning Theory
UN:	United States
UNISA:	University of South Africa
WHO:	World Health Organization

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In the rapidly evolving landscape of the twenty-first century, leadership is recognised not merely as an art but as a value-driven imperative vital for transformation across all fields, a master building block of the health system, a cornerstone, and a driver of change including mental health care (Sulosaaria, Kosklinc & De Munter 2022:1; Deng, Gulseren, Isola, Grocutt & Turner 2022:627). The ongoing transition from traditional to modern leadership approaches presents fascinating twenty-first-century challenges, particularly in nursing, namely, the ageing generation of nurse leaders, the replacement of current nurse leaders, stability and adequacy in the workforce and restructuring of the healthcare system where innovative approaches are brought to the fore (Jooste 2018:17; Darbyshire, Hungerford, Thompson & Lauder 2020:1).

However, effective clinical leadership development in mental health care requires more than just innovative approaches. It necessitates a supportive environment that fosters growth and evolution. Chisengantambu, Robinson and Evans (2018:192) posited that given the complexities inherent in their profession, this support is particularly significant for up-and-coming nurse managers as future leaders to enhance a robust support system of management practices, construction of formidable organisational leadership, and attracting more nurse leaders to mental health settings. This is supported by Algunmeeyn, Mrayyan, Suliman, Abunab and Al-Rjoub (2023:1) who attested that clinical leadership embraces clinical excellence where multidisciplinary teams and mentoring impact quality patient care and quality for successful role transition.

The National Department of Health (NDoH) highlighted the importance of effective leadership as a strategic function underpinning successful healthcare delivery, according to its fifth domain in the National Core Standards of Health established in 2011 (South Africa 2011). Leaders need a motivator, counsellor and mentor for development and fitting into the rapid scientific advances in the healthcare workforce

and the issue of offering little to no preparation for upcoming leaders will impact leadership in the clinical setting (Koopman, Englis, Ehrenhard & Groen 2021:138). A culture where mentoring is woven into the fabric of leadership development needs to be encouraged.

Mentoring in nursing is paramount to enhancing the professional growth of future clinical nurse leaders as it seeks to provide leadership development opportunities (Institute of Medicine United States [US] Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing 2011:283). Mentoring creates opportunities for personal and career advancement and job satisfaction (Ghitulescu, Khazanchi, Tang & Yu 2021:888; Merga & Mason 2021:1). The clinical leader, in this fourth industrial revolution era, becomes a quality care practitioner who is technologically advanced, and contributes to the scientific discipline of nursing (Wahidin, Wibowo, Abdillah, Kharis, Jaenudin, Purwanto, Mufid, Maharani, Badi`ati, Fahlevi & Sumartiningsih 2020:277).

Clinical leaders of today bear a challenging responsibility as they are expected to manage the units and resources effectively, innovatively, and improve healthcare. The upcoming leaders must be educated as the new workforce and learn on the job, understand how to mobilise resources, be empowered and enlightened (Darbyshire et al 2020:1; Gunalan & Sathyanarayanan 2021:402). Davis and Morley (2022:226) commented that clinical leaders must be well prepared to take the leadership baton as part of succession planning. The development of transformational leaders capable of steering mental healthcare delivery calls for a comprehensive mentoring framework that nurtures novice leaders.

Considering this, the current study focuses on developing a clinical leadership-mentoring framework for nurse managers in mental health care. This framework aims to provide the necessary guidance to support the sub-domain of oversight and accountability in the leadership and governance domain, thereby fostering the growth of mental health leadership. Furthermore, with mental health issues being a burgeoning global concern, the need for a targeted approach to clinical mental health care is more pressing than ever (World Health Organization [WHO] 2021). Thus,

prioritising clinical mental health settings is vital for effectively addressing the rising tide of mental health disorders.

This chapter will delve into the changing landscape of clinical leadership in mental health care, beginning with the evolution of leadership styles and the issues they raise in current practice. It then poses research questions focusing on these challenges and potential solutions. The purpose and objectives of the study will be outlined, along with the potential impact of the research. The guiding research paradigm and underlying theoretical frameworks will be clarified, followed by an overview of the methodology and the strategies of the trustworthiness of the research study. The chapter will conclude by addressing ethical considerations and the thesis chapter outline.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Leadership in a clinical healthcare setting can be dynamic and challenging. A leader must have followers and relationships are built between those who lead and those who follow. Leadership involves motivating and influencing others to achieve an organisational goal (Booyens, Jooste & Sibiya 2019:207).

According to the National Health Strategic Plan 2020/21-2024/25 (NHSP), South Africa 2020, Goal 3 aims to improve the quality of care through enhanced leadership and governance within the health sector (South Africa 2020). Concurrently, Pillar 7 of the NHSP focuses on bolstering governance and leadership, intending to improve oversight, accountability, and overall health system performance at all levels. The mutual goal of these initiatives is to facilitate better quality care through strong leadership and robust governance practices.

It is in line with the above statement that mentoring becomes an important aspect of leadership development in nursing. Makhaya, Lethale, and Mogakwe (2023:1) indicated that mentoring in clinical settings is an overly critical component where nurse leaders are responsible for creating a conducive learning environment that will foster professional growth and quality patient care. Peer mentoring in the clinical setting will enhance a culture of care as the mentor will be focused on an organisational culture where the potential leadership role is developed for the improvement of the

organisation (Joung, Im Kang, Yoona, Leea, Lima, Choa, Chaa & Choia 2020:1). Values, attitudes, decision-making and development processes will be emphasised to assist the upcoming leaders in the leadership role and practices and the organisational culture (Bendak, Shikhli & Abdel-Razek 2020:2). Yetim (2022:50) added that mentor-mentee relationships bring change and transformation in an organisation.

Meyer, Naude, Shangase and van Niekerk (2021:160) stated that an experienced nurse manager, who is a trusted advisor, teacher, and supporter, willingly and intentionally guides an inexperienced nurse into a leadership position, by being involved in the empowerment and professional development of the individual. This was confirmed by Bezuidenhout (2021:291), who explained that in mentoring, an experienced and wiser person guide and nurtures an inexperienced person on a long-term reciprocal process type of relationship for career progression and advancement. Mentoring for leadership development is essential as mentoring is viewed as a developmental partnership that builds the mentee's strengths and interests in leadership, and fosters personal growth, knowledge, and skills (Amparbeng & Pillay 2021:554). This development aligns with the Gauteng Department of Health (GDoH) clinical mentorship programme planned for implementation in 2011, with health care providers to equip the providers with clinical knowledge, skills, and attitudes for competence in providing quality care (NDoH 2011:5). The programme, however, was not planned for leaders in mental healthcare, hence the need for a leadership-mentoring framework for leaders in mental healthcare settings.

1.3 PROBLEM STATEMENT

The researcher's background in mental healthcare settings has provided first-hand insights into leadership transition challenges. As an operational manager, the researcher was required to step into the role of the assistant nurse manager during their absences. This task was not straightforward without the presence of a mentor to guide this novice operational manager through the nuances of higher-level leadership. Consequently, without adequate support, one might question their leadership efficacy and even contemplate leaving the profession or department where they are tasked with leadership responsibilities.

Koenig (2019:54) challenged nursing professionals to assess whether they are fulfilling their mentorship roles for emerging nurse leaders. Mentors are more than teachers; they function as motivators, counsellors, referral agents, door openers, and role models. For a young, uncertain new nurse leader, the presence of such mentors can alleviate frustrations tied to their new leadership role and guide their leadership journey.

Breed, Downing and Ally (2020:2) underscored that an organisation's success relies heavily on leadership. As first-level leaders, unit managers must be motivated and capable of inspiring others. Novice clinical nurse leaders may lack comprehensive leadership skills at the onset of their roles and require experienced leaders to guide their progression.

Healthcare systems worldwide grapple with multifaceted challenges such as complex clinical health problems, financial constraints, organisational structures, and quality of care. Consequently, clinical leadership is highlighted as a potential solution to these issues (Hofmann & Vermunt 2021:253).

The need for robust clinical leadership development in nursing is vital for transforming the health and mental health care systems in South Africa (SA). The current literature on the topic of mental health nursing leadership is scant. Some earlier studies have discussed frameworks of succession planning (Breed et al 2020:1) and the role of mental health nursing leadership (Grove, Clarke, Currie, Metcalfe, Pope & Seers 2020:1), while others have focused on the influences of nursing transformational leadership style due to the growing shortage of nursing leaders (Deng et al 2023:625; Aydogdu 2023:1). Most current mentoring studies predominantly concentrate on mentoring emerging nurse educators in nursing faculty leadership roles (Clochesy, Visovsky & Munro 2019:62; James, Watkins & Carrier 2022:1) or on supporting nurse mentor development within nursing education (MacLaren 2018:66; Linares, Higueras, Martin-Ferreres, Torre, Capellades & Fernández-Puebla 2020:1; Vauhkonen, Saaranen, Cassar, Camilleri, Martín-Delgado, Haycock-Stuartf, Solgajova, Elonen, Pasanen, Virtanen & Salminen 2024:1).

A discernible gap in the literature, however, is the lack of studies concentrating on mentoring, developing future clinical nursing experts, and addressing the clinical challenges faced in mental health care settings. Within this context, the researcher identifies a need to develop a clinical leadership-mentoring framework specifically for nurse managers in mental health settings within Gauteng Province (GP).

1.4 RESEARCH QUESTIONS, PURPOSE, AND OBJECTIVES

This section outlines the current study's research question, purpose, and objectives.

1.4.1 Research questions

In this research study, the problem statement has guided the formulation of the research questions. The problem statement highlighted the lack of a clinical leadership-mentoring framework specifically for nurse managers in mental health settings. The research questions were:

Phase 1: Situational analysis

- What leadership-mentoring opportunities and challenges are novice clinical nurse leaders facing in mental health care settings?
- What leadership-mentoring opportunities and challenges do establish clinical nurse leaders face in mental health care settings?
- What are the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting?

Phase 2: Framework development

- What should a clinical leadership-mentoring framework for nurse managers in mental health care consist of?

Phase 3: Framework evaluation and validation

- What is the efficacy of the existing clinical leadership-mentoring framework in improving leadership abilities among mental health care professionals?

- How do subject matter experts perceive the developed framework through a structured questionnaire, to validate the effectiveness and relevance of the framework?

1.4.2 Research purpose

The research purpose, which is generated from a research problem and research questions, outlines the essence and captures the intent of a study (Brink & van Rensburg 2022:60). For this research, the purpose and objectives were outlined as follows.

- The purpose of this study is to develop a clinical leadership-mentoring framework for nurse managers in mental health care to foster growth in mental health leadership.

1.4.3 Research objectives

The research objectives are outlined in three phases, namely:

Phase 1: Conducting a situation analysis with the following objectives:

- To explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders face in mental health care settings.
- To explore and describe leadership-mentoring opportunities and challenges established clinical nurse leaders face in mental health care settings.
- To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting.

Phase 2: Framework development

- To develop a clinical leadership-mentoring framework for a mental health care setting.

Phase 3: Framework evaluation and validation

- To evaluate the clinical leadership-mentoring framework for a mental health care setting.
- To validate the developed framework through a subject matter expert questionnaire.

1.5 SIGNIFICANCE OF THE STUDY

The study may assist with the development of a clinical leadership-mentoring framework. The findings of this study may improve the clinical leadership of nurse managers in mental health care institutions. The study may also assist in improving the positivity and confidence of upcoming nurse leaders as strategies to enhance and strengthen leadership development will be outlined.

The DoH document regarding the National Strategic Direction for Nursing and Midwifery Education and Practice 2020/21-2025/26 Goal 4 (South Africa 2020:19), speaks to leadership, management, and governance. It is concerned with the empowerment, competency, accountability, and capacity of national, provincial, and district nurse leaders and managers. The study may assist in the development of policies regarding leadership and governance. Mentoring policies in the clinical sector can be investigated for bringing about reform and development in clinical leadership.

The researcher's purpose for undertaking the research study will contribute to an in-depth understanding of mentoring for clinical leadership, add new dimensions, and foster growth in mental health leadership. No studies were done on leadership for mentoring within the mental health clinical setting therefore the researcher's development of a mentoring for clinical leadership framework will bring improvement of leadership within the mental health clinical settings. The study's findings will be shared in conferences, workshops, and research articles, thus expanding, and transferring the use of the framework, even for other disciplines and/or clinical leadership settings.

1.6 DEFINITIONS OF TERMS

The following definition of terms is applying to this study:

1.6.1 Clinical leadership

Hofmann and Vermunt (2021:253) defined clinical leadership as the leadership of clinicians in the context of their clinical roles, which involves broadening clinicians' existing roles, training, and competence and this does not replace clinical practice with formal management positions.

For this study, clinical leadership shall refer to mental health leadership, where a positive influence is given by an experienced clinical nurse manager to an inexperienced/novice clinical nurse manager in mental health care to promote and improve the novice's potential to lead and coordinate a team, whilst also developing and enhancing leadership excellence.

1.6.2 Mental healthcare setting

The Mental Health Care Act 17 (2002:6) defines a health establishment as an organisation, structure, or location that provides care and support for rehabilitation and treatment, therapeutic or diagnostic interventions, or other health services to individuals, and includes establishments like clinics, hospitals, mental health hospitals, and community health and rehabilitation centres.

In this study, a mental health care setting shall refer to a public mental health hospital where persons receive care treatment and rehabilitation in units managed by clinical nurse managers. The mental health care setting shall refer to the two public mental health hospitals in GP.

1.6.3 Mentoring

Mentoring is an intense form of a role-framework process where an experienced person collaborates with an inexperienced person, intending to impart knowledge and

new skills (Bezuidenhout 2021:289; Meyer et al 2021:160). Henderson, Hughes, Hurley, and Smith (2022:3302) added that it is a teaching-learning process between a more knowledgeable, experienced person with wisdom, transmits knowledge and extends psychosocial support to an inexperienced person, for career and professional development, over some time.

In the context of the current study, mentoring will refer to the relationship between an experienced clinical nurse manager and a novice clinical nurse leader in mental health care to guide, supervise, support, and monitor progress in the leadership of a novice clinical nurse manager by an experienced, knowledgeable clinical nurse manager in mental health care.

1.6.4 Framework

Chinn, Kramer and Sitzman (2022:263) define a framework as a representation of an experience outlined and described as pictures, diagrams, mathematic notations, or physical material.

For this study, a framework shall refer to the symbolic representation of the clinical leadership-mentoring framework for nurse managers in mental health care settings.

1.6.5 Nurse managers

Meyer et al (2021:3) define a nurse manager a nurse who manages people and patients in the healthcare facility, using the scientific knowledge and skills learned.

For this study, a nurse manager shall refer to a deputy nurse manager and an assistant nurse manager who provides effective leadership and support to a novice leader, the operational manager, in a mental health care setting to ensure proper administration and decision-making powers within a unit. In this study, nurse managers and nurse leaders are used interchangeably.

1.7 FOUNDATIONS OF THE STUDY

The research paradigm and theoretical foundations in research will be discussed below.

1.7.1 Research paradigm

Gray and Grove (2021:817) present a paradigm as a constellation of philosophical or theoretical concepts that shape our understanding of the world. Furthermore, Chinn et al (2022:264) define a paradigm as a criterion used to assign value and worth to a process, product, or discipline and its methods of knowledge development.

The researcher adopted a constructivist approach to navigate the research process in this study. In constructivism, the constructivist and the participants construct meaning concerning experiences or areas of inquiry (Tie, Birks & Francis 2019:2). Davis, Jones, Settles, and Russell (2022:1068) posited that constructivism aims to theorise the sociocultural contexts and structural conditions of individual accounts. The choice of constructivism allowed the researcher to probe and comprehend the phenomena of leadership and mentoring as construed by managers within a mental health clinical setting.

Cognitive constructivism was pertinent to the study as it sought to glean the perspectives of assistant and operational nurse managers concerning their interactions, knowledge transfers mechanisms, and adaptive strategies implemented to make actions viable for developing leadership skills. This paradigm facilitated the understanding of how knowledge and skills are imparted from experienced individuals to those less experienced, thus reinforcing the rationale for adopting a constructivist approach in this study.

1.7.2 Theoretical framework

A theoretical framework provides an explanation and interpretation for a phenomenon under study. It can be seen as a foundation on which a study is built in theory-based studies (Luft, Jeong, Idsardi & Gardner 2022:2; Polit & Beck 2021:786). Salawu,

Bolatitio and Masibo (2023:2104) added that theoretical frameworks give a general representation of relations, outlining the theoretical portion of the work that should be done and the current theories that researchers have provided in the field to support the research project. These researchers added that a theoretical framework may also be considered as a collection of related theories that direct the research. Jaakkola (2020:20) posited that a theoretical framework will assist in developing theoretical assertions that establish new constructs and interactions between constructs, forecast interconnections between constructs, recognise unique linkages between constructs, and describe the reasons behind the results of a series of events.

Two theoretical frameworks align with the study: Bandura's social learning theory (SLT), established in 1977, and McGregor's transformational leadership theory of 1978. Bandura's SLT is concerned with observation. In SLT, there is an interaction between people, and learning takes place through observation, imitation, and modelling within a social context. Attention, motivation, attitudes, and emotions enable learning to take place as the behaviour of others is observed (Firmansyah & Saepuloh 2022:299). The operational manager observes how the assistant manager leads and follows the steps.

This theoretical framework aligns with the paradigm of cognitive constructivism outlined earlier in the sense that SLT posits that people learn from one another via observation, imitation, and framework and is perceived as a bridge between behaviourist and cognitive learning theories because it encompasses attention, memory, and motivation. New knowledge and skills are acquired by paying attention and as the individual pay attention, observations are retained for reproduction later and continuation with the newly learned behaviour (Yarberry & Sims 2021:240). The operational managers observe and imitate the assistant managers' leadership skills; hence, the SLT was relevant to the study.

The researcher acknowledges the use of theories and the significant alignment of the SLT to this study, however, opted to apply inductive reasoning for analysing and understanding the data collected. Wijayanto, Priyatiningsih, Herman, Sudadi and Saputra (2023:1019) indicated that inductive reasoning starts with observing an object or event and proceeds to derive conclusions about the observed entity. Inductive

reasoning offers a framework for generalisation that goes beyond statistical testing and compels one to consider the boundary conditions of a hypothesis and make analyses by finding similarities, differences, and links between the features, breaking down information into its constituent parts, and creating links between them (Borgstede & Scholz 2021:5; Misrom, Muhammad, Abdullah, Osman, Hamzah & Fauzan 2020:159). The researcher used the raw data to produce themes and categories.

1.7.2.1 Bandura's social learning theory

SLT posits that people learn from one another via observation, imitation, and modelling. The fundamental aspects of this theory, which is cognitive based, are understanding, predicting, and reshaping behaviours (Yildirim, Isik, Gulcek & Aylaz 2020:1366; Yarberry & Sims 2021:240). SLT entails four steps, namely the attentional phase, retention phase, reproduction phase, and motivational phase.

The inexperienced nurse leader pays attention to the continuous mannerisms, culture, and processes the experienced leader leads a team. In this study, the researcher is more concerned with the reinforcement of behaviour by the experienced leader towards the inexperienced leader.

The second assumption in SLT entails that rewarded observed behaviour will be repeated. The inexperienced nurse leader will imitate the experienced leader's behaviour and manner of doing things, and that will build confidence in the inexperienced leader. Sound leadership principles will be adhered to through support, guidance, and affirmation from an experienced leader. In SLT, behaviour is learned through role-modelling, identification, and human interaction (Varcarolis & Fosbre 2021:342).

In the mentoring for leadership framework, the researcher aimed to achieve processes of learning and sharing of information and skills from experienced leaders to inexperienced leaders.

1.7.2.2 Transformational leadership theory

As propounded by McGregor Burns in 1978, the transformational leadership theory suggests that leaders can instigate innovation and change within their followers and the organisation. These leaders cultivate an entrepreneurial spirit, facilitate innovation, and exhibit a strong sense of care and ethical character. Transformational leadership encapsulates that leaders and followers become partners, pursuing a common goal. Such leaders champion change, introduce innovative ideas and build trust-based relationships to generate synergy in the workplace (Melnyk & Fineout-Overholt 2019:335).

The first element of this theory emphasises shared achievements and the communication of a shared vision. Leaders in this framework motivate and inspire, show consideration for their subordinates, foster a culture of collaboration, demonstrate respect, and bring out the best in their followers. They are also committed to team building (Booyens et al 2019:211). Melnyk and Fineout-Overholt (2019:335) support this by outlining the four dimensions of transformational leadership: idealised influence, inspirational motivation, intellectual stimulation, and individualised consideration. These aspects were pertinent to developing a leadership-mentoring framework in the mental health clinical setting, given that a transformative leader requires such attributes.

The second element of the transformational leadership theory underscores the significance of nurturing trusting relationships. In the ever-changing workplace environments, the mentee should be empowered and supported by the mentor and be allowed to come up with innovative ideas, for the improvement of working conditions and quality patient care. The mentee must build the confidence of the mentee to lead by leading by example and forming trusting relationships (Aydogdu 2023:1751).

The third element involves the leader empowering followers to participate in decision-making and risk-taking. The leader is result-driven and delegates tasks and responsibilities to create a power-sharing environment where information and strategic directions and decisions are made together (Fotso 2021:573). An experienced leader can inspire and empower inexperienced leaders, hence the relevance of the

transformational leadership theory in this study. The objective of the clinical leadership-mentoring framework was to promote growth and development within mental health leadership.

Finally, transformational change is the fourth element of the transformational leadership theory. The leader creates an environment where members continually learn and adapt to changes, moving away from traditional structures. Clear goals, objectives, planning, and procedures are put forward for the upcoming leaders under the expert leader's monitoring, coordination, and motivation. Adaptation to leadership changes, trends, diverse working forces, shared decision-making and organisational changes is encouraged (Fotso 2021:579; Meerits & Kivipold 2020:960). This element proved significant in the researcher's aim to develop a leadership-mentoring framework.

1.8 RESEARCH DESIGN AND METHODS

A qualitative approach and grounded theory design were used for the study. Glaser and Strauss (1967:6) outlined that in grounded theory design, data is used for developing a theory, and this assists the researcher in not approaching the research with pre-existing concepts. Still, that theory should emerge from the data without making assumptions (Schurink, Schurink & Fouché 2021:298).

The research questions aim to describe the experiences of study participants, generate a framework or theory, and bring an understanding of human behaviours and experiences within a social or cultural context (Gray & Grove 2021:135).

The researcher aimed to explore and describe the mentoring for leadership opportunities and challenges that novice and expert clinical nurse leaders face in mental health care settings and to develop a mentoring for leadership framework for clinical leadership in mental health care settings. The design will be discussed in full in chapter three.

1.8.1 Setting and population of the study

The research was conducted at two public mental health care institutions in Gauteng Province. The province has private and public mental health care institutions that admit mental health care users voluntarily or involuntarily. The two institutions selected for the research are situated in various locations, one on the western side and the other on the eastern side of Tshwane, the capital city of GP. The institution is in the east of Tshwane and caters for individuals with intellectual disabilities. The one institution located in the west of Tshwane caters for a range of mental health care users as stipulated in the Mental Health Care Act 17 of 2002. Both institutions have acute and chronic units managed by operational nursing managers. The two institutions have a history of more than a hundred years of establishment and have been catering to mental health care users from all over GP and the surrounding provinces.

The population consisted of assistant nursing managers and operational nursing managers working in the two public mental health care institutions in GP, as these individuals participate in leading mental health care institutions. The total population was included in the study.

1.8.2 Sample and sample methods

The total population for the study who were purposefully selected was fifty-six (56), consisting of nineteen (19) assistant nursing managers and thirty-seven (37) operational nursing managers.

1.8.3 Data collection methods and procedures

Data were collected through focus group interviews (Gray & Grove 2021:811) at the two mental health care institutions with assistant and operational nurse managers. Observation and field notes were additional data (Polit & Beck 2021:795). The data collection will be discussed in full in chapter three.

1.8.4 Data analysis

Grounded theories approach analysis was relevant for this phase of the research, as the researcher was able to analyse the perceptions, attitudes, understanding, knowledge, values, and experiences of participants regarding mentoring for leadership in a mental health clinical environment (Creswell, Ebersohn, Eloff, Ferreira, Ivankova, Jansen, Nieuwenhuis, Pietersen & Plano Clark 2021:123). The data analysis will be discussed in chapter three.

1.8.5 Framework development, evaluation, and validation

In this study, framework development draws from the survey list described by Dickoff and James (1968:197). The constructed framework was evaluated using a checklist designed based on the evaluation criteria presented by Chinn, Kramer and Sitzman (2022:264). The framework validation was conducted by employing a face validity checklist based on the research of Bölenius, Brulin, Grankvist, Lindkvist, and Söderberg (2012:3), as well as content validity standards outlined by Sangoseni, Hellman, and Hill (2013). A full description of the design and methods will be presented in chapter three.

1.9 ETHICAL CONSIDERATIONS

The University of South Africa (UNISA) Ref: HSHDC/748/2017 (refer to **Annexure A**), permission request from Gauteng DoH (refer to **Annexure B**), Gauteng DoH, GP Ref: GP_201801_009 approval letter (refer to **Annexure C**) and the two institutions also permitted the use of the institutions as study settings (refer to **Annexure D, E, F** and **G**).

Protecting human rights is a justifiable course expected from researchers in biological and human research (Gray & Grove 2021:195). Every being has human rights by just being human and these rights function as a basis and framework for protection should one be interested in taking part in a research study. A researcher must protect the research participants and ensure that the research benefits outweigh its risks (Brink & van Rensburg 2022:33). The researcher signed the university declaration of

confidentiality, regarding security and confidentiality of data and identifiable information (refer to **Annexure H**).

The Belmont Report outlines the importance of protection from psychical and psychological harm to human subjects during the conduction of research by ensuring that proper information is given on consent forms and information leaflets regarding research to be undertaken, publication of research data that adheres to anonymity, and the importance of the establishment of standards and ensuring that participants also gain from the research (Belmont Report No. 78 1979:12).

During research conduction, the researcher must be aware of and adhere to the declarations for respect of human rights and bioethics. It becomes paramount for the researcher to adhere to and protect participants so that the ethics of care, virtue, and justice are accounted for (Booyens et al 2019: 45).

The following human rights were taken into consideration:

1.9.1 Right to self-determination

The above right is based on the principle of respect for persons, whereby the researcher allows autonomy with no external controls. In autonomy, the participants have a right to decide whether to participate in the study without being forced, pressured, or coerced (Grove & Gray 2023:107).

A participation information leaflet was issued to participants (refer to **Annexure I**). The information leaflet clarified the study and indicated to participants the right to withdraw without penalty, if feeling uncomfortable. The participants voluntarily took part in the study, after signing an informed consent (refer to **Annexure J**). The participants' demographic information was captured on a demographic information leaflet (refer to **Annexure K**).

1.9.2 Right to privacy and dignity

Gray and Grove (2021:203) explain that the extent of privacy considers the principle of respect and entails that information that needs to be shared or withheld from others depends on the participants, as the information embraces attitudes, behaviours, opinions, and records. Participants have a right to determine the confidential handling of the shared information (Strydom & Roestenburg 2021:124).

To adhere to the above right, the researcher did not collect any data from participants without their knowledge, and the extent to which the participants wanted to share information was respected. The focus group interviews were conducted in the nursing management boardroom, a safe, private venue behind closed doors, where no disruptions or interferences from outside occurred. The participants' identities were protected by using codes on the collected data and not the names.

1.9.3 Right to anonymity and confidentiality

In anonymity, a participant's identity in a research study cannot be linked to the participants as the researcher shares no personal information in line with the participant's responses (Strydom & Roestenburg 2021:124), whilst in confidentiality, the participants cannot be linked to the information provided and the participant's identity is not divulged to the public (Grove & Gray 2023:109). In focus groups, however, participants may feel uncomfortable participating in a group discussion with colleagues due to open identity (Brink & van Rensburg 2022:170).

To this effect, participants were requested to keep the information and identities of members private. External confidentiality was ensured by allocating numbers to participants' data during interviews and not mentioning names in publications. Data collected was stored in a safe with controlled access.

1.9.4 Right to protection from discomfort or harm

This right is based on the principle of beneficence, where the researcher is expected to protect participants from harm that may be physical or psychological (Grove & Gray

2023:110). Some psychological risk was anticipated in this research as focus group interviews were conducted. Some participants felt uncomfortable speaking in front of their colleagues for fear of victimisation. The researcher may refer such matters to the psychologist on duty at the facility.

The participants were allowed to withdraw from taking part in the research if feeling uncomfortable without penalty. The researcher reassured the participants during a briefing about the research to be conducted and even during the entire data collection process. No spiritual, economic, social, or legal harm was anticipated in the study.

The risk involved was that some participants may not be keen to speak in a group and may feel intimidated to speak in front of their colleagues. A debriefing session was held to address the risk, after an interview session by the researcher to clarify and put the participants at ease.

1.9.5 Right to fair treatment

In the principle of justice, the researcher is expected to treat participants fairly, as individuals or as a group, in an equitable manner to the treatment of other persons exposed to the same situation (Grove & Gray 2023:111). To adhere to this principle of fair treatment, which is based on the principle of justice, where the researcher chooses participants that are linked to the research study (Brink & van Rensburg 2022:38). The participants were selected for reasons related to the research problem, regardless of age, race, and socioeconomic status. The entire population was included in the study.

1.10 MEASURES OF TRUSTWORTHINESS

Polit and Beck (2021:806) outlined that the level of assurance that qualitative researchers have on their information and interpretation depends on adherence to the to the principle of trustworthiness. Lincoln and Guba (1985:195) identified four operational techniques for ensuring trustworthiness in qualitative research: credibility, transferability, dependability, confirmability, and authenticity. These will be discussed in detail in chapter three.

There are, however, other criteria that can be followed to enhance the trustworthiness of a research study. Tracy (2010:840) discussed the eight “Big-Tent” criteria for qualitative research: worthy topic, rigour, sincerity, credibility, resonance, significant contribution, ethical and meaningful contribution.

1.10.1 Worthy topic

The researcher deems the topic under study to be a worthy topic, as it is relevant and significant to the leadership within the nursing profession that needs to align itself with the new trends of leadership aiming at setting direction, opening possibilities for upcoming leaders to achieve potential in leading and building context of improvement in health care settings.

1.10.2 Rich rigour

In qualitative research, rigour signifies that the study was conducted according to the accepted scientific standards, maintaining high objectivity throughout the process (Gray & Grove 2021:79).

The researcher adhered to the theoretical framework of the research, used the correct sample relevant to the research under study and ensured that the data collection and analysis processes relevant to the study were correctly followed.

1.10.3 Meaningful coherence

Tracy (2010:840) stated that a research study will have meaningful coherence; it achieves what it purports to be about if it uses methods and procedures befitting its stated goals and has meaningful coherence to literature, research questions, and findings.

The researcher ensured that the reviewed literature connected and correlated to the data collected, and findings outlined in the study. Data collection and analysis methods relevant to the study were followed and applied.

1.10.4 Sincerity

This concept relates to the end goal of a research study, where the researcher investigates self-reflection, honesty, vulnerability, and transparency. The researcher will honestly reflect on how biasness was dealt with during the research and what mistakes and joys were encountered during the study (Tracy 2010:841).

In this study, this was reflected by the researcher by being open and approachable to participants during the conduction of the research and by taking into consideration, the needs of participants, like, answering any questions and concerns that participants had regarding the topic under study or information outlined on the information leaflet.

1.10.5 Credibility

In qualitative research, a study is considered credible, if there is confidence in the truth of the data and interpretation thereof. The study needs to be conducted in a way that will enhance the believability of the findings and the reader will find confidence that the researcher has produced results that reflects the true value of the views of the participants in the study (Polit & Beck 2021:569; Brink & van Rensburg 2022:130).

The researcher took field notes in addition to the tape-recorded interviews and used the expertise of an independent coder to analyse the data, to get a clear and meaningful interpretation. A theoretical framework relevant to the topic under study was outlined and used.

1.10.6 Resonance

Tracy (2010:844) defines resonance as the researcher's ability to affect the audience and to have a continuous and severe effect on the audience by being able to express in writing in a creative, complex, and artistic manner the deep feelings and perceptions expressed by participants.

Chapter four entails data analysis, clearly outlining the resonance, with a clear description and deep meaning of the subject under study.

1.10.7 Significant contribution

A research study that has a significant contribution contributes to the climate of knowledge, improves practices, liberates, and empowers, and can generate ongoing research. The study should give theoretical, heuristic, practical, or methodological significance (Tracy 2010:846).

In terms of theoretical significance, the current study anticipates contributing to existing theoretical concepts, building other theories, or bringing new understanding of the phenomena under investigation. Heuristic significance gives substantive suggestions and enables researchers to explore more related topics. The practical relevance allows researchers to enquire if the knowledge gained is valuable whilst methodological significance introduces new research approaches (Tracy 2010:846).

The researcher, under the topic of the significance of the study, has outlined how this research will contribute to the enhancement and improvement of clinical leadership, development, and improvement of leadership and mentoring policies and addressing leadership challenges in governance and positive practice environments.

1.10.8 Ethical measures

Ethics in research involves one's character, disposition, and morals to know whether a behaviour is right or wrong and conforms to a code or set principles. This enables a researcher to be careful of wrong and right when researching as it prevents research abuses and emphasises the sensitive and humane treatment of participants by the researcher (Strydom & Roestenburg 2021:118).

1.11 STRUCTURE OF THE THESIS

The thesis is organised into seven chapters, each addressing distinct elements of the research:

Chapter 1 offers an orientation of the study, laying out the introduction, background, and significance of the research problem. This chapter also clarifies key concepts,

outlines the study's theoretical foundations, research design and method, and delineates the scope of the study.

Chapter 2 presents a comprehensive literature review of the research topic and methodologies. This synthesis of existing literature provides a context for the research at hand.

Chapter 3 articulates the research design and methods, detailing the population, sampling strategy, and ethical considerations. This chapter also encompasses data collection and analysis methods and the measures taken to ensure the study's trustworthiness.

Chapter 4 provides an analysis, presentation, and description of the research findings. It discusses data management and analysis techniques, outlines sample characteristics, and presents a comprehensive overview of the research findings.

Chapter 5 presents a discussion of the findings. It outlines a thorough discussion of the results on the data gathered.

Chapter 6 offers a detailed description, development, and evaluation of the framework derived from the study's findings. Any revisions or enhancements to the framework are also discussed here.

Chapter 7 concludes the thesis by summarising and interpreting the research findings, conclusions, and recommendations. This final chapter also outlines the study's contributions and limitations.

1.12 SUMMARY

This chapter has introduced the study, exploring the background and rationale behind the research. The purpose and objectives of the research have been articulated, and the significance of the study, its theoretical underpinnings, research design, and methods have all been outlined. This introduction also presents a roadmap of how the research chapters will unfold. The following chapter will present a detailed exploration of the literature related to the study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

Clinical leadership and mentoring within healthcare, have been indicated as the driving force for quality care, which affects service development, favourable clinical outcomes, and employee engagement (Gunalan & Sathyanarayanan 2021:1). A need to develop leaders has been recognised as there is a rapid change in the healthcare environment, which challenges the leadership approaches and their effect on healthcare outcomes (McGowan, Hale, Bezner, Green-Wilson & Stokes 2020:231). The nature of mental health care requires effective leadership to navigate the complexities of treatment, interdisciplinary collaboration, and patient management. There is critical importance for the development of clinical leadership skills among nurse leaders, a recognition of the importance of effective clinical leadership to patient outcomes and participation in clinical leadership (Gunalan & Sathyanarayanan 2021:5; Kakemam & Goodall 2019:108). It is imperative to investigate and comprehend the connections between clinical leadership and mentorship for managers in mental health clinical settings, given the growing need for high-quality mental health treatment (Kemp, Chwastiak, Petersen, Bhana, Wagenaar, Unützer & Rao 2024:126).

2.2 OBJECTIVE OF THE LITERATURE REVIEW

The primary objective of this literature review is to explore the theoretical foundations, leadership styles, and importance of mentoring in mental health clinical leadership. Additionally, the review will evaluate the challenges clinical leaders face in mental health settings and how mentoring can serve as a mitigating factor. The review aims to highlight successful integrations of clinical leadership and mentoring and the strategies for overcoming the implementation of mentoring for leadership. The review will conclude by identifying gaps in current research and establishing the rationale for the present study.

2.3 SEARCH STRATEGY

The literature review encompassed a wide range of sources to ensure a robust understanding of the existing research and theories related to leadership, mentoring, mental health settings, and the intersection of these areas.

A range of search engines and databases were used to conduct this literature review, including PubMed, Google Scholar, Scopus, and Web of Science. These databases were chosen due to their extensive coverage of the medical, health sciences, social sciences, and psychological disciplines. The literature review was conducted exclusively in English to ensure a clear and cohesive interpretation of the existing research, nevertheless, papers published in other languages were considered if their abstracts were available in English. This strategy reduced language bias and ensured a clear and cohesive interpretation of the existing research.

Key search terms used in various combinations included "leadership", "mentoring", "nurse managers", "clinical leadership", "transformational leadership", "mental health settings", "healthcare", "mental health clinical setting", "leadership-mentoring model", "nursing", and "clinical nursing". Boolean operators were employed to refine the search and obtain the most relevant literature.

2.4 THEORETICAL FOUNDATIONS OF CLINICAL LEADERSHIP AND MENTORING

The theoretical foundations that underpin clinical leadership and mentoring provide a framework for understanding and applying effective leadership and mentoring strategies in the complex and dynamic field of mental health care. Key theoretical frameworks include transformational leadership theory, situational leadership model, SLT, and psychosocial development theory. The role of the literature in grounded theory will be discussed first.

2.4.1 Grounded theory

The role of a literature review in a grounded theory study is a topic of considerable debate among researchers. Traditionally, grounded theory research has been associated with a less conventional approach to literature reviews, as the methodology itself is inductive and aims to generate a theory grounded in empirical data (Charmaz 2014:1075). However, the literature review can still be pivotal in grounded theory studies.

The literature review identifies knowledge in a particular field, highlights gaps in the literature, clarifies information that is already known, links theory to practice, shapes the researcher’s structure on the subject, places the research project in the historical, methodological and theoretical context of a particular and identifies what research has been performed and what topics require further investigation in a specific field of knowledge practice (Leite, Padilha & Cecatti 2019:2).

On the other hand, opponents of incorporating a literature review in grounded theory studies argue that preconceived ideas stemming from the literature might hinder the researcher's openness to the data, constraining the development of a truly 'grounded' theory as outlined by Glaser in 1992. This perspective stems from the belief that grounded theory should emerge purely from the data, with no pre-existing concepts guiding the research process. This is associated with Glaser's version of grounded theory, which advocates for a more 'emergent' approach.

Tie et al (2019:3) posited that grounded theory aims to generate theory from data collected methodically and examined through comparative analysis. The data is used to construct inductive analysis to generate conceptual frameworks or ideas. Charmaz and Thornberg (2021:305) added that as a methodical approach to research, grounded theory directs the collection of data and offers explicit guidelines for its analysis, thus developing a theory that provides an abstract knowledge of one or more key issues in the world under study, is the method's defining goal. They also added that in grounded theory investigations, the researcher's analytical emphasis is determined throughout the study process rather than before the commencement of empirical inquiry. Grounded theory denotes an inductive investigation where the

researcher questions information provided by participants or gathered from previous studies, thus validating concepts and their causation with others (Mokgohloa, Kanakana-Katumba, Maladzhi & Xaba 2021:314).

The literature review on grounded theory, outlined by the researcher in chapter one, indicated that a grounded theory approach was used, where data collected from the participants was used, to develop a clinical leadership framework without the researcher making assumptions about the participants' lived experiences. The researcher will approach the literature on leadership for mentoring, with an open mind, conscious of the potential influence on data interpretation.

2.4.2 Transformational leadership theory

Transformational leadership theory, proposed by James MacGregor Burns in 1978, emphasises the importance of leaders inspiring and motivating their teams through shared vision and values. This theory posits that effective leaders go beyond transactional exchanges and create a vision that transcends individual interests, fostering a sense of collective purpose and commitment (Deng et al 2023:627). Transformational leadership is relevant in mental health care, where interdisciplinary collaboration and patient-centred approaches are crucial.

Transformational leaders in mental health clinical settings can inspire teams to embrace innovative approaches, advocate for patient well-being, and actively contribute to a positive organisational culture. Transformational leaders can motivate healthcare professionals to overcome challenges and actively implement continuous improvement initiatives (Deng et al 2023:630).

2.4.3 Situational leadership model

The situational leadership model, developed by Paul Hersey and Kenneth Blanchard in 1982, revolves around the idea that leadership styles should be flexible and adapted based on the readiness or maturity of followers. This model categorises followers into four stages of readiness: directing, coaching, supporting, and delegating (Cortes 2023:19). In mental health clinical settings, where healthcare professionals possess

varying levels of expertise and experience, the Situational Leadership Model becomes valuable for tailoring leadership approaches accordingly.

Leaders using the situational leadership model in mental health care can assess the readiness of their teams and adjust their leadership styles to provide the necessary guidance and support. When dealing with less experienced staff, a leader may adopt a more directive style, gradually transitioning to a coaching or supporting style as the staff members gain expertise (Cortes 2023:19).

2.4.4 Social learning theory

SLT, proposed by Albert Bandura in 1977, emphasised the importance of observational learning and modelling in the developing behaviour. In the context of mentoring in mental health settings, SLT suggests that mentorship involves learning through observing and imitating experienced leaders (Khushk, Ihsan Dacholfany, Abdurohim & Aman 2022:3).

This theory highlights the significance of role modelling and the impact of positive mentor behaviours on the professional growth of mentees. In mental health clinical settings, where experiential learning is crucial, mentorship programmes that incorporate the principles of SLT can be effective. Mentees observing the practices of experienced leaders are likely to acquire technical skills values and attitudes that contribute to effective clinical leadership in mental health care (Khushk et al 2023:2).

2.4.5 Psychosocial development theory

Psychosocial development theory, developed by Erik Erikson, posits that individuals go through a series of psychosocial stages throughout their lives, each characterised by specific developmental tasks and challenges (Rorije, Damen, Janssen & Minnaert 2023:14). In the context of mentoring in mental health settings, this theory suggests that mentorship can contribute to the psychosocial development of mentees by assisting them in navigating the challenges inherent in their professional roles.

Psychosocial development theory highlights the importance of mentorship in fostering the development of identity, competence, and autonomy in mental health professionals. Mentors contribute to resolving psychosocial tasks and challenges mentees face, enhancing their overall professional development (Rorije et al 2023:14).

2.5 CLINICAL LEADERSHIP STYLES IN MENTAL HEALTH CLINICAL SETTINGS

Clinical leadership in mental health settings requires an understanding of various leadership styles, as the complex nature of mental health care demands adaptability and a patient-centred approach. Distinct styles include autocratic, participative/ democratic, servant, and transactional leadership.

2.5.1 Autocratic leadership style

The autocratic leadership style is characterised by centralised decision-making, where leaders make quick and decisive decisions, without involving the followers. This style may find efficacy in crises, in mental health clinical settings ensuring prompt actions and clear directions. Its long-term application may however, stifle creativity and innovation, potentially leading to decreased employee engagement, high absenteeism, and labour turnover (Oyindobra, Johnson & Julianah 2022:192).

Rosing, Boer and Buengeler (2022:3) added that this style's strength lies in its ability to streamline the decision-making and power processes of the leader, where the leader acts quickly and makes unilateral decisions, and provides clarity in roles and expectations, without consultation with the team. In mental health emergencies, where swift and decisive actions are paramount, autocratic leadership can effectively maintain order and prevent chaos. Autocratic leadership style weaknesses become apparent when considering the mental health care's collaborative and interdisciplinary nature. Autocratic leadership has a detrimental impact on outcome factors such as team interaction, organisational commitment, task performance and job execution (Du, Li & Luo 2020:2).

While valuable during emergencies, autocratic leadership is insufficient to promote the multidisciplinary cooperation necessary in clinical leadership as individuals will be less

likely to perform additional duties because of the low level of reciprocity between the leader and followers and its suppressive style (Du et al 2020:2). The authoritarian leader and mentor in the clinical leadership environment, will not involve the mentee in decision-making and problem-solving, which are required for growth for this upcoming nurse leader.

2.5.2 Participative/democratic leadership style

The participative/democratic leadership style teaches confidence and promotes collaboration, inclusivity, and shared decision-making. Followers can contribute, participate, and exchange ideas and believes in decision-making, seek advice, and allow a flow of communication between the leaders and the followers (Oyindobra et al 2022:192; Kadiyono, Sulistiobudi, Haris, Wahab, Ramdani, Purwanto, Mufid, Muqtada, Gufron, Nuryansah, Ficayuma, Fahlevi & Susila 2020:364; Raupu, Maharani, Mahmud & Alauddin 2021:1559).

In mental health clinical settings, where interdisciplinary collaboration is essential, this style fosters a sense of ownership and responsibility among team members. It enhances teamwork, values diverse perspectives, and encourages open communication, however, this leadership style, is time-consuming and is believed to be operative where the employees are highly skilled and believed to be experts in their field (Oyindobra et al 2022:193).

The intricacies of providing mental health treatment are well suited for the democratic and participative leadership style. In addition to empowering team members to actively participate in patient care, it fosters a healthy organisational culture and recognises the value of a variety of perspectives in developing all-encompassing solutions. According to Kadiyono et al (2020:364), in the democratic leadership approach the leaders make decisions with other members, giving them a democratic authority for decision-making and more influence over systems, implementation processes, and policy-making processes. This style's emphasis on inclusivity makes it well-suited for mental health clinical settings where collaborative decision-making and professional competence are paramount, and morale is positively raised (Raupu et al 2021:1558). Furthermore, the strengths of the participative/democratic leadership style align with

the complexities of mental health care, emphasising teamwork, open communication, commitment, consultation, and shared decision-making (Wahidin et al 2020:278). This leadership style can be useful for mentoring for clinical leadership as the mentor and the mentee will have open communication, consult, and share ideas on how to lead effectively and be committed to embracing growth.

2.5.3 Servant leadership style

The servant leadership style prioritises empathy, humility, authenticity, stewardship, and a focus on the well-being of followers. Leaders and followers engage and motivate one another. The leader persuades followers, does not use own authority, and motivates others to reach higher levels. The interests of all parties are considered to add value to an organisation (Khuwaja, Ahmed, Abid & Adeel 2020:4; Muff, Delacoste & Dyllick 2022:275). This approach aligns well with the compassionate nature of mental health care, contributing to a positive organisational culture that values patient and staff satisfaction. The strengths of servant leadership lie in its emphasis on empathy and humility, creating a supportive environment conducive to the well-being of patients and staff. Through their interactions, leaders and followers encourage others to reach greater moral and motivational standards (Khuwaja et al 2020:4).

Bonaiuto, Fantinelli, Milani, Cortini, Vitiello and Bonaiuto (2022:423) posited that by valuing servant leaders as stewards of their teams, this style contributes to a positive organisational culture, aligning with the compassionate ethos of mental health care as leaders will establish relationships with the mentor, build and develop leadership autonomy. However, its application in the mental health clinical setting may be limited due to its potential idealism and difficulties with making fast decisions, the lessened role of the leaders and retraining for leadership.

2.5.4 Transactional leadership style

The transactional leadership style focuses on rewards and punishments based on performance, emphasising adherence to protocols and standards. This style may ensure order and adherence to guidelines in mental health clinical settings, providing clear expectations and consequences, as it promotes distributive justice. A mutual

understanding prevails as the leader provides followers with what they value and in return, gets what is wanted from them (Kadiyono et al 2020:364; Curado, Henriques, Jerónimo & Azevedo 2022:2; Fotso 2021:571). Transactional leadership has potential implications in managing some facets of mental health treatment, specifically in upholding order and guaranteeing protocol adherence. Highly skilled, transformational leaders set a compelling, transparent agenda and motivate others to pursue it (Saleem, Zhang, Gopinath & Adeel 2020:3). On the other hand, its usefulness can be restricted in situations where adaptability and creativity are essential for providing mental health care.

As the mentor teaches the mentee how to lead, expecting the mentee to function as an independent leader, transactional leadership, with its emphasis on systems of recognition, reward or punishment and engagement in a mutually dependent relationship where leaders provide something of value to the follower while receiving what they want, may be advantageous for the leadership for mentoring. Subordinate control, self-attraction, and immobility are additional traits of transactional leadership that may harm mentoring for clinical leadership (Specchia, Cozzolino, Carini, Di Pilla, Galletti, Ricciardi & Damiani 2021:2; Fotso 2021:571).

2.6 IMPORTANCE OF MENTORING IN CLINICAL LEADERSHIP

Clinical leadership in mental health settings demands unique skills, and mentoring emerges as a pivotal mechanism for developing the next generation of leaders in this specialised field.

2.6.1 Knowledge transfer and practical wisdom

The mentor-mentee relationship extends beyond the mere transfer of knowledge; it encompasses guidance, support, and opportunities for professional development and career growth that can benefit an organisation (Blake-Beard, Shapiro & Ingols 2021:3). Mentoring in clinical leadership within mental health settings significantly impacts personal and professional growth, leadership skills enhancement, and the overall well-being of mentees, which is not focused only on professional growth but also on social connectivity (Henderson et al 2022:3301).

Mentoring is a crucial avenue for transferring knowledge and practical wisdom within mental health clinical settings. Experienced leaders, acting as mentors, share their insights and experiences with mentees, providing a unique perspective that goes beyond formal education and training (Templeton, Jeong & Pugliese 2021:2). Less seasoned clinical leaders can learn the tacit knowledge that is frequently difficult to transmit through textbooks or official training programmes through mentorship. Bandura's SLT emphasised the transfer of knowledge and skills through observation, interaction, and influence. Attention, memory, and motivation play an important role in bringing behavioural changes (Yarberry & Sims 2021:241; Firmansyah & Saepuloh 2022:299). This is especially important in mental health settings, where the dynamic nature of mental health care necessitates a thorough comprehension of clinical procedures as well as the larger context in which they unfold. Within this context of mentoring for clinical leadership, the experienced clinical leader is responsible for nurturing and developing a non-experienced leader to reach professional and personal maturity.

2.6.2 Personal and professional growth

The mentor-mentee relationship is a catalyst for personal and professional growth. Mentees benefit not only from the knowledge and experience of their mentors but also from the personalised guidance and support provided. The mentee gains mutual growth where emotional learning that is reciprocal, coherent, and meaningful is developed. Self-confidence, social and leadership skills are learned in mentoring relationships (Henderson et al 2022:2; Kragt & Day 2020:4).

The mentee's capacity to handle stress, develop resilience, cultivate emotional intelligence, and implement innovative leadership strategies can be greatly enhanced by the mentor's assistance, particularly in mental health settings where clinical leaders are subjected to intense emotional and psychological demands (Abusamra, Rayan, Obeidat, Hamaideh, Baqeas & ALBashtawy 2022:2; Gunawan, Aungsuroch, Fisher, Marzilli & Hastuti 2023:493). This is especially important in a career where good patient care depends on compassionate leadership and the capacity to oversee challenging interpersonal situations as a leader. In mentoring for clinical leadership,

the mentor's compassionate side needs to be visible to deal with patient care and leadership stressors.

Collins, Owen, Digan and Dunn (2020:60) and Deng et al (2023:630) alluded that in transformational leadership, it is expected of a leader to be an idealistic influencer, inspirational motivator, intellectual stimulator, and individualistic considerer. Through this, the expert leader can develop the upcoming leaders' potential to lead.

2.6.3 Enhancement of leadership skills

Mentoring plays a significant role in enhancing leadership skills among clinical leaders in mental health settings. The mentor-mentee relationship provides a platform for mentees to develop and refine their leadership abilities through real-world scenarios and practical insights. Mentors, drawing on their experiences, can offer guidance for emotional development in leadership and decision-making (Henderson et al 2022:3; Kragt & Day 2020:4). Furthermore, the relationship between mentor and mentee facilitates the identification and development of leadership characteristics that are pertinent to mental health settings. This includes abilities like teamwork, crisis management, and the capacity to modify leadership philosophies to meet mental health treatment requirements (van Diggele, Burgess, Roberts & Mellis 2020:2; Aydogdu 2023:2).

Mental health leaders need mentorship to help them develop the diverse skill set necessary for effective leadership as they manage the intricate interactions between medical, psychological, and social issues. Moreover, the mentor-mentee dynamic allows identification and cultivation of specific leadership competencies relevant to mental health settings. This includes skills such as crisis management, team collaboration, rapport-building, communication and leadership skills and the ability to adapt leadership styles to the unique demands of mental health care (Aggar, Shinners, Penman, Mainey, Kurup, Hallett, Doran & Raddi 2021:2).

As mental health leaders navigate the complex interplay of medical, psychological, and social factors, mentoring facilitates the multifaceted skill set required for effective leadership. The nurse leader and mentor are responsible for supporting the mentee in

adapting to the collaborative structure of patient care and adapting to a leadership style that suits the mentor.

2.6.4 Job satisfaction and retention rates

Research indicates a positive correlation between mentorship and job satisfaction and retention rates in mental health clinical settings. The supportive environment created through mentoring relationships contributes to the mentee's overall job satisfaction, fostering a sense of belonging and professional fulfilment. Supportive leadership, participatory management and participatory planning processes positively impact job satisfaction (Prentice 2022:281; Dziuba, Ingaldi & Zhuravskaya 2020:20). In the high-stakes and emotionally charged environment of mental health care, where clinicians are often exposed to challenging and complex cases, job satisfaction becomes a critical factor in maintaining a resilient and motivated workforce. The mentor's role in providing support, acknowledging achievements, and offering constructive feedback contributes significantly to the mentees' overall satisfaction and well-being. Through practical and supportive clinical leadership, job satisfaction and retention are enhanced, and the quality of patient care is improved (Enghiad, Venturato & Ewashen 2022:99).

2.6.5 Quality of patient care

Mentoring in mental health clinical settings directly impacts the quality of patient care. The mentor-mentee relationship facilitates a transfer of clinical knowledge and a commitment to patient-centred care and ethical practice. Stanley and Stanley (2018:173) attested that clinical leaders should be competent to mentor others in quality nursing practice and care as they are visible in the practice. They influence others by practising what they preach. Furthermore, the mentor's influence extends beyond technical skills to encompass the development of a compassionate and patient-focused approach where quality service and productivity are maintained (Dziuba et al 2020:21). In mental health settings, where the therapeutic alliance between clinicians and patients is central to treatment outcomes, mentoring becomes a vehicle for instilling values of empathy, cultural competence, and ethical decision-making in the next generation of clinical leaders.

2.7 CHALLENGES IN CLINICAL LEADERSHIP IN MENTAL HEALTH SETTINGS

Leaders in mental health care face unique challenges, some of which are deeply rooted in systemic issues. This section explores the systemic difficulties encountered by clinical leaders in mental health settings, with a particular focus on the stigmatisation of mental health issues, insufficient funding, and a shortage of qualified staff.

2.7.1 Stigmatisation of mental health issues

One of the prominent systemic challenges in mental health clinical leadership is the pervasive stigmatisation of mental health issues. Despite strides in raising awareness and promoting mental health advocacy, the societal stigma persists, influencing both public perception and organisational culture within healthcare settings. This stigma and lack of empathy can be from self, due to the pressure felt from family members, community members and health professionals in health facilities (Edwards & Kotera 2021:1123; Valery & Prouteau 2020:1). Clinical leaders, operating within this stigmatised context, often encounter challenges in making decisions that prioritise evidence-based practices and patient-centred care. The fear of judgment or misconceptions about mental health conditions can influence leadership decisions, potentially hindering the implementation of progressive and practical approaches to mental health care. Overcoming this systemic challenge requires a concerted effort to destigmatise mental health issues at both societal and organisational levels.

2.7.2 Insufficient funding

Insufficient funding is a systemic challenge that significantly impacts clinical leadership in mental health settings. Mental health services often receive less financial support than other areas of healthcare, despite the increasing recognition of the importance of mental well-being. Funding for professional development can boost competency in mentoring for leadership (Mlambo, Silén & McGrath 2021:8). Clinical leaders, tasked with optimising patient care and ensuring the well-being of their staff, must navigate these financial constraints.

Budgetary limitations may impede the recruitment of qualified personnel, hinder the adoption of advanced technologies, and limit the scope of mental health interventions. The consequences of insufficient funding are far-reaching, affecting the quality and accessibility of mental health care, and placing additional strain on clinical leaders to achieve optimal outcomes with limited resources. Gunawan et al (2023:499) attested that unit budgeting and planning are essential leadership roles as leaders plan for human and material resource use. The clinical leader is challenged to conduct unit-related activities and mentoring, due to insufficient funds making it difficult to appoint more registered nurses in units, to assist with other work-related activities while mentoring the upcoming leader.

2.7.3 Shortage of qualified staff

A shortage of qualified staff is a systemic challenge that exacerbates the complexities of clinical leadership in mental health settings. A practical nurse mentor must juggle the challenge of a workforce shortage and maintain the mentee's morale as part of the characteristics of a clinical nurse mentor (Mollahadi, Nouri & Moradian 2021:262). Clinical leaders face the daunting task of managing workload distribution, maintaining quality standards, and ensuring the well-being of both patients and staff in the face of workforce shortages. The shortage of qualified staff can lead to burnout, increased stress levels among existing staff, and challenges in delivering timely and comprehensive mental health care services (Dall'Ora, Ball, Reinius & Griffiths 2020:2). Strategies to address this systemic challenge involve workforce planning, recruitment initiatives, and the creation of supportive work environments that enhance staff retention.

2.8 MENTORING AS A MITIGATING FACTOR

This section explores the role of mentoring as a potential mitigating factor in addressing these challenges and fostering resilience among clinical leaders. The following topics are addressed below: addressing the stigma of mental health issues, fostering a supportive organisational culture, providing professional development opportunities, and navigating professional networks.

2.8.1 Addressing stigma of mental health issues

Mentoring relationships create a safe, accepting environment where mentees can freely express their worries and ask for advice on difficult choices. As a reliable source of guidance and trusted advisor, the mentor's position can enable mentees to confront stigmatising behaviours and promote compassionate, inclusive approaches to mental health. Programmes for mentoring can be critical in reducing the stigma attached to mental health as the leader will learn assertive ways of protecting mental health care users from social stigma. Shahwan, Goh, Tan, Ong, Chong and Subramaniam (2022:1) explained social stigma as negative attitudes that the public has toward those who have mental illnesses and is aligned with prejudice and discrimination stereotypes. Even some professionals may suffer from mental health-related illnesses, causing internal stigmatisation and may be afraid to accept the mentor or mentee role considering the public and personal stigmatisation attached to mental health (Valery & Prouteau 2020:1). Bechara Secchin, da Silva Ezequiel, Vitorino, Lucchetti and Lucchetti (2020:200) added that medical professionals are impacted by mental discomfort, which also affects their professional development. Mentors, who are frequently seasoned clinical leaders, can assist their mentees in overcoming the difficulties presented by social stigma, to gain confidence in decision-making and problem-solving in mental health clinical settings.

2.8.2 Fostering a supportive organisational culture

Mentoring programmes contribute to developing of a supportive organisational culture, which is crucial for clinical leaders facing systemic challenges. Through mentorship, mentees gain insights into effective leadership strategies and learn how to cultivate a positive and inclusive work environment. A positive organisational culture cultivates professional development, commitment, excellent performance, and positive attitudes of mentees which indicates that they are valued (Mlambo et al 2021:9; Chen, Hao, Ding, Feng, Li & Liang 2019:5).

Observing and learning from mentors who have successfully created supportive cultures within their teams, mentees are better equipped to implement similar strategies in their leadership roles. Curado et al (2022:3) posited that peer support can

promote the mentee's work function, involvement, and satisfaction. SLT explains that emotional support plays an important role in the development and progress of a mentee. This statement supports transformational leadership where focus is on empowering and creating effective teams through engagement and motivation (Firmansyah & Saepuloh 2022:299; Collins et al 2020:61).

2.8.3 Providing professional development opportunities

Mentoring programmes offer invaluable professional development opportunities for clinical leaders in mental health settings. As mentees navigate systemic challenges, mentors guide them in developing a diverse skill set that goes beyond clinical expertise. Alexandrou (2021:725) researched professional learning and development for change, conceptualisation, innovation, and opportunities. The study emphasised that professional learning development challenges a person to be more flexible and innovative in approaching development.

Drawing on their own experiences, mentors can provide insights into navigating bureaucratic structures, advocating for increased funding, and strategically addressing workforce shortages. Even in challenging times, organisations should prioritise employees' personal growth and create initiatives to encourage development (Yarberry & Sims 2021:245). Professional development programmes must address intended learning goals and improve outcomes of mentoring for leadership (Hubers, Endedijk & van Veen 2022:838; Sancar, Atal & Deryakulu 2021:1).

A shared mission between a mentor and mentee and strong leadership skills are essential for the sustainability of mentoring for leadership in mental health clinical settings (Romijn, Slot & Lesema 2021:2). By exposing mentees to real-world scenarios and providing guidance on effective leadership practices, mentors contribute to the development of clinical leaders who are resilient, adaptable, and well-prepared to address systemic challenges.

2.8.4 Navigating professional networks

Clinical leaders in mental health settings must often collaborate with various stakeholders, including policymakers, advocacy groups, and other healthcare professionals. Mentors leverage connections to address systemic challenges effectively. The mentor's role extends beyond individual guidance to facilitating introductions, sharing resources, and providing insights into the dynamics of professional relationships within the mental health landscape. Through mentorship, clinical leaders gain access to a broader support system that enhances their ability to influence positive change within their organisations and the wider mental health community. Hagqvist, Oikarainen, Tuomikoski, Juntunen and Mikkonen (2020:2) maintained enhancing interprofessional education programmes can promote safe and quality patient care mentoring culture.

New leadership practices and developing new skills require continuous learning from others. Layden (2023:53) posits that professional peer support and learning-centred environments are intended to foster supportive, professional networks in mentoring for leadership. Sarabipour, Hainer, Arslan, de Winde, Furlong, Bielczyk, Jadavji, Shah and Davla (2022:1378) indicated different online platforms that can be used such as the National Research Mentoring Network, Peer Advising Resources, Group Principal Investigators Network that can be used for mentoring opportunities, though not specifically for clinical leadership.

2.9 EVALUATING THE EFFICACY OF CLINICAL LEADERSHIP-MENTORING MODELS

Assessing the effectiveness of clinical leadership-mentoring models in mental health settings requires a multifaceted approach, delving into various key performance indicators and employing diverse research methodologies. This evaluation is crucial for understanding the impact of mentoring on staff satisfaction, and the overall leadership competencies and effectiveness of mental health clinical settings.

2.9.1 Staff satisfaction

Staff satisfaction is a pivotal indicator of the efficacy of clinical leadership-mentoring models. High satisfaction levels among mentees indicate that the mentoring relationship positively influences their professional experience. Surveys and interviews are commonly employed to gather quantitative and qualitative data on staff satisfaction. Participants are asked about their experiences with mentoring, the perceived impact on their professional development, and their overall satisfaction with the mentoring programme (Gorges, Neumann & Störtländer 2022:2; Enghiad et al 2022:99; Davis et al 2022:1967).

Curado et al (2022:2) alluded that supportive leaders bring satisfaction to followers, and they respond through dedication and positivity in work performance. There is a positive correlation between mentoring experiences and increased satisfaction levels among clinical leaders. This indicates that mentoring contributes not only developing leadership competencies but also to the overall job satisfaction of mentees.

2.9.2 Leadership competencies and effectiveness

Muff et al (2021:276) defined responsible leadership as having a multi-level system thinking approach to corporate social responsibility, leading innovation, and change, understanding systems, stakeholder relations and inclusion, innovation, long-term activation, and a sustainable mindset.

The integration of evidence-based practices is a hallmark of effective clinical leadership-mentoring models. Assessing the degree to which mentees incorporate evidence into their decision-making processes involves evaluating their adherence to established protocols and best practices.

Working collaboratively, interpersonal skills and dynamics, personal characteristics, team orientation, being an active listener, having knowledge and skills to lead, personality traits, and being able to engage with others, are competencies that make mentoring for leadership an effective process (Gilli, Nippa & Knappstein 2023:60;

Fotso 2021:570; Dirani, Abadi, Alizadeh, Barhate, Garza, Gunasekara, Ibrahim & Majzun 2020:385).

Several studies tracked the career progression of mentees and provided insights into the sustained integration of evidence-based practices over time (Pryce, Deane, Barry & Keller 2021:45; Skjevik, Boudreau, Ringberg, Schei, Stenfors, Kvernenes & Ofstad 2020:272; Grocutt, Gulseren, Weatherhead & Turner 2022:404; Tolan, McDaniel, Richardson, Arkin, Augenstern & DuBois 2020:2086). The researchers measured the lasting impact of the mentoring relationship by comparing the practices of mentees before and after their participation in mentoring programmes.

2.10 CLINICAL-LEADERSHIP MODELS IMPLEMENTATION CHALLENGES AND STRATEGIES

This section outlines the mentoring for clinical leadership models implementation challenges and strategies. This is not an effortless process considering the dynamics involved. The challenges are, resistance to change, resource constraints, and lack of organisational support which are discussed in detail below.

2.10.1 Resistance to change

Resistance to change is a pervasive challenge in healthcare settings, including mental health clinical environments. Introducing clinical leadership-mentoring models may face resistance from clinical leaders and organisational stakeholders. Established routines and practices can be deeply ingrained, making it challenging for individuals to embrace a new paradigm, especially one that involves changes to leadership structures and dynamics. Organisational changes produce technical, structural, and conceptual innovation, to improve the dynamics and bring organisational progress. Adaptation to change affects individuals differently and the attitudes and behaviours of individuals may frustrate the purpose of change (Du et al 2020:2; Damawan & Azizah 2020:49).

2.10.2 Resource constraints

Resource constraints, both in terms of financial and human resources, present a significant challenge in implementing mentoring programmes. Allocating time and personnel for mentorship activities can be difficult in environments where staff are already stretched thin, and financial resources are limited (Guo, Xiong, Wang, Li, Wang, Xiao, He, Xiang & Xu 2022:3260). The perceived competition for resources with other essential aspects of mental health care can hinder the prioritisation of mentorship initiatives. Providing human and informational resources can relieve the mentors from having to do ward administrative duties while being delegated the responsibility to mentor upcoming leaders (Layden 2023:58).

2.10.3 Lack of organisational support

The success of mentoring for clinical leadership models is contingent on solid organisational support. There is a correlation between organisational support and employees' feelings about their jobs, such as their willingness or level of job satisfaction to continue working, as well as additional psychological components of care, such as happiness and well-being (Churruca, Falkland, Saba, Ellis & Braithwaite 2023:7).

In some instances, the leaders may not fully understand or appreciate the value of mentoring in enhancing clinical leadership. The absence of a supportive culture may result in a lack of enthusiasm and commitment from mentors and mentees, undermining the effectiveness of the mentoring programme. Organisational support encourages individuals by giving them organisational recognition, which creates internal motivation, and quality work production (Chen et al 2019:5).

2.11 POTENTIAL STRATEGIES FOR SUCCESSFUL INTEGRATION AND IMPLEMENTATION

This section discusses strategies that influence the successful integration and implementation of mentoring for clinical leadership. These include fostering a culture of continuous learning, securing leadership buy-in, allocating dedicated resources,

establishing mentorship training programmes and having ongoing evaluation and feedback mechanisms. These are discussed in detail below.

2.11.1 Fostering a culture of continuous learning

Overcoming resistance to change within an organisation requires fostering a culture of constant learning. Clinical leaders are responsible for applying theories and knowledge learned to support the professional development and constant learning of upcoming leaders (Amparbeng & Pillay 2021:555). Emphasising the benefits of mentorship in terms of enhanced professional growth and leadership skill development might help to generate a positive narrative surrounding the implementation of mentoring programmes.

Organisations may provide funding for educational initiatives that promote the advantages of mentoring and ease concerns about disrupting long-standing practices. In the professional development model, Romjin et al (2021:3) addressed the who, what and how of professional development where the translation of belief, knowledge and experience was put into practice for continuous learning.

2.11.2 Securing leadership buy-in

Getting organisational leadership on board for mentoring for clinical leadership is critical. Leaders must acknowledge mentoring as a calculated investment in cultivating a proficient and adaptable clinical workforce. Involving the leadership in mentoring programmes' planning and design stages guarantees their advocacy and dedication. Leadership support enhances performance and productivity (Chen et al 2019:11). The active endorsement and participation of executives in mentoring activities create a favourable atmosphere within the organisation which leads to high-performing, satisfied, and committed individuals who value work interpersonal and professional relationships (Navajas-Romero, Ariza-Montes & Hernández-Perlines 2020:2).

2.11.3 Allocating dedicated resources

Resource limitations might be lessened by designating specialised resources for mentorship programmes. This entails setting time in work schedules for mentoring activities, offering mentors and mentees training, and dedicating funds to maintain the programme's infrastructure. Organisations can convey their value for clinical leader development by allocating resources in a way that shows a commitment to mentorship. Navajas-Romero et al (2020:3) indicated that availability of resources, turnover, emotional strain, and exhaustion.

2.11.4 Establishing mentorship training programmes

Organisations should set up mentorship training programmes for mentees and mentors alike to improve the efficacy of mentoring relationships. These courses provide participants with the information, abilities, and communication strategies they need to successfully negotiate the challenges of a mentoring relationship. Leadership training programmes impact leadership competencies as they increase the leaders' knowledge of stakeholder-related concerns, patient-centeredness, collaboration, accountability, cultural competence, communication, and ethical decision-making (Skjevik et al 2020:275).

Leadership training programmes affect leadership abilities as leaders are taught more about systems understanding, ethics and values, change and innovation, stakeholder interactions, and self-awareness—all of which are critical for mentoring in leadership (Muff et al 2021:281). Wahidin et al (2020:282) noted that attending different trainings, seminars, workshops, and other leadership-related support activities can be a component of other training programmes to enhance leadership competencies.

2.11.5 Ongoing evaluation and feedback mechanisms

Continuous evaluation and feedback mechanisms are essential for refining and adapting mentoring programmes to meet the evolving needs of clinical leaders. Regular assessments allow organisations to identify areas of improvement, measure the impact of mentoring on leadership competencies, and make data-driven

adjustments. Rosser, Edwards, Kwan, Ito, Potter, Hodges and Buckner (2023:282) confirmed that evaluation of mentoring programmes is of utmost importance as it increases nurse mentors' knowledge, skill, attitudes, and organisational readiness, particularly concerning evidence-based practice.

Feedback can also enhance a sense of relatedness between the mentee and the mentor, contributing to self-confidence and motivation. Future-focused feedback, which collaborates the generation of ideas, planning, and problem-solving can enhance improvement on mentoring for leadership (Ajjawi, Kent, Broadbent, Tai, Bearman & Boud 2022:1347; Gnepp, Klayman, Williamson & Barlas 2020:22). Feedback is meant to be descriptive, constructive, and non-judgmental during the mentoring process and evaluation will allow the mentor to compare against set standards whether the mentoring for leadership role was achieved (Jug, Jiang & Bean 2019:245).

Despite strides in comprehending clinical leadership and mentoring in mental health settings, significant gaps persist in the existing literature. These gaps warrant attention as they represent areas where further investigation is essential to advance the understanding of effective leadership in mental health care. Hagqvist et al (2020:2) emphasised that culturally competent nurse leaders and healthcare professionals provide quality care services and maintain excellent leadership roles as they are responsive to the demands of cultural diversity in health and leadership.

Another underexplored area is the role of technology in mentoring within mental health clinical settings. Gilli et al (2023:53) attested to the 21st-century leadership skills and encompassed learning skills, life skills and literacy skills that include information, media and Information and Communication Technologies. The authors emphasised the need to prepare the next generation of leaders for future work challenges, encompassing digital technology skills. Exploring how technological tools can either enhance or impede the mentorship process is essential for adapting mentoring practices to the evolving landscape of modern mental health care.

Previous studies provided insights into the immediate effects of mentorship, understanding how mentorship influences leadership roles, career advancement, and

job satisfaction over an extended period is vital (Fard, Azadi, Khorshidi, Mozafari, O'Connor, Budri, Moore & Patton, 2020:1; Smith, Umberfield, Granner, Harris, Liestenfeltz, Shuman & Smith 2021:1; Buck, Dorrell & Winslow 2023:7; Imran, Rog, Gallichio & Alston 2021:1).

2.12 RATIONALE FOR THE CURRENT STUDY

This study intends to add to the body of knowledge by concentrating on developing and evaluating a mentoring for clinical leadership framework for nurse managers in mental health clinical settings. The research acknowledges the challenges that clinical leaders encounter in mental health care and aims to mitigate these by implementing a customised mentoring framework.

The impact of technology and cultural competence, as well as the changing landscape of mental health care, are acknowledged in the study. The field of mental health care is constantly evolving, and clinical leaders need to adapt to the changing technical breakthroughs while navigating the complexity of diverse cultural contexts and incorporate technological advancements into their practices. Technology education's main objective is to increase technological literacy, where individuals can create and assess their knowledge of technological systems and solutions, products, and trends, giving a thorough understanding of how and why things are done (Hubers et al 2022:828).

Effective leadership in mental health care requires cultural competence, and it is crucial to comprehend how mentoring can improve cultural competency. Delivering fair treatment and effective leadership in a variety of mental health settings requires an inclusive and culturally aware approach. The study aims to provide leaders with valuable techniques to negotiate the intersectionality of cultural competence and clinical leadership by addressing this part of the mentoring for clinical leadership framework. Cultural competence brings improvement, awareness, and continuous acquisition of skills, knowledge, and sensitivity towards diverse cultural contexts for adopting appropriate attitudes and health interventions (Lin, Guo, Chen, Liao & Chang 2021:2). Leaders need to adjust to the revolutionary changes brought about incorporating technology into mental health treatment. The study recognises that an

inclusive and culturally sensitive approach is essential for providing equitable care and effective leadership in diverse mental health settings. By addressing this aspect in the mentoring for clinical leadership framework, the study aims to contribute practical strategies for leaders to navigate the intersectionality of cultural competence and clinical leadership.

The study aims to close the information gap about the use of technology in mentoring in mental clinical settings, which is acknowledged. For a framework to be developed that is in line with the current state of mental health treatment, it is imperative to comprehend how technology can either help or hurt mentoring relationships. The study offers suggestions on how mentoring programmes might best use technology to support the development of leaders.

2.13 SUMMARY

The reviewed literature comprehensively explored clinical leadership and mentoring in mental health clinical settings. Discussions were outlined regarding the theoretical underpinnings, variety of leadership philosophies, and critical functions of mentoring in developing successful clinical leaders.

The literature review in this chapter highlighted mentoring in the clinical setting. Most of the mentoring articles were based on qualitative studies and systematic reviews on students and mentors in the clinical learning environment and mentoring in academia/higher education and diverse academic disciplines. Few articles were on graduated professional nurses. The next chapter will outline the research design and method.

CHAPTER 3
RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter aims to explain the research design and methods used to meet the research objectives in Chapter 1. A research design acts as a plan or blueprint for conducting a study (LoBiondo-Wood & Haber 2018:510; Gray & Grove 2021:234). The methods and materials are presented in three distinct phases (refer to **Figure 3.1**) as outlined below:

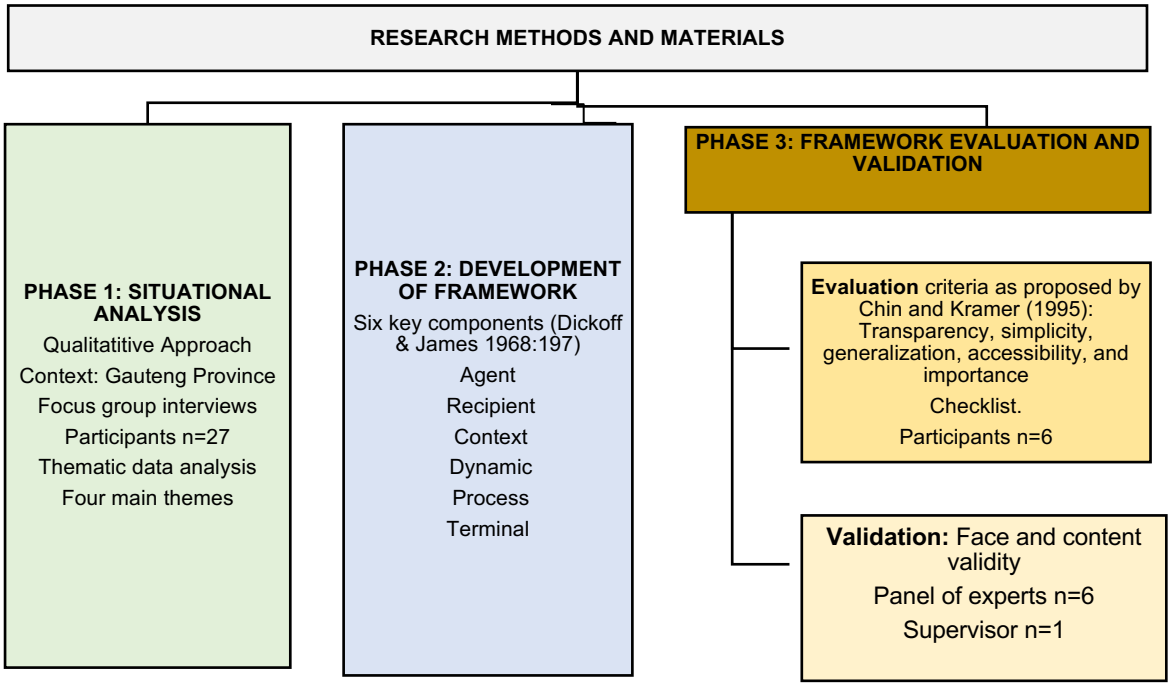


Figure 3.1: Overview of the research design and materials

3.2 PHASE ONE: SITUATIONAL ANALYSIS

In the first phase, a qualitative research approach was employed to explore and describe the mentoring for leadership opportunities and challenges that novice and established clinical nurse leaders face and to identify the mentoring for leadership characteristics of a clinical nurse leader in a mental health setting. The qualitative approach refers to research that seeks to understand human experiences,

perceptions, and social processes that are unfolding in different individuals' life contexts relating to circumstances, experiences, and values (Jo-Brown 2018:39).

In the qualitative research approach, experiences, cultures, social processes, and individual perspectives are described, and complex interpretive practices are embraced and understood in their terms to formulate and find meaning and interpretations and make sense of the worldviews (Gray & Grove 2021:91; LoBiondo-Wood & Haber 2018:111). Qualitative research studies are conducted in natural environments to understand the views of those who are more knowledgeable about the phenomenon and is more concerned with meaning, human experiences, understanding from the viewpoint of a participant and discovering new knowledge (Brink & van Rensburg 2022:122; Grove & Gray 2023:63). The qualitative approach was conducted through the grounded theory design described in the next section.

3.2.1 Grounded theory design

Grounded theory design involves systematic guidelines for gathering and analysing data to develop a new theory or model. Charmaz (2017:3) advocated that grounded theory be viewed as a constructivist theory as it generated its theory from actions, interactions, and interrelation of categories of information based on data collected from participants (Polit & Beck 2021:481). In the process of data collection, the researcher needs to be careful not to influence the information given by participants and should make appropriate application of the findings for the development of a new theory.

It is in the process of data collection or interviewing that reflexivity plays a vital role, where the researcher needs to introspect and do self-awareness and examinations relating to data collection and analysis to avoid biases (Gray & Grove 2021:821). In reflexivity, the researcher needs to explore and consider the researcher's influence on participants' understanding of the research under study, own values of the research under study, and be self-aware of the conscious and unconscious influence of the study. Reflexivity also entails an act of self-reference where the researcher bends back and is affected by the phenomena under investigation (Tomaselli 2018:144). The researcher ensured that participants could give their views regarding the topic under study without influencing or interfering during interviews. The researcher can,

however, acknowledge being touched by the perspectives shared by participants, given her own experiences with the same occurrences.

Grounded theory design embraces a process of how the researcher can give a holistic account of how participants interpret or experience phenomena and, in the process of analysing the data, reveal insights that can be used in developing a new theory or model. Creswell and Poth (2018:163) outlined the following aspects as the defining features of grounded theory:

- Concurrent participation in both data gathering and analysis.
- Creating analytic codes and categories based on the gathered data.
- Conducting comparisons at every stage of data analysis.
- Enhancing theory development throughout the process of data collection and analysis.
- Memo writing provides detailed explanations of categories, establishes relationships between categories, and highlights gaps.
- Sampling is focused on constructing theories rather than achieving population representativeness.
- Performing a literature review after the completion of an independent analysis of data.

3.2.2 Research context (natural setting)

In qualitative research, data are collected where participants experienced the problem under study. This assists the researcher in gathering information by talking directly or face-to-face with participants and observing participants' behaviour within that context. The researcher can observe and understand the participants' value within a comfortable, familiar, and natural space (LoBiondo-Wood & Haber 2018:93; Polit & Beck 2021:794). In this study, the researcher interviewed the participants regarding clinical leadership and mentoring within their own working space, which was the two mental health healthcare institutions in Gauteng Province, South Africa.

3.2.3 Population and sampling

The following section outlines the current study's population and sampling process.

3.2.3.1 Population

Gray and Grove (2021:411) define a target population as the complete people meeting the sampling criteria. Researchers may not have access to the target population; hence an accessible population is considered. This population is a portion of the target population that the researcher can access reasonably and has typical characteristics (Gray & Grove 2021:804; Jo-Brown 2018:64; LoBiondo-Wood & Haber 2018:213). The researcher is interested in a group referred to as a population from which the researchers' sample can be selected as they meet the criteria for the research study (Brink & van Rensburg 2022:140)).

The study population in this research was operational managers and assistant managers of two public mental health care institutions in Gauteng Province. The total population was fifty-six (56) individuals. From this total, nineteen (19) were assistant nursing managers and thirty-seven (37) were operational nursing managers. Both institutions had male and female participants, who differed in age and work experience. The reason for selecting the two categories was that the two groups shared managerial responsibilities. Both interacted with each other relating to clinical leadership and mentoring and were accessible.

3.2.3.2 Sampling

Sampling is a process of selecting a specific group or element from an entire population. A sample forms a subset, or fraction of a larger part, a small part of the population that the researcher is interested in researching (Strydom 2021:228; LoBiondo-Wood & Haber 2018:215). Purposive sampling was relevant for the study. In purposive sampling, the researcher selects participants who are conversant and most informed about an area of study (Polit & Beck 2021:799). The operational and assistant managers were purposively selected for the conduction of the study. The

size of the final sample was twelve (12) assistant nursing managers and fifteen (15) operational nursing managers.

In grounded theory, theoretical sampling may also be considered should verification or additions to categories or theory be considered. This sampling method is a convenient type, where the researcher samples incidents, people, or units, depending on their potential to contribute to developing and evaluating a theory under construction. In this process, after analysing the data of an initial sample, the researcher selects a further sample to refine emerging categories and theories. This process is continued until data saturation is reached and no added information is obtained from the added sample (Creswell et al 2021:86). Theoretical sampling was not relevant for the study, as no refinement or confirmation of categories or themes that emerged was necessary.

3.2.3.2.1 Inclusion criteria

An inclusion criterion, which can also be looked at as an eligibility criterion, entails the requirements that a researcher has identified and must be present in an element or participant to be included as part of a sample or target population (Gray & Grove 2021:812).

The inclusion criteria for the study were outlined as follows:

- Operational and assistant nursing managers involved in clinical nursing leadership in mental healthcare institutions which was the focus of the study.
- Operational and assistant nursing managers having a minimum of one year of experience in clinical leadership in mental healthcare institutions as they had knowledge about the subject being investigated.
- Operational and assistant nursing managers who were interested and voluntarily provided written consent to participate in the study.

3.2.3.2.2 Exclusion criteria

An exclusion criterion entails the characteristics or elements in a person or subject, which can cause elimination or exclusion from a target population (Gray & Grove 2021:810; LoBiondo-Wood & Haber 2018:511).

The exclusion criteria for the study were outlined as follows:

- Operational and assistant nursing managers who were only engaged in administration duties in the mental healthcare institution where the data was collected.
- Operational and assistant nursing managers who were on any type of leave during the data collection period.
- Operational and assistant nursing managers engaged in clinical nursing leadership and have more than one year of experience but declined to participate in the study, expressing no interest and refused to provide written consent.

3.2.4 Data collection

Gray and Grove (2021:808) define data collection as a systematic process that is deemed relevant for gathering information in a research project to address specific objectives, questions, and hypotheses of a study. The process involves interrelated activities that offer an audit trail of detailed descriptions of the procedures used to gather data, determine the conclusions, and justify the method chosen (Brink & van Rensburg 2022:157). This section will describe the data collection method and the researcher as a critical instrument.

3.2.4.1 Recruitment of participants

Recruitment of participants comprised identifying, accessing, and communicating with the potential participants regarding the process, and involvement in the study from the beginning to the end (Gray & Grove 2021:821). UNISA ethics approval was granted in November 2017. Recruitment took place only after the researcher was granted approval from the DoH and the institutional permission to conduct the research. These

approvals were only granted in 2018. After obtaining ethical permission from the institutions as discussed in Chapter 1 section 1.9, the researcher attended managers' departmental meetings to introduce the study and to recruit the managers. The researcher attended the operational managers' meetings in early February and March 2020. The researcher was granted permission by the two institutions, to conduct the research study, but was made aware that the institutional activities should not be interfered with, hence the interviews were conducted in the first quarter of 2020, even though permission letters were signed in 2018. The researcher had to adhere to the institutional requirements. The researcher was also affected by the COVID-19 pandemic after data were collected. An e-mail was also sent to the deputy nursing managers first, requesting permission to meet with the assistant and operational managers. The researcher wanted to gain trust and establish rapport with the managers before the conduction of the research. The deputy nursing managers of both institutions granted the researcher the opportunity to attend the meetings. A brief outline of the purpose of the research to be undertaken was given, including expectations from participants, risks involved, potential benefits, rights of participants, confidentiality and anonymity, ethical approval, and declaration of conflict of interest.

The other recruitment strategy that was used was from the institutions itself, where the researcher sent the information leaflet (refer to **Annexure I**) to the Chief Executive Officer's secretary, who was given the responsibility to distribute it to the managers, before the dates of conducting the focus group interviews and for preparation of the venue. The information leaflet contained the topic under study, its background, and purpose, procedures, risks and benefits, informed consent, right of withdrawal from the study, and particulars of the researcher and supervisor. The researcher was allocated a correspondence partner in each institution and this person was responsible for ensuring that the dates and times were set for the interviews, and that participants were reminded timeously of a date scheduled to attend the interviews. Dates and times were discussed with the correspondence partner, to avoid disrupting the managers' daily activities and meetings.

3.2.4.2 Obtaining informed consent

The researcher obtained permission first from the institutions where the research was planned and made an appointment with the assistant managers and operational managers to explain the research study. During recruitment, the researcher explained the process of obtaining consent from the participants through an informed consent form. An informed consent, which included the participants'' demographic information section (refer to **Annexure J** and **K**), outlined the information needed by the researcher from the research participants, assists the participants' understanding of the research study before them granting consent to participate and allows participants to choose whether to participate in the study or not (Brink & van Rensburg 2022:39; Grove & Gray 2023:111). The informed consent forms were distributed to all the assistant managers and operational managers during the meeting. Participants were given a minimum duration of forty-eight hours to decide about participation and to allow them an opportunity to seek clarification from the researcher about the study if needed before completing and returning the informed consent form. The researcher's contact number was made available to all potential participants in case they wanted clarity or had questions regarding the study. No calls were received by the researcher for clarification. The completed and signed informed consent forms were placed in a designated drop box located in the boardroom and then collected by the researcher after five days of distribution.

3.2.4.3 Data collection method

The data collection process entails gathering precise, systematic, and relevant information on the topic under study and can answer the research questions and objectives (Grove & Gray 2023:493). Diverse sources and instruments can be used to collect data in qualitative research.

Research instruments need to be ready before a researcher collects data. Focus group interviews are interviews where a group of individuals, usually four to twelve participants are assembled and guided by a moderator to share opinions and experiences simultaneously (Kasorn, Puangpaka & Chomchuen 2020:365). Group

dynamics, synergies for accessing information and interaction of participants play a significant role as the researcher seeks to understand questions relating to social processes or to examine knowledge and ideas that operate within a given cultural or group context (Polit & Beck 2021:787).

Geyer (2021:361) indicated that focus group interviews are advantageous as more participants can be brought together at a time to generate diverse qualitative data, but they can also be disadvantageous. Furthermore, Geyer (2021:361) shared the following advantages of focus group interviews:

- Participants can engage in the critical examination of each other's perspectives.
- The interaction within the group generates a wide range of varied and valuable data.
- Participants tend to feel more at ease expressing their opinions in a group rather than one-on-one.
- Focus groups diminish the influence and authority that a researcher may exert during individual interviews.
- Focus groups are particularly suited for gathering information on subjects that have not been extensively researched or published.
- Focus group interviews are a cost-effective method for gathering and utilising data.

The following section describes the focus interview pilot test and the actual focus interview of the study.

3.2.4.3.1 Pilot focus group interview

A pilot test is a procedure used by a researcher on a smaller version of participants with the same characteristics as the participants assessed to identify the strengths and weaknesses of a research instrument. This enables a researcher to refine or change the instrument (Bruce & Klopper 2018:463; Grove & Gray 2023:500).

For this study, two participants were selected for interviewing to detect the flaws of the research questions outlined. These individuals were chosen as they shared the same characteristics as the participants and were not included in the selected participants.

Results of the pilot interview indicated that the questions may not be easy for the participants to understand and answer, hence, the questions were then rephrased for the actual interviews. The questions that were rephrased were:

- How would you identify an effective clinical leader and mentor was rephrased to: What do you view as the characteristics or attributes of an effective clinical leader and mentor?
- How do experienced leaders dela with the challenges faced regarding clinical leadership mentoring was rephrased to: How can the clinical leadership -mentoring role be improved?

A pilot interview was conducted with two managers who were not going to take part in the study to check and clarify the questions asked for their relevance to the research under study and to check if participants could understand the questions. The two managers were not included in the main research, as one was an assistant manager in an acting position for the Nursing Managers' post, and one was the Nurse Manager in the acting position of the Chief Executive Officer.

3.2.4.3.2 Actual focus group interviews

The researcher conducted focus group interviews separately between the operational nursing and the assistant nursing managers. The focus group interviews were conducted with four to six members each to guarantee a well-controlled group dynamic and sufficient time for comprehensive feedback. This strategy mitigates the time constraints that can occur in larger groups. The interviews were conducted for an hour at the time and date that was chosen and suitable for the managers to attend, as per the arrangement with the correspondence partner. Participants were allowed to share viewpoints in a non-threatening environment, the boardroom, which was quiet and without distractions. Careful planning for interviews that require a quiet location, comfort, privacy, accessibility, and safety of participants plays a significant role in interviews (Gray & Grove 2021:497).

The researcher prepared a list of questions, referred to as an interview guide for the focus group interviews (refer to **Annexure L**). The questions were used for both assistant and operational nurse managers and each had to relate the answers to the position one occupied. Questions covered the following topics regarding clinical leadership mentoring: definition, characteristics, opportunities, challenges, and recommendations.

The researcher reminded the participants about the study's objectives so that they would feel free to give their input without feeling intimidated. Ground rules were set, where individuals had to raise a hand before answering to avoid over-domineering by other participants and derailing the topic under discussion. In some instances, the researcher tactically requested the domineering participants to allow others to air views and provide input to the debate. The researcher was careful enough in conducting the interviews to ensure that relevant questions were asked. As indicated earlier, probing, paraphrasing, and clarifying communication techniques were used to tap into the deeper meanings of what participants expressed.

During the focus group interviews, the researcher needed to guard against a participant taking over the whole interview session or group power dynamics by facilitating and taking control over the group interviewed (Geyer 2021:363). This was done by the researcher laying down the rules of how each participant would answer and how each would be allowed to give input. The researcher used an interview guide to pose the different questions for the research under study. Participants were allowed to elaborate on their feedback on questions asked without interference as the researcher listened and analysed every response.

3.2.4.4 Researcher as the vital instrument and use of multiple methods

In qualitative research, the researcher collects data by observing documents, observing participants' behaviour, or interviewing participants, using open-ended questions. The researcher is viewed as the main instrument where subjectivity engages data collection (Schurink, Schurink & Fouché 2021:400).

Using multiple methods, including communication techniques, field and observational notes, and memos, in addition to the deployment of a competent researcher as an instrument, can improve the findings' validity, reliability, and depth. These elements are further discussed in the following sections.

3.2.4.4.1 Competencies of the researcher

The researcher had previously undertaken a research project for a master's degree where focus group interviews were used for data collection. Furthermore, the researcher has a qualification in Nursing Science Education, where facilitation skills were taught. In addition, as an educator, the researcher facilitated nursing students daily. Moreover, the researcher is a trained mental health nurse who has experience working in mental health care institutions where the work involved individual therapeutic interviews and group therapies with mental health care users. Overall, these competencies prepared and refined the skills and competencies of the researcher in doing focus group interviews for this study.

3.2.4.4.2 Facilitative communication techniques

Communication techniques assist in establishing an excellent researcher-participant relationship and are essential if the researcher wants to obtain correct and relevant data. Effective use of communication techniques assists in creating a relationship where the other person feels safe to explore and express oneself without fear. Verbal and non-verbal communication techniques/cues can be used. Verbal communication entails words that an individual speaks, while nonverbal communication entails body gestures such as facial expressions, body posture, and hand movements (Varcarolis & Fosbre 2021:92). The researcher was able to use verbal and non-verbal cues during the interview.

- **Non-verbal cues**

Silence, nodding, and eye contact are some of the non-verbal cues that the researcher used to facilitate communication (Varcarolis & Fosbre 2021:92). The use of silence and nodding by the researcher enabled the participants to feel free and open to talk and share their views and feelings on leadership and mentorship. The participants

were confident that the researcher showed interest, actively listened, and responded to what transpired. In other instances, probing was used to increase the detailed exploration of the questions, and this enhanced rapport and a therapeutic relationship between the researcher and participants (Middleton 2022:182).

- **Verbal cues**

Verbal and non-verbal communication cues can be used during a conversation. In verbal communication, the person uses words to speak; in non-verbal communication, the person uses body gestures like facial expressions, body posture and hand movements. Paraphrasing, clarifying, and probing are some verbal cues that an interviewer uses to gain more information from a participant. In paraphrasing, the interviewer can translate to the interviewees in more precise, fewer words to gain confirmation of what was said (Varcarolis & Fosbre 2021:92).

The researcher used the verbal cues of paraphrasing, clarifying, and probing to gain more meaning from what the participants expressed when answering questions during the focus group interviews.

3.2.4.4.3 Field and observational notes and audio recording

Field notes are part of a researcher's self-reflection notes, which guide the researcher about what worked in gaining access, ethics, and data gathering and will assist the researcher during the data analysis process. Field notes give a narrative account of what happens during researcher data collection and what was observed during the interview process (Polit & Beck 2021:525; Gray & Grove 2021:328). Field notes were recorded during the focus group interviews. The researcher wrote down what she observed and noted from the participants during the interviews, such as facial expressions one talking about emotional appearance, and non-verbal cues. This assisted the researcher during data analysis.

Observation is another way that a researcher collects data by listening, smelling, touching, or seeing in the immediate surroundings, and it can be unstructured as the researcher may spontaneously observe and record what is seen or happening (Gray & Grove 2021:817). In this instance, the researcher observed the group dynamics

during the focus group interview, such as the participation of all members who attended and observed whether participants were free to talk or felt intimidated to speak and overpowering the conversation by some participants. This would be useful during data analysis. As indicated in the previous chapter, focus group interviews have advantages and disadvantages, and observation of group dynamics plays a crucial role. This was information that the researcher went back to and read and familiarised herself with what transpired during the interview sessions.

The researcher recorded the interviews for a smooth facilitation of the transcription process. An audio recorder assists the researcher in overcoming the systemic biasness in qualitative research and ensures rigour and validity (Rutakumwa, Mugisha, Bernays, Kabunga, Tumwekwase, Mbonye & Seeley 2020:566).

Taking the field and observational notes added value to the memoing process in grounded theory. These notes were used when data analysis was done for comparison and quality check.

3.2.4.4.4 Memoing

In this process, the researcher writes down ideas during data collection and analysis. The researcher goes back and forth between interview participants, to fill gaps that might have been missed. Memos assist the researcher in writing out thoughts relating to how data formulate into clusters and themes, and what might even be left assists the researcher in reflecting on and describing patterns in data (Polit & Beck 2021:552). In memoing, the researcher records ideas related to field notes, transcripts, or codes (Gray & Grove 2021:349). In this process, the researcher kept a notepad containing written ideas that came to mind relating to the literature review, interviews, and transcription that the researcher felt might be useful. Memoing was also done during the process of data collection and data coding. The researcher recorded all ideas to prevent any potential loss of information, ensuring its availability for future utilisation within the research process. Ideas that came up during the researcher's relaxation time were immediately jotted in the notepad to avoid being forgotten for later use. Ideas may emerge during awkward times like sleeping, walking, or driving and must be written down as soon as possible to avoid being forgotten. Memoing assists the

researcher in recording insights (Gray & Grove 2021:349). The researcher identified and wrote properties befitting each code that formed part of the data analysis as discussed in the data analysis section.

3.2.5 Data analysis

Data analysis aims to systematically organise, synthesise, and interpret the data (Polit & Beck 2021:783). In data analysis, the researcher searches for statements relating to relationships and underlying themes and explores and describes data collected to build a grounded theory. Grouping data into similar patterns or familiarity, which leads to a picture or schematic relationships, entails categories or formation of themes (Melnyk & Fineout-Overholt 2019:648).

Imaginative engagement with data and an emphasis on flexibility as analysis advances, are the hallmarks of constructivist grounded theory as it uses techniques such as memo writing, constant comparisons, and theoretical sampling (Grove et al 2020:6).

According to Marshall and Rossman (2019:217), the following seven steps assist the researcher in practical qualitative data analysis.

- Data arrangement
- Data immersion
- Data coding
- Themes generations
- Providing interpretations by using analytic memos
- Alternative understanding exploration
- Compiling a written report

The researcher and the independent co-coder (refer to **Annexure M**) followed the analysed data according to Marshall and Rossman's (2019:217) data analysis steps as follows:

3.2.5.1 Data arrangement

The researcher organised the data per the date and time the focus group interviews were held. Data were collected from two mental healthcare institutions. Findings indicated the specific group interviewed and the interview date. This was matched with the field and observational notes to avoid confusion. A written sketch was drawn to clarify and align the information. The dates, institution, number of participants, and field and observational notes were indicated on the data-gathering activities.

3.2.5.2 Data immersion

The researcher repeatedly read the raw data, field, and observational notes to become familiar with what transpired in each focus group interview session. Tape-recorded information was listened to make meaning of what the participants shared regarding the issue of clinical leadership and mentoring. This was not an easy task as there was a lot of information in the field and observational notes and tape-recorded information. The researcher followed the entire process so that coding and categorising the data could be done effectively. The grounded theory steps were read in conjunction with this process as the researcher did not want to miss the processes involved in grounded theory. A researcher can relive the experiences and become familiar with different phrases that participants used to describe a phenomenon by reading, thinking, observing, and listening to audio tapes. This indicates that the researcher is immersed in the data, dwelling with the data, and fully invested in the data (Gray & Grove 2021:812).

3.2.5.3 Data coding and themes generation

Qualitative research brings about a large volume of data that a researcher needs to reduce, making it more effective to use and attach meaning. In the coding process, the researcher can reduce the volume of data by naming, labelling, and sorting to find themes, patterns, and phrases (Gray & Grove 2021:806).

As the researcher investigated grounded theory research, open, axial, and selective coding processes were followed. The expertise of an independent coder was sorted for verification and confirmation of codes and themes outlined by the

researcher. A discussion was held between the independent coder and researcher to reach a consensus on the categories and themes outlined. **Figure 3.2** below indicates the coding process using the grounded theory of qualitative data analysis.

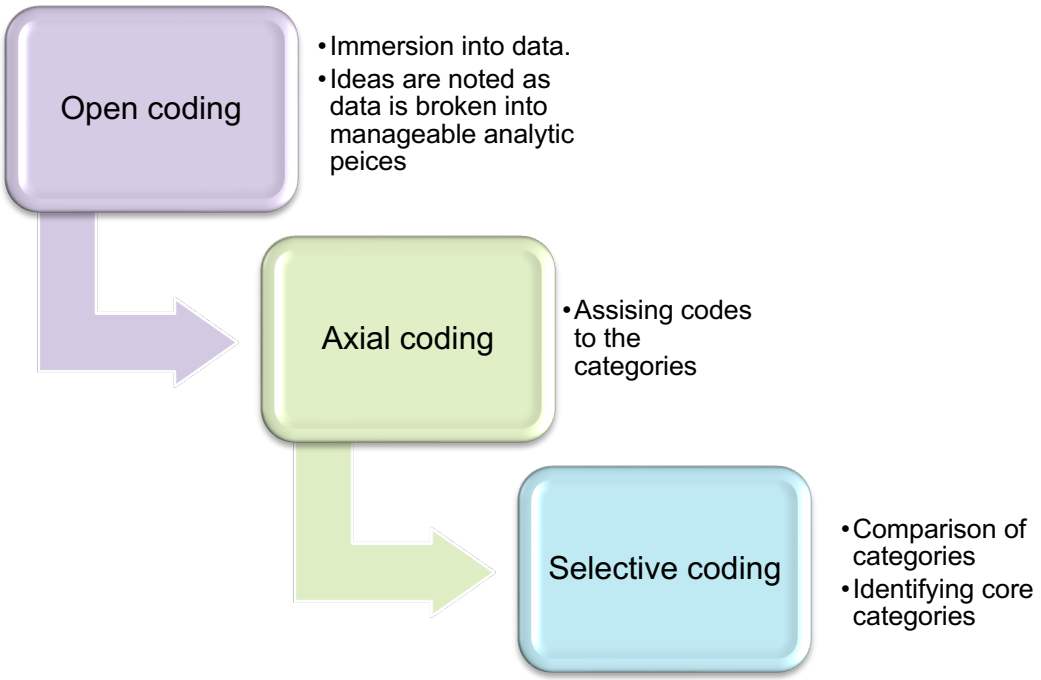


Figure 3.2: Using grounded theory methodology for data analysis (adapted from Gray & Grove 2021:345)

3.2.5.4 Providing interpretations by using analytic memos

In the coding process above, the researcher investigated the formation of themes, selected the specific elements of the data for categories, and attached meaning to elements. Gray and Grove (2021:344) outlined that the coding process reflects the philosophical basis of a study.

The researcher wrote notes while listening to the audio tapes and compared to the observational and field notes, to make meaning of the data. Reflective notes on how the interview process went were jotted down. It was essential to reflect on how participants expressed ideas and understood the phenomena under study. The categories outlined were broken down into themes and sub-themes.

3.2.5.5 Compiling a written report

This signifies the final stage of the data analysis procedure (Marshall & Rossman 2019:217). The findings can be conveyed using tables, figures, and written elucidations (Nyaloko, Lubbe, Moloko-Phiri & Shopo 2023:6). The findings of this inquiry were structured in a textual narrative format, accompanied by tables and figures, which enhanced the overall presentation of the results. In addition, the presentation of findings was supported by incorporating exact citations from the raw data.

3.2.6 Trustworthiness

In qualitative research, trustworthiness relates to the degree of trust that can be given to the research process and the findings and the confidence in the data analysis (Grove & Gray 2023:504). The four operational techniques of trustworthiness outlined by Lincoln and Guba (1985:195) that the researcher used were credibility, transferability, dependability, confirmability, and authenticity (Polit & Beck 2021:806).

3.2.6.1 Credibility

In credibility, the researcher seeks to find the truth, make sense of the data, and demonstrate confidence in the truthfulness of the data. The researcher must be able to defend the appropriateness of the research questions, study design, data collection and analysis methods, and theory choices (Brink & van Rensburg 2022:130; Polit & Beck 2021:782). Techniques involved in credibility include prolonged engagement, persistent observation, triangulation, peer debriefing and member checking (Brink & van Rensburg 2022:130). The researcher used the following strategies to enhance the credibility of the research:

3.2.6.1.1 Prolonged engagement and persistent observation

Polit and Beck (2021:799) posit that a researcher must invest enough time during data collection, to gain in-depth knowledge and understanding of a phenomenon and group under study, enhancing the credibility and rigour of the research study. The researcher

was available to engage with the participants for the first time in a managerial meeting while introducing the research study plan. This was done to build trust and brief participants on the research.

The other measure of prolonged engagement was done when the researcher took the field and observational notes during the interview sessions. The researcher wanted to capture what transpired during the interview sessions for use during data analysis. The researcher conducted the interviews until data saturation was reached, as the truth of the findings had to be depicted at the end of the study, and determining what counted and what was not relevant to the study was necessary. In qualitative data gathering, data saturation is reached when additional data gathered reveals redundant information (Polit & Beck 2021:783). Data collection was done in February and March 2020 respectively.

3.2.6.1.2 Triangulation

The process involves collecting and integrating data from various sources and finding relationships from different points of view to get accurate representation (Gray & Grove 2021:826; Polit & Beck 2021:806). Data collection from operational and assistant managers showed that the researcher wanted to seek information from various sources. Two different institutions were used to collect data, and the researcher got viewpoints from individuals from different environments. A comparison of the views from distinct categories of personnel and the two different institutions added to the triangulation process. The researcher used focus group interviews, audio tapes, field, and observational notes as data collection methods, which were, in the end, used in integration to build up the richness of the research data. The thematic analysis of the data added to the triangulation process.

3.2.6.1.3 Peer debriefing

During the peer debriefing process, the researcher aims to get the accuracy of the research study by involving individuals who are not part of the study and may be experts in the method of use for the survey so they can discuss or debate the research process. Other than the researcher, these individuals ask questions and

make interpretations to validate and enhance the trustworthiness of the research (Creswell & Creswell 2018:325; Polit & Beck 2021:796). The researcher submitted tape recordings, transcripts, field notes, and observational notes to a panel of colleagues with expertise in qualitative research for scrutiny. The supervisor was given two tape recording sessions to evaluate as part of the role as the researcher's guide.

3.2.6.1.4 Member checking

In the process of member checking, also known as respondent validation, or dialogue regarding the researcher's interpretations of the informant's reality and meaning, the researcher returns the data or results to participants, holds discussions or debriefings with the participants to verify for accuracy, correct errors, and get additional information (Creswell & Creswell 2018:341; Polit & Beck 2021:792). This was done after the data analysis process. The researcher went back to discuss the transcripts with the participants to check if there was anything omitted or whether there was any additional information that the participants wanted to include.

3.2.6.2 Dependability

In dependability, the trustworthiness of the qualitative data is assessed for its stability over time and conditions (Polit & Beck 2021:784). Brink and van Rensburg (2022:131) articulate that for the researcher to ensure that dependability is achieved, the following needs to be taken int consideration: how the raw data was collected and recorded, how data was transcribed, how the themes were structured, how the collection instrument was pre-tested, and how field notes and reflective notes were captured.

The researcher kept a research audit, which entailed the recruitment process of participants, the date and times of interviews, the venue, the participants who took part, transcripts, field and observational notes, and the data analysis process that included the coding process and meetings held with the co-coder.

3.2.6.3 Transferability

Brink and van Rensburg (2022:132) articulate that the extent to which findings can apply to other or similar contexts answers the transferability aspect. This can be compared to external validity, where findings can have meaning for similar groups or settings (Gray & Grove 2021:548).

To adhere to the transferability principle, the researcher gave detailed descriptive data on the topic under study and developed a framework. The research was done at only two public mental health care institutions. Clinical leadership and mentoring are of utmost importance in any other institution. This information and framework may be tried or transferred by other institutions that find it relevant to their setting.

3.2.6.4 Confirmability

In confirmability, other researchers can review the audit trail and agree with the researchers' conclusions that the conclusions are logical, dependable, and credible and are supported by the data. The researchers can agree on data accuracy, its meaning and relevance (Brink & van Rensburg 2022:131; Grove & Gray 2023:493). To ensure confirmability, the researcher kept an audit trail that was made available.

3.3 PHASE TWO: DEVELOPMENT OF FRAMEWORK

The development of the conceptual framework should exhibit precision and logical coherence (van der Waldt 2020). In this study, the survey list developed by Dickoff and James (1968:197) served as a guiding roadmap in developing the conceptual framework. The survey list includes six key components: agent, recipient, context, dynamic, process, and terminal. The findings from phase one were used as building blocks for developing the conceptual framework. The researcher developed the framework by:

3.3.1 Description of components

This section provides a detailed description of each element of the conceptual framework. Furthermore, the role and significance of each component within the context of your study were explained. This included discussing how each component contributed to the overall understanding of the phenomenon under investigation.

3.3.2 Illustration of components

Diagrams were used to visually depict each component to enhance clarity and make it easier for readers to grasp the structure of the conceptual framework.

3.3.3 Description of contents of the components

Each component was further elaborated with specific data from phase one and literature to provide a comprehensive overview of the concepts encapsulated within each component.

3.3.4 Assembling six components to develop a new conceptual framework.

Assembling these individual components created a cohesive and integrated conceptual framework to display relationships between components and how they collectively contributed to the research question in phase two.

3.3.5 Brief description of the new developed conceptual framework

Finally, the researcher briefly described each component using colour coding to highlight its uniqueness and how this framework advances understanding of the phenomenon under investigation. The detailed descriptions of the development of the framework are further elaborated in Chapter 6. The following section discusses the evaluation and validation of the framework.

3.4 PHASE THREE: EVALUATION AND VALIDATION OF THE FRAMEWORK

The final phase of the current study was comprised of two stages: evaluation, and validation of the conceptual framework developed in phase two.

3.4.1 Evaluation

In this first stage, the developed conceptual framework was evaluated using the checklist designed based on the criteria proposed by Chinn, Kramer and Sitzman (2022:264). The evaluation criteria included transparency, simplicity, generalisation, accessibility, and importance (refer to **Annexure N** and **O**). The evaluation was conducted by a panel of experts which included two senior lecturers from higher education institutions, two operational managers and two assistant nursing managers from mental health care institutions (Döringer 2021:12). Each panel member was invited through email with a consent form. After signing the consent form the checklist and the framework with a brief description were also emailed for evaluation. The researcher provided the respondents with contact numbers in case clarity was required. The feedback obtained from the expert panel was examined and the framework did not need adjustment based on the panel's input (Cullen & Brennan 2021:11).

3.4.2 Validation

Validating a conceptual framework is crucial for effectively depicting a research study's interrelationships, concepts, and variables. The developed conceptual framework was assessed for robustness and reliability using content and face validity (Connell, Carlton, Grundy, Taylor Buck, Keetharuth, Ricketts, Barkham, Robotham, Rose & Brazier 2018). The same panel used for the evaluation process in **section 3.4.1** assessed the validation of the developed framework using a face validity checklist derived from the work of Bölenius et al (2012:3) and content validity according to the criteria outlined by Sangoseni, Hellman and Hill (2013). The face validity criteria included relevance, importance, purpose, appropriateness, and intuitiveness while the content validity criteria comprised comprehensiveness, relevance of items,

representativeness, agreement of experts, and alignment with objectives (refer to **Annexure P**).

3.5 SUMMARY

In this chapter, the researcher discussed aspects of the qualitative research approach and grounded theory, population and sampling, data collection and analysis, and the study's trustworthiness. Furthermore, the framework evaluation and validation methodology were described. Chapter four will detail the presentation and interpretation of the study findings.

CHAPTER 4
RESEARCH FINDINGS

4.1 INTRODUCTION

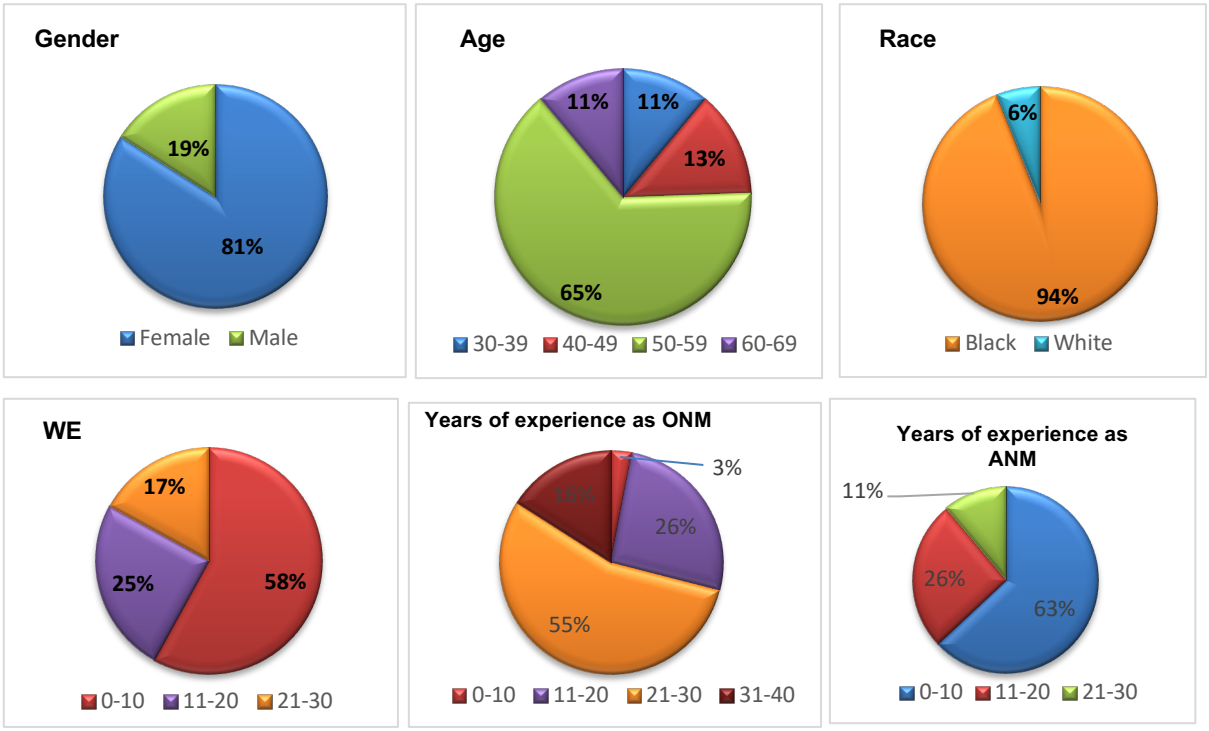
In this chapter, the researcher discusses the outcome of the data analysis. The data were analysed using inductive reasoning, facilitating the systematic emergence of insights from the raw data, focusing on the phenomenon being studied, without any preconceived notions from theories (Shin 2019:301). The researcher concentrated on the objectives of the study as outlined in phase one of the study, namely:

- To explore and describe the leadership-mentoring opportunities and challenges novice clinical nurse leaders face in mental health care settings.
- To explore and describe leadership-mentoring opportunities and challenges established clinical nurse leaders face in mental health care settings.
- To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting.

4.2 DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

The research was conducted at two public mental health care institutions in Gauteng Province with assistant managers and operational managers. Out of the nineteen (19) assistant nursing managers, twelve (12) participated. Two assistant nursing managers were on night duty in both institutions on a rotational basis and could not participate in the study. Out of the thirty-seven (37) operational managers, fifteen (15) participated in the research study. Two operational managers were on night duty in both institutions on a rotational basis and could not participate in the study. On one of the planned sessions, two operational managers withdrew from the study, citing that they were not interested in participating anymore. Out of the total number of twenty-seven participants (n=27), where a total of five participants (n=5) were males, which represented nineteen percent, and a total of twenty-two participants (n=22) were females, which represented eighty-one percent. **Figure 4.1** outlines the percentage of males and females in the institutions within the managerial positions.

A higher percentage of the participants were aged between fifty (50) and sixty (60) years of age (refer to Figure 4.1), giving a challenge to the development of young and upcoming nurse managers as most are reaching retirement age. Ninety-four percent (94%) of the participants were black, with only six percent (6%) of whites in the institutions. No other races were represented in the research study as no other races worked as operational managers or assistant nursing managers in the two institutions. Fifty-eight percent (58%) of the participants had work experience of twenty-one (21) to thirty (30) years of working in mental health care institutions as indicated in **Figure 4.1** where work experience is written as 'WE". Fifty-five percent (55%) were operational managers (OM), and sixty-three percent (63%) were assistant nursing managers (ANM) as outlined in **Figure 4.1**.



WE: Work experience; ONM: Operational nursing managers; ANM: Assistant nursing managers

Figure 4.1: Participants' demographic profile

4.3 OUTLINE OF THE THEMES, CATEGORIES AND SUB-CATEGORIES

The data provided an overview of the themes, categories, and subcategories and the evidence, reflecting clinical nurses' leadership and mentoring experiences, competencies and the opportunities and challenges they face in mental healthcare settings. Four themes emerged, and each theme had its categories and sub-

categories. The central storyline indicates that the experiences of clinical nurse leaders working in mental health care settings reflect those specific interpersonal skills and intrapersonal qualities noted in successful leaders and mentors. These clinical leaders recount their own experiences of being mentored and identify the factors and strategies that facilitate the mentorship of novice leaders. Institutional and professional challenges and difficulties can impede mentorship when working with mentees. Clinical nurse leaders reflect on opportunities, or a lack thereof, for promotion into leadership positions within a mental health care setting and indicate the importance of sound mentorship to facilitate the process. The summary of the themes, categories and sub-categories is outlined in **Table 4.1**.

Table 4.1: Theme classifications

Themes	Categories	Sub-categories
4.4.1 Theme one: The personal characteristics of an effective clinical nurse leader and mentor	4.4.1.1 Interpersonal skills	4.4.1.1.1 A positive role- model 4.4.1.1.2 Communication skills 4.4.1.1.3 Fair but firm 4.4.1.1.4 Consistency 4.4.1.1.5 Understanding the mentees 4.4.1.1.6 Motivational and non-judgmental attitudes
	4.4.1.2 Intrapersonal qualities conducive to leadership	4.4.1.2.1 Not forcing one's own beliefs and values on others. 4.4.1.2.2 Making and taking decisions 4.4.1.2.3 Being compassionate and understanding
4.4.2 Theme two: Clinical leadership Mentorship	4.4.2.1 Experiences of being mentored	4.4.2.1.1 Positive experiences 4.4.2.1.2 Informal mentoring 4.4.2.1.3 Insufficient mentoring 4.4.2.1.4 Trial and error learning
	4.4.2.2 Factors facilitating effective mentoring	4.4.2.2.1 Knowledgeable and experienced mentors 4.4.2.2.2 The right candidate with leadership potential 4.4.2.2.3 Open-door policy 4.4.2.2.4 Support of seniors, managers, and colleagues, and having a strong team

Themes	Categories	Sub-categories
	4.4.2.3 Mentorship strategies	4.4.2.3.1 Induction, orientation, and written protocols 4.4.2.3.2 Guidance and development through accompaniment 4.4.2.3.3 Exposing mentees to the demands of the next level manager's responsibilities 4.4.2.3.4 Learning by standing in for or relieving superiors 4.4.2.3.5 Continuous, ongoing mentorship and training 4.4.2.3.6 Adequate monitoring and feedback 4.4.2.3.7 Presenting as a developmental tool 4.4.2.3.8 A culture of mentorship
4.4.3 Theme three: Challenges experienced during clinical leadership mentoring	4.4.3.1 Institutional and professional challenges experienced by leaders	4.4.3.1.1 No scope of practice determined for nurses in mental health. 4.4.3.1.2 Shortage of resources that put pressure on the leader. 4.4.3.1.3 Administrative and night duty responsibilities 4.4.3.1.4 Lack of authority and autonomy in decision making 4.4.3.1.5 Insufficient support from superiors
	4.4.3.2 Challenges encountered in the mentorship of novice leaders	4.4.3.2.1 Reluctance to be mentored.

Themes	Categories	Sub-categories
		4.4.3.2.2 Disrespect for the knowledge, authority, and position of superiors 4.4.3.2.3 A lack of seriousness and responsibility toward duties 4.4.3.2.4 Ethos and unethical behaviour 4.4.3.2.5 Motivated by reward rather than a vocation. 4.4.3.2.6 Difficulties with discipline 4.4.3.2.7 Interference of Labour Unions 4.4.3.2.8 New versus old school of nursing
4.4.4 Theme four: Opportunities for clinical leadership positions	4.4.4.1 Opportunities available	4.4.4.1.1 Mentoring courses
	4.4.4.2 Lack of opportunities	4.4.4.2.1 Limited advancement to leadership positions
	4.4.4.3 The role of mentorship in promotional leadership opportunities	4.4.4.3.1 Exposure to high-ranking leadership positions

4.4 THEMES, CATEGORIES AND SUB-CATEGORIES OUTLINED

In this section, each theme, category, and sub-category was outlined as per participants' views. Codes to distinguish the participants in the different focus groups were used. Codes U, V, W, X, Y, and Z refer to the focus group and the number or letter following it relates to the identification number of the participant on the transcript (e.g., U1 indicate that a quote is from participant one in focus group U=17/02/2020). These are the dates of the focus group interviews and the codes thereof:

- U = 17/02/2020
- V = 18/02/2020
- W= 19/02/2020
- X= 03/03/2020
- Y= 11/03/2020
- Z =23/03/2020

Data saturation occurred in the last interview conducted on 23 March 2020, hence the researcher did not continue with the interviews.

4.4.1 Theme one: The personal characteristics of an effective clinical nurse leader and mentor

The first central theme identified was the personal characteristics of a nurse leader and mentor, including interpersonal and intrapersonal skills and qualities. These attributes encompass a range of qualities essential for successful leadership and mentorship in a clinical setting.

4.4.1.1 Interpersonal skills

This section delineates the personal attributes of a proficient clinical leader and mentor, with a specific emphasis on a positive role model, communication skills, firmness and fairness, consistency, understanding, motivation, and non-judgemental attitude. Interpersonal skills are identified as abilities that an individual must be able to

interact or communicate well with others and include specific skills such as communication, trust-building, conflict resolution, cohesion, and productivity (Bruce & Klopper 2018:262).

4.4.1.1.1 A positive role-model

Participants agreed universally that leaders must be impeccable role models to those they mentor and lead by example. Doing this would assist in deep learning of behaviours expected in this role. It would also assist the novices in managing themselves. A negative role model would equally enforce negative learned behaviour. The participants verbalised that leaders must lead by example, be an example and be role models. The following quotes evidenced this:

> *"If you lead, you must lead by example." (V7)*

> *"And then you need to be an example, … so that people can learn from your behaviour or … how you do things. […] So, you need to be an example to the people you are mentoring so that they can easily learn and not forget." (Z3)*

> *"You are role modelling for this person so that they can know how …to cope with higher responsibilities." (Y2)*

4.4.1.1.2 Communication skills

The participants emphasised that communication needed to be clear. Effective communication skills enable individuals to form satisfying relationships with one another.

The participants stressed the importance of effective communication with mentees and expected a leader to have excellent verbal and non-verbal communication skills, convey information clearly and understandably, and talk to an individual in private, in a calm manner and with a low tone.

The participants emphasised the necessity for a leader to have good listening skills and stated that leaders should demonstrate great patience with those they mentor. Patience was indicated as a requirement from a leader that could equally foster deep learning, which takes time. Listening was said to be a skill and a good leader must be able to listen to give a relevant response to what was stated:

"…good communication skills…" (Y1)

"You also need to be able to communicate clearly in a language where the new (staff member) … can understand [sic] what you actually mean." (U1)

"I think a good leader has to be a person who has good listening skills." (W3)

"Be a good listener" (X3)

"…and patience, you know. If you…if you are trying to guide someone that is new, you need to have patience." (U3)

4.4.1.1.3 Fair but firm

According to the participants, leaders should be sympathetic and fair in their mentoring and supervision of subordinates but must also be assertive and firm in their dealings with staff. The following comments supported this:

"Be firm and always be fair." (Z1)

"[.. you should be sympathetic … and be assertive because …they can take you, for example… for granted and… do things as they wish. So, being assertive will… assist you to meet your objective]" (Z3)

"A good leader also has to be assertive at all times." (Y3)

4.4.1.1.4 Consistency

Participants stressed the need for a leader to be consistent when dealing with followers. Consistency is a valued characteristic and participants indicated that leaders need to maintain consistency to avoid causing problems for the mentees in the leadership role.

> *"A mentor should be having …it's consistency, should always be consistent." (U6)*

> *"The best thing is consistency … each one of us has got their own perspective on what they're doing." (X3)*

4.4.1.1.5 Understanding the mentees

Many participants expressed that good leaders must be able to understand people, as their mentees are all individuals and are different. The leadership-mentoring role needs to be approached differently to get the most out of those being mentored. Knowledge of each mentee is essential to reach objectives.

Some participants noted that it is not enough for leaders to understand their subordinates but that this skill is contingent on their capacity to understand themselves. Self-awareness was outlined as an important characteristic of an effective mentor and leader.

> *"…a mentor should… be an understanding person […] in most of the cases as a mentor you will be working with a different person, and you need to understand …different personalities and accommodate those personalities." (Z3)*

> *"Know your people and know their strengths and weaknesses and how to deal with each and every one of them." (Y1)*

"If you work in a group where the objective is followed but the way to get to the objective might differ …and if the overall leader allows for such … personal individual characteristics…to be part of their management style." (U4)

4.4.1.1.6 Motivational and non-judgmental

Participants indicated that leaders should avoid being judgmental of those they are leading. The mentees expect a non-judgmental attitude, open-mindedness, motivation, and encouragement of others from the leader.

"As a leader and mentoring them, …I should not judge." (Z2)

"Your personality should be, um, very calm, um, have a non-judgmental attitude as a manager, be able…be open-minded, you know, in any situation." (X1)

"…should avoid being judgmental because sometimes we become so judgmental that we overlook the good things that one is doing, and we tend to generalise." (Y1)

4.4.1.2 Intrapersonal qualities conducive to leadership

Participants indicated some desirable intrapersonal attributes of leaders and mentors, which were identified as being responsible and not forcing one's own beliefs and values on others, being able to solve problems, being able to make and take decisions and being compassionate and understanding, with a positive attitude.

4.4.1.2.1 Not forcing one's own beliefs and values on others.

Participants indicated that a leader who needs respect and teamwork should be very considerate of others, respect their beliefs and values and not force his/her own beliefs and values on others. The following statements highlighted this:

"…you cannot force someone to…to learn if she is not or he is not willing to learn. But if you can encourage them." (W5)

4.4.1.2.2 Making and taking decisions

Participants argued that an effective leader and mentor should be bold enough to make decisions and own up to the decisions taken. One of the requirements for a nurse leader is to be accountable and responsible and decision-making as a leader, should not be taken lightly. The participants had the following statements to say:

"You have to do problem-solving." (Y1)

"To take decisions and follow up on those decisions." (W1)

4.4.1.2.3 Being compassionate and understanding

For some participants, having a compassionate and understanding leader and mentor was ideal for effective mentoring. A leader who lacked the two components was going to be a challenge when mentoring an upcoming leader as the mentee needed to be supported and encouraged. The participants shared the following statements:

"And also, you must have a good, um, or a positive attitude." (Y3)

"…must be a motivating person and have compassion." (X1)

"I think h…as a mentor, for you to improve … leadership (in) others, you must also be understanding and able to motivate them." (V12)

4.4.2 Theme two: Clinical leadership mentorship

The second main theme, "clinical leadership mentorship," includes subthemes such as experiences of being mentored, factors facilitating effective mentoring and mentorship strategies.

4.4.2.1 Experiences of being mentored

The essential attributes for experiences of being mentored were indicated as positive experiences, informal mentoring, insufficient mentoring, and trial and error mentoring.

4.4.2.1.1 Positive experiences

Participants who were mentored were mentored by their seniors and many stated that the mentoring they received was very beneficial. Others indicated that they were mentored by the operational managers they found in the units they were allocated and promoted to work in. Others attended a management course where they were taught how to lead.

> *"I was mentored by my senior." (Z1)*

> *"We were given mentors when we started here. Eh, the seniors were mentors…mentoring us. Um, up until now we…we work, like, in sections but you know there…there's a…a…a senior whom you can always call and say, you know, I'm challenged with this, um, can you help me with it?" (U5)*

> *"With me, when I was, like, appoint…appointed as a manager, fortunately there was another operational manager in the unit that I was, before I was, like, allocated a unit on my own. It was, like, a type of accompaniment […] I mean, given in-services on how to manage things, problem solve…solving, crisis management, in terms of looking at what she's doing and then also allowing me to do that by myself." (W6)*

Participants were positively influenced by leaders and mentors willing to mentor and take them through their leadership journey. The positive experiences were an indication that the upcoming clinical leaders needed some sort of guidance for them to master the skill of leadership.

4.4.2.1.2 Informal mentoring

Even though some participants did not have formal mentoring, they benefited from informal mentoring from seniors or colleagues during an informal conversation. The way the participants got benefits from informal mentoring is reflected in the below quotes:

> "*It wasn't formal … when I started, there were A-S-Ds in front of me. […] Then wouldn't feel that you are being mentored but because…you sit together, and you discuss issues and you have tea, together and during the tea, you say I've got this problem, blah-blah-blah, and …you know, you discuss. and that is why …we survived, you know, without the formal mentoring." (U3)*
>
> *"Ja, those discussions are very, very helpful and I will say it's really mentoring us because when you have a problem, you just ask the group." (U6)*
>
> *"...perhaps our morning handing-over that now runs …that we can pick up immediately small issues before they become big, and we can actually call upon the same approach and we all then go out and do the same thing that, on the concern that was raised. So, I think that day-to-day, um, discussions actually pay up some good." (U4)*

4.4.2.1.3 Insufficient mentoring

Participants indicated that they were never mentored. Participants indicated that the mentors lacked tools and skills in mentoring, mentors did not make time for mentoring, and others felt they were thrown under the bus and had to navigate the leadership process on their own.

Participants indicated a lack of mentoring in specific leadership skills. Some identified a lack of mentoring to be business-minded leaders, not being mentored to be able to work and plan on their own, and a lack of being mentored for leadership positions.

Some participants started in a managerial position in a trial-and-error manner. Participants had the following to say regarding insufficient mentoring:

> *"Ja. …during some of our times actually …things were very difficult because the mentoring …was not, you know, because people back then still lacked, tools and skills […] people didn't find time actually to mentor us." (V8)*

> *"I was never mentored, that's the unfortunate part, but through the mercy of God and being eager to learn, I managed as an operational manager. I was thrown to under the bus […], but I managed." (Z3)*

> *"I personally was never mentored." (Y3)*

4.4.2.1.4 Trial-and-error learning

Insufficient mentoring resulted in participants having to self-mentor through trial-and-error and hands-on learning, which was sometimes frustrating but was fulfilling after mastering the skill. A participant described learning through hands-on self-sufficiency as a positive mentorship experience that developed leadership skills and confidence in running a unit.

> *"It was trial and error, ma'am. You either survived or you drowned and if you drowned you had to go and fix what you did wrong. And that caused tears and it caused the good feeling." (U4)*

> *"…having to overcome a lot of things on your own." (V8)*

> *"I came here…fresh from college, then I was a professional nurse here for seven years. During those seven years, because of shortage, on many occasions I was left in the ward as a senior person, and …on those occasions I got that opportunity to learn how to be a leader because I was handling, eh, from cleaners up to the … other professional nurses as well. So, I would say I was mentored very well, and I didn't miss a step." (Z1)*

4.4.2.2 Factors facilitating effective mentoring

This segment delineates the factors facilitating effective mentoring, which include knowledgeable and experienced mentors, the right candidate with leadership potential, an open-door policy, and a support system from management and colleagues.

4.4.2.2.1 Knowledgeable and experienced mentors

According to participants, mentors must be knowledgeable, and importantly, be able to impart their knowledge and experience to mentees.

> *"You need knowledge and experience because you have to be actually experienced in the area in which you are working." (V8)*

> *"We are here to mentor and teach other people, and we are here to impart knowledge." (Y1)*

> *"Be skilful enough to, um, portray the necessary knowledge to them." (U1*)

4.4.2.2.2 The right candidate with leadership potential

The development of leaders implies a need to recruit suitable people into the nursing profession. If unsuitable candidates are recruited in the recruitment process, it will be very challenging to develop the leadership potential of such individuals.

The participants had the following opinions regarding recruitment and selection:

> *"Ja, I think we need to start maybe from the…maybe at the college level as a selection process, as a matter of screening the type of the…the nurses that need to be nurses. This is where we have to start." (V12)*

"As much as politics are part of life now, I think we have lost, uh, focus, we've been swallowed by political, issues, forgetting that we deal with human life. So, we need to go back, we need to look at our criteria [sic] …(for) attracting… nurses." (Y2)

Participants highlighted the following regarding leadership potential and ensuring that such individuals are not lost to the other professions:

"One of the most important things [sic] about leadership is being able to spot a person with potential …and once you spot that person, ensure that that person doesn't slip away from your hand. Ever since my college days, I have seen potential leaders dropping out, losing them to other professions. So, it's very important to spot the person with potential and groom that person." (Z1)

"Can you actually teach somebody to be a leader or a manager? They should have those attributes and characteristics, but can't we help a little bit to build on that with specific courses? Like…and I'm thinking…I'm making a simple example, a disciplinary course […] a financial course." (U4)

"...must be able to identify potential in people or people that he or she will be supervising so that she can be able to groom or develop such persons towards … (their) potential." (Y2)

4.4.2.2.3 Open-door policy

In the course of being mentored, mentees require easy access to their mentors and feel comfortable about approaching them for assistance. Participants highlighted that a mentor needs to be approachable, accessible, open, and welcoming. The following comments evidence this:

"Approachable and accessible because your… (up)coming manager must be able to access you, must be there for you…or (you) for them." (X6)

"…if anyone will probably have to ask you something, they must be free to come and ask you." (U2)

"...the mentor needs also to be open and welcoming and accepting." (U3)

4.4.2.2.4 Support of seniors, managers, and colleagues, and having a strong team

The importance of support from senior staff and colleagues was emphasised as was the need to build a strong team. According to the participants, good mentorship was more possible with a strong team and each staff member had to be an example of working within a team to achieve common goals.

The participants highlighted these aspects with the following statements:

"With the group that I'm working with, as …the participant already said, we talk to each other, we ask questions where we are not certain, and then built … each other every day, we hold meetings, and we learn from there." (U2)

"It was my first time being an operational manager […] I got a lot of support …from the management part …from the person who was supervising me." (W2)

Participants highlighted the following comments regarding teamwork:

"I think really we can achieve our goals as managers working together, communicating, being consistent, …having the same understanding in terms of procedures, policies, you know, you will be able to work towards a common goal." (X1)

"You must be able to see, because other people are stronger in people management, other people are strong in administrative duties, others are strong in education, and so on, and so you must… be able to identify that and support because … such, thing(s) can help you or help a team it." (Y2)

4.4.2.3 Mentorship strategies

Mentorship strategies can be outlined for achieving effective mentoring relationships and developing effective mentoring programme. To perform optimally in their position, newly appointed staff members and nurse leaders require clarity on what is expected. The participants outlined the following mentorship strategies: Induction, orientation, written protocols, guidance, and development through the accompaniment of the mentee; exposing mentees to the demands of senior management, learning by relieving the supervisor in absentia and continuous ongoing mentorship and training.

4.4.2.3.1 Induction, orientation, and written protocols

Participants indicated that induction, orientation, and written protocols are preliminary requirements for effective mentorship. The following statements highlighted this:

> *"Show the, um…the incoming person into a position a way in and out of the challenges of the position so that the person should understand, um, the…the…the…what is expected of him or her." (Z3)*

> *"What is expected of them." (U1)*

> "*The way in which I understand clinical leadership mentoring in mental health it means that when you are mentoring someone you are mentoring that person in a practical situation, showing them everything, but it starts with the orientation of the ward." (V7)*

> *"…orientation, …a newly qualified person by … a very experienced person into how to go about in performing your duties as a professional." (U6)*

Furthermore, it was made clear by some participants that written protocols, policies, and procedures are not always standardised, and some find this to be an area that is sorely lacking. This ends up in a process where one must find a way and develop

policies that may not be relevant and related to what is expected. The participants highlighted this by the following statements:

> *"The daily go-about, you know, of the hospitals. We are the people that actually start putting in procedures, we develop it ourselves [sic], and policies and …because there was a lack from the department's side and then also how do you mentor if you don't have a…a guide?" (U1)*

> *"The top leaders that are above us can help us…to make protocols that …are workable for nurses. Because …some departments you find there are no proper guidelines for nurses to follow […] if…a situation like this crops up, this is how you need to do it. So, you find that people live in fear of saying, so, I don't know how I will handle a situation like this if it arises." (Y4)*

Moreover, some participants believed that it was essential to ensure that staff understood any existing policies and procedures and to develop and expand on them where necessary.

> *"We can work within the very same framework actually to improve our policies or protocols that are currently in operation." (V8)*

> *"… then after sitting down with them, uh, eh, they understand the policies, the protocols, the procedures, that's when they…now they are aware of, eh, like, the things that we are doing." (W4)*

In addition, another participant astutely points out that written protocols cannot replace effective mentoring and that the two must be used in tandem.

> *"People have different needs. One prefers to walk together, the other one wants a procedure in writing, tell me to do this specific responsibility one, two, three. That's a very difficult, um, way of managing because if you leave out anything then you've missed out and that person feels inadequate. But you also need to*

combine the two. The mentoring being together plus practical procedures that we speak the same language, and that the consistency can be supported." (U4)

4.4.2.3.2 Guidance and development through accompaniment

Many participants agreed that the most effective mentorship of leaders is achieved through the mentor's one-on-one accompaniment of the mentee, whenever possible. Participants highlighted that support and accompaniment by an experienced person will enable an upcoming leader to grow and perform the leadership role efficiently and effectively. In addition, participants also emphasised the importance of a trusting relationship which will build the new leader to take the baton from the old leader and move on with it in confidence.

"Supporting and assisting and developing a person to be a leader." (X3)

"Accompanying a new operational manager into the role as an operational manager, being the person that… practically to show her the ropes." (X4)

"It is practical if you do it that way because the one-on-one creates a trusting relationship and then the learner is not uncomfortable to come with uncertainties …because there's a good supporting relationship between the two and all questions are then viewed as…as constructive and you can actually build into your new leader plus, plus, plus." (U4)

"Accompanying a person of a lower rank to be able to take responsibility onto another higher rank." (Y4)

This may imply the mentee shadowing the mentor.

"...actually, at the matron's office we have a mentoring programme where the newer ASDs will get then an opportunity to go to managerial meetings …and then actually shadow a more experienced assistant manager, or the nurse manager then, to accompany them, even to outside meetings like cluster

meetings, and not only inside the hospital. […] But that's only actually you know, on assistant manager level." (U1)

"Someone like the incoming leader, showing him the ropes, if possible being with him in meetings for him to observe on how things are done." (Z1)

According to a participant, both the mentor and mentee learn from working alongside each other.

"*You are gaining an experience of being a leader while you are working alongside …you are with them. And that's the best way to learn, because …you get the opportunity to learn how they work, how they interact with the client, and at the end you actually become the best leader because there is nothing, they can hide away from you, you are there with them every day." (V8)*

4.4.2.3.3 Exposing mentees to the demands of the next level manager's responsibilities

The leadership mentor's responsibility is to expose the mentee to more and new leadership responsibilities. This can be done by allocating some duties and responsibilities to the next management level to familiarise the mentee with the required skills while still being supported. Participants highlighted that assigning tasks and delegating managerial duties and exposure to responsibilities that one is not acquainted with will empower and build confidence to lead in the new and upcoming leader. The following statements supported this:

"It involves …um, exposure, exposing a person to another level of expectations, a higher level …of managing, of becoming a manager or a leader …by maybe… additional delegation, of duties related to the said, um, a component of leadership." (Y2)

"...assigning tasks, … higher than the level that he's functioning and appointing him and exposing him to other tasks that he's not used to, maybe above his level, and giving him support throughout." (Y1)

"A way of involving …uh, probably a supervisor to another level …of management extra, responsibilities relating to just maybe…uh, making them be acquainted with…upper management skills. So, it's just that you put them like to be empowered what the upper-level manager is doing." (Y3)

4.4.2.3.4 Learning by standing in for or relieving superiors

Many participants stated that the hands-on experience that up-and-coming leaders get by standing in for their superiors when they are not there is invaluable to their development. Some indicated that they learned by these means but, in their institution, this approach was no longer the practice.

"The upcoming …manager can take over when the senior manager is not present." (X5)

"I was exposed from my upcoming years …to leadership, you know, to act on behalf…of my supervisor. But then now currently where I am, when I look at that… such opportunity is not really created for the possible coming candidates." (Y2)

"In the past we actually used … to have a O-M that's working closely with you and when you are not there, they relieve you, for two weeks or for a month period. But that's currently not happening now anymore." (U1)

Operational managers interpret this as their superiors trying to avoid doing their work and pushing it to the next available person:

"The people that [we] would like to mentor, they think … [we] are offloading our responsibility, so they don't want to do that. …it's their thought … we don't want

to do our job, so they will be…uh, they are doing our job for us, and we will be just sitting. While we are trying to uplift them for the future." (Y3)

4.4.2.3.5 Continuous, ongoing mentorship and training

Participants verbalised that leaders must teach continuously, and in-service programmes are put in place for them to grasp the processes. The participants emphasised that continuous teaching must occur as one cannot grasp everything taught in one session. The following comments evidenced this:

"Do continuous teaching for them to understand and for them to learn how to be leaders in future." (Z2)

"If it can be continuously, because some other people…like, you can't grab a lot of things in…in a short period …So, if it can be continuously, it will be better. […] …the week must not end… without, eh, teaching people something." (W4)

"We need to have in-service training." (V12)

4.4.2.3.6 Adequate monitoring and feedback

Participants expressed that they needed to hear from the mentor whether they were progressing and what needed to be improved for effective leadership development. The participants expressed the following statements:

"... how can the clinical leadership mentor role be improved? It can be improved by giving proper feedback." (V12)

"Being mentored, we have to have feedback just to hear, um, how far am I being mentored?" (X5)

"We should also know how to give a proper, you know, negative feedback. Because at time we tend to hold that back thinking it will rupture a relationship between us and the person we are mentoring we need a good approach." (V8)

4.4.2.3.7 Presenting as a developmental tool

Participants experienced the ability to present at meetings, to management or in training as an essential skill for leaders, therefore, any opportunity to practice and develop this skill was viewed as beneficial for a novice leader's development. The participants suggested that an opportunity to present will empower them to take control and show they can make their own decisions. Therefore, the opportunity to present reports, research or in-service training should be encouraged. The participants gave the following comments:

"We need a group of people who have masters […] and then people can present and be able to, … open or be able to communicate more often … in presentation, you know, to grow their presentation skill… Because I think it's what we need as managers to be very good in, terms of presentation skills." (X1)

"The next thing is their report. […] Because it will develop you during the presentation, …when you've got, you know, caseloads that you've got to present for. It will improve your knowledge, it will improve your skills, and your communication and it will also boost your confidence when you have to face the students." (V8)

4.4.2.3.8 A culture of mentorship

Some participants expressed that mentoring should be conducted by leaders and encouraged by staff at all levels, especially professional nurses. Participants mentioned that professional nurses are responsible for instilling a culture of mentorship at all levels of nursing and that subordinates should have their supervisors mentoring them irrespective of the category. Mentoring should flow from one level to

the other and be a practice in a unit. Importantly, staff should be mentored on how to mentor others. The assumption should not be made that staff automatically know how to mentor. The following comments evidenced this:

> *"As an operational manager, I feel that it's not fair that you can mentor everybody in the ward. Yes, you've got your professional nurses, but the professional nurses must take it down to the enrolled nurses. Enrolled nurses must take it down to the auxiliary nurses. …that's, yeah, a recommendation." (W2)*

> *"So, the challenges are this. Currently you cannot draw a line between a professional nurse, …and a staff nurse. They think alike. Professional nurses no longer guide their juniors, simple as that." (V7)*

> *"…the attitude of the potential mentors …or the professional nurses in the ward where there's this expectation for them to actually mentor the new nurses […] we cannot enforce …people actually to do the right thing. Maybe we need a totally different approach, providing them with the skills and knowledge of mentoring itself, how do you mentor somebody? Maybe we are taking it for granted that professional nurses when they come from the college, that they know how to mentor." (V8)*

4.4.3 Theme three: Challenges experienced during clinical leadership mentoring

This section presents the third main theme, "challenges experienced during clinical leadership mentoring," which is further elaborated under the sub-themes institutional and professional challenges experienced by leaders and challenges encountered in the mentorship of novice leaders.

4.4.3.1 Institutional and professional challenges experienced by leaders

This section outlines the institutional and professional challenges experienced by leaders, explicitly focusing on no scope of practice determined for nurses in mental health, shortage of resources that put pressure on the leader, administrative and night duty responsibilities, lack of authority and autonomy in decision making, and insufficient support from superiors.

4.4.3.1.1 No scope of practice determined for nurses in mental health

The SANC serves as a regulatory body for the nursing profession. One of its objectives is to promote the provision of nursing services that comply with universal norms and values and have a function to establish, improve, and control conditions to determine nurses' scope of practice (SANC 2005: s3c & s4l). The regulatory body, however, does not have any scope of practice relating to mentoring in a mental healthcare institution but outlines the scope of practice as a general nurse and midwife. Participants shared the following opinions:

> *"...because there is no scope of practice from Nursing Council of somebody who has actually done that who's a nurse specialist at the mental health, you know, level. You cannot continue to practice something that you are not empowered to do. So, the culture does not even support you. […] you pass and you're on your own…at the mental health, you know, level." (V8)*

> *"Because people have forgotten that, apart from the job description that you are having, you also have the scope of practice that you are supposed to practice under." (V7)*

4.4.3.1.2 Shortage of resources that put pressure on the leader

Participants expressed that the lack of resources negatively impacted their leadership and mentoring ability. Expectations from the communities, technological challenges, and shortage of personnel impacted the mentoring role of the leaders. The

multifaceted nature of leadership responsibilities and the many challenges leaders face create pressure on them. The expectations and responsibilities placed on a leader regarding patient care and administrative roles within a unit put pressure on the leader to the extent that mentoring is put aside to meet the needs and obligations of a unit. Participants indicated that personnel and patients rely on the leader for decision-making and problem-solving. Participants shared the following statements:

> *"…the other challenge that we have is a shortage. We have too many gaps." (Z1)*

> *"[The] top managers are putting expectations…for the community on us but meanwhile …we don't have resources, we don't have the equipment, we don't have this and that." (Y4)*

> *"Yeah, one of the challenges there to me is the technology, the recent technology that is ever-changing … with the resource, with the minimum resource that we are having." (V13)*

> *"…and then sometimes it feels like when you have challenges of let's say absenteeism or resources." (V3)*

> *"It's very, very challenging. Everybody looks up to you to actually, …you are there for the staff members as well for the patients." (V9)*

4.4.3.1.3 Administrative and night duty responsibilities

The heavy administrative load and night duties remove leaders from their subordinates for extended periods, limiting their oversight duties toward staff and depriving them of a role model and mentor. The participants expressed that the mentors do not have time to develop the upcoming leaders due to other work commitments like meetings. Only one person may be allocated to mentor and still has other unit responsibilities. Participants shared the following statements:

"When it comes to the operational manager, we tend to spend less time in the ward…we spend less time in the wards and more time in the meetings …and running the matron's office. So, …people tend to misbehave or be discouraged. If we spent more time in the wards and with these people, we'll be able to show how them…or show them how leadership should be." (Z1)

"[When working] at night…you can see maybe your staff three times in a week. In seven days, you see them three days." (Z3)

"You don't devote much time in developing this person because you haven't got time." (VH)

"…you'll find that there's only one person who's responsible for the student and this person when they are not there then the students are lost." (V8)

4.4.3.1.4 Lack of authority and autonomy in decision making

Many participants stated that although they are held responsible for what happens in the ward, they are not given the autonomy to decide how best to run their wards and meet their objectives. Participants expressed that often those making decisions or conveying information to upper management do not always have first-hand knowledge of the ward situation to do so adequately or correctly. Thus, participants wish to be part of the decision-making process and make a more substantial contribution. Participants shared the following statements:

"I feel that we, being long in this service, we are underutilised. We've got the knowledge, we've got the skills, we've got the experience, but you are underutilised." (Y1)

"...but … other team members, they need to recognise that we are experienced, we are knowledgeable, and we can contribute. […] we want to make a massive contribution." (V8)

"It seems as if …your hands are tied; you can't do anything. Even though you know something, you want to do…you want to decide certain… issues, you can't because that person…the supervisor said, no, …." (Y1)

"If we can be allowed to come up with suggestions or solutions for the challenges that we identify… and this is how we see it going forward." (Y4)

4.4.3.1.5 Insufficient support from superiors

Supervisors are not always available, leaving new or middle management leaders feeling isolated and unsupported. This leaves the middle managers unable to make decisions as they feel they are thrown into the deep without proper guidance. Participants said that they sometimes felt left alone, struggling, without support, and unsure whether they were making proper decisions. The participants shared the following statements:

"...your superiors …being scarce, you know, scarce from you, the in-charge, and your people […] So, …you end up feeling alone sometimes you find that you need your…your leader, there are challenges, you can't find her or him in the office. So, you struggle alone, né, with the patients or whatever. You can't make proper decisions because she's not there to support you. So, what we need is their support." (Y1)

"One of the negative challenges is that you…you are actually thrown in the midst and then, um, you do not have managers actually on site to…to actually walk this trajectory with you. You are on your own and you are facing these workers." (V9)

"…they need to be involved. … it will lift us up as nurses. Because we want our… top management or the managers … it will make things much easier, and everyone will see that this is what I want to do, …we will have that spirit of wanting to be more…if you are just a professional nurse who even wants to be on the leadership level." (Y3)

4.4.3.2 Challenges encountered in the mentorship of novice leaders

Most challenges impacting a leader's ability to mentor effectively can be traced back to attitudes displayed by some mentees. This manifests as a reluctance to be mentored and some behaviour that is disrespectful, irresponsible, and even unethical at times. Subordinates are frequently disinterested in their duties and are rewarded, not vocationally driven. Leaders are challenged in their ability to apply corrective discipline and find the Unions' role particularly challenging.

This section describes the challenges encountered in the mentorship of novice leaders, with a particular emphasis on reluctance to be mentored, disrespect for the knowledge, authority, and position of superiors, a lack of seriousness and responsibility toward duties, ethos, and unethical behaviour, motivated by reward rather than a vocation, difficulties with discipline, interference of labour unions and new versus old school of nursing.

4.4.3.2.1 Reluctance to be mentored

Participants experience that the attitude of some of the staff indicates that they do not wish to be mentored and thereby gain work advancement and promotions. Some of the upcoming leaders showed no interest in being prepared for the higher leadership level. The participants gave the following statements:

> *"Some [of the] managers, even if you want to empower them, will feel that it is not their duty. They do not want to be empowered with the next level of employment …they have this thing of it's not their duty which makes us feel that, okay, they don't want to be empowered." (X6)*

> *"But you find that people don't want to accept that little opportunity that is there and that is how I see …the attitude mostly play… a role." (Y4)*

> *"The attitude also plays a very big role because once, eh, you want to…mentor someone and then he or she has … a bad attitude towards what you are*

mentoring to, then it's going to cause a lot of problems because that person will not agree to whatever that you are trying to help him or trying to teach him." (Y3)

4.4.3.2.2 Disrespect for the knowledge, authority, and position of superiors

Some managers expressed that some subordinates disrespected their authority, negatively impacting their ability to mentor them effectively. The subordinates disregarded their jurisdiction and never bothered to take any orders given. The negative attitudes of the mentee make it challenging for the mentor to do the mentoring role. Some subordinates openly challenge or are perceived threatening to their superiors. This makes it particularly difficult for new leaders to emerge and be confident to want to take the leading role and position. The participants verbalised the following statements:

"…there's a lot of a negative attitude towards…towards especially managers and whatever. Because whatever you say, there's so much questioning about it. […] I don't know whether they want to see if you know more …or …maybe they know more than you." (U6)

"…they don't take orders and they … challenge your authority because, …you are operational managers, but they have been there long before you." (V8)

"And sometimes it just comes […] a group, coming to just confront – you about maybe an issue from the ward. So, you feel like you are being attacked or you feel also threatened." (U2)

4.4.3.2.3 A lack of seriousness and responsibility toward duties

In the mentoring process, the experienced leader/mentor delegates leadership responsibilities to the mentee, who needs to be responsible and accountable and embrace what is taught. A mentee who shows no interest will fail to grasp the leadership techniques handed down and is not serious and willing to learn. Some

participants indicated that subordinates appeared uninterested, bored, and did not take the mentorship seriously, which frustrated the leader who had to take the mentoring role. Some mentees never bothered to volunteer to oversee a unit if the leader was knocking off duty. The following statements evidenced this:

"It's lack of commitment and failing to take responsibility." (V4)

"I don't know whether it's, uh, boredom, low morale, because of the type of the mental healthcare users they are nursing, the type of work. It seems as if they lose interest…" (Z2)

"I think they don't…they are not taking these mental healthcare users serious [sic]. I always tell them that we must always treat these mental healthcare users as our own." (Z3)

"According to me, um, mentoring leadership it would start with the seriousness of …the upcoming leaders. If somebody doesn't take her or his work serious [sic] it's very hard to mentor that person." (Z3)

4.4.3.2.4 Ethos and unethical behaviour

Participants raised concerns about some subordinates' lack of ethos and ethics. Some upcoming leaders demonstrated a lack of work ethics and a sense of duty. Participants pointed out that some put themselves and not their work first and focused more on their rights than patients. No extra effort is put into the work. The participants highlighted the following concerns:

"There is this committee of ethics where we try to develop, […] ethical issues. So, we are trying to teach nurses about professionalism, how to behave as nurses, and then again that will also teach them how to become better leaders…of tomorrow or the future better leaders." (W5)

"So, people will come to work, and they want to do the bare minimum like you were saying because what's in there for me?" (V8)

"And then they also lack these, eh, work ethics and they lack a sense of duty. You know, when you wake up in the morning you tell yourself that I'm going to work, already you know what you are going to do. So, it comes back to the attitude." (Y1)

"The other problem that I experience with up-and-coming leaders is … they put themselves first, before the actual work, which is nursing. From which, if you do that, the patient will suffer […] They want to focus on the rights of the nurses before the rights of the patient." (Z1)

In addition, some participants need an ethics committee and in-service training on ethics. The following statements evidenced this:

"Maybe we can have an ethics committee and the staff development to do in-service training about code of conducts and to…to, eh, teach them from…eh, from the start to improve, I think we can be able to mentor them as leaders." (Z2)

"…and I believe no matter how…intelligent you can be if you don't develop a certain type of professional principle in first year, you can have so many qualifications, and doctorates and whatever. If you missed that ethics class, I usually say to other people it's like they missed the ethos class." (V3)

4.4.3.2.5 Motivated by reward rather than a vocation

Participants experience that some subordinates are only motivated by money and reward and not by nursing and care as a vocation. This results in less commitment and interest in their work, which makes mentoring such a person difficult. The following statements were highlighted:

"...what they are mostly looking at, it's cash, money in their bank, not care, hence they are not eager to learn from their managers." (Z3)

"The money issue is also there that I will not take this challenge because I'm not going to be paid for it. It's not my responsibility…" (Y3)

"The other thing is that, um, people always do work to get, um an external reward… So, they…we…we no longer getting satisfaction out of, you know, doing things because we are enjoying it because we are helping somebody else grow." (V8)

4.4.3.2.6 Difficulties with discipline

As part of oversight, leaders are required to apply discipline as a corrective measure when necessary. Some participants found this difficult because they are restricted in applying discipline as management as unions interfere in the disciplinary process. Other participants verbalised that discipline is not used constructively. A participant explained that some leaders make the mistake of trying to be friends and being too familiar with their subordinates. This impacts their ability to take on the leadership role and apply discipline when required.

One of the most common challenges raised by participants was that of unions. Some participants expressed that much of the negative attitudes of those supervised are fuelled and influenced by unions. Unions affect the leader's ability to manage effectively. This is disruptive and can impact the mentorship process negatively. Participants indicated that individuals focused on job descriptions and did not want to go the extra mile. The participants gave the following quotes:

"... there is this culture of discipline …really not in a sense of building people." (Y2)

"So, you are even afraid to discipline people because every time when we try to do something they will tell you about unions, unions, unions." (W5)

4.4.3.2.7 Interference of Labour Unions

One of the most common challenges raised by participants was that of unions. Some participants expressed that much of the negative attitudes of those supervised are fuelled and influenced by unions. Unions impact the leader's ability to manage effectively. This is disruptive and can impact the mentorship process negatively. Participants indicated that individuals focused on job descriptions and do not want to go an extra mile. The participants gave the following quotes:

> *"If you go to the ward to supervise, if something's not done, let's say maybe something has happened in the ward and you try to correct the behaviour or what-what, the next thing is that the union member will be calling you." (X4)*

> *"It goes back to the influence of labour, the unions, because it's like, … people now are focused on my job description – nobody is willing to go the extra mile anymore. Nobody is willing to sacrifice amid all these challenges of resources." (V7)*

4.4.3.2.8 New versus old school of nursing

A conflict between those nurses identified as being "old-school", having qualified and trained many years in the past, and those more recently qualified with different approaches, knowledge and skills were identified by many participants as being a challenge.

A participant explained how dismissive of the knowledge newly qualified professional nurses can be of those they consider to be "old-school". While this participant was confident that older leaders keep up to date with knowledge, another indicated that some leaders might lack confidence due to having already forgotten a lot of what they learned during their training in the past and being confronted by new, highly informed students. Conversely, new, and younger managers experience challenges mentoring older subordinates, some of whom may have been employed in the institution for longer.

Many participants believe that old and new staff members should strive to work together to close the gap and foster greater understanding and acceptance. The new skills and expertise should be welcomed and utilised as new graduates have much to offer. The following quotes highlighted this:

"….like, labelling you as … you are from the old school…" (W6)

"It's a generational thing. Generations have changed and… people see things differently now or perceive things differently." (Y2)

"The other challenge of my mentoring them it's the young nurses are looking at us old nurses as old-school. They don't want to learn from us. They want to teach us because they are from college. […] Whereas we attend workshops to update, upgrade ourselves, … we attend in-service training, we know what is happening at the moment in the nursing fraternity, but they want to teach us their shortcuts instead of quality care." (Z3)

"We must do away with…the we-and-them attitude". (V8)

"We need to also close that gap in terms of having a common understanding. Maybe…the interaction and the mentoring will come up where ... we('ve) got the same sense of understanding so that it works better." (W6)

4.4.4 Theme four: Opportunities for clinical leadership positions

Participants outlined negative and positive factors relating to opportunities for leadership positions. Opportunities and lack of mentorship opportunities were outlined, as the role of mentorship in promotional leadership opportunities.

4.4.4.1 Opportunities available

Participants from a focus group were confident that opportunities for development into leadership are readily attainable, one even citing herself as an example of starting as

a junior professional nurse and working up to the position of operational manager. Others from the focus group volunteered the types of positions available for up-and-coming leaders. A participant indicated that she benefited from taking a course that prospective leaders or new managers could address help them develop their skills and thereby leadership opportunities. The following statements outlined these:

"More opportunities to up-and-coming leaders." (Z1)

"You also need a staff development personnel and, eh…and…and infection control and O-H-S and quality assurance. Those are the opportunities for them to grow to be leaders of tomorrow." (Z3)

"…I attended the hospital management course for…it was a six-month course, but it was more like a three-year course with the University of Wits, and I learned a lot of things from there, leadership, lead management, finance management. A lot of information that you go through in that course is exceptionally good. I wish the department can actually bring it back. But I think the Sisulu [SP] is similar to that one." (X1)

4.4.4.2 Lack of opportunities

Participants from another focus group expressed that the institutions have limited or no leadership mentoring opportunities. Participants outlined that individuals are interested in obtaining certificates but are not focused on leadership growth. The other concern was the number of years required, before one is appointed into the operational management position. The other participants mentioned the attitude of the leader relating to mentoring opportunities. Participants stated the following:

"The opportunities are very poor here in this institution." (Y4)

"In this institution there are no opportunities." (Y1)

"We [have] become more certificate-oriented rather than creating more opportunities for people to grow," (Y2)

"Some people, I think …they take it as if maybe …they don't see an opportunity of becoming a leader one day because of the structures that the government has put in. Even if you can be available, avail yourself, you know, be supportive, be motivating for this person, their attitude will still obstruct their way …of growing in the profession or …in the leadership." *(Y4)*

4.4.4.3 The role of mentorship in promotional leadership opportunities

Notably, some participants linked a lack of opportunity for promotion to higher leadership positions to a lack of mentorship to prepare them with the skills and confidence they would need to apply for such positions. This confirms that the strategies outlined in successful mentoring are valid. Participants indicated that they spent most of their leadership roles at the operational level in a unit due to a lack of efficient mentoring in higher leadership positions. Non-exposure to problem-solving and responsibilities in leadership positions prevent the novice leader from applying for higher leadership opportunities. The participants shared the following statements:

"We are not mentored to become, you know, business-minded in such a way that you are able to plan and manage […] I'm twenty-three years in the position of operational manager but for me I feel that I have reached a cul-de-sac […] we are short of knowledge that we can be proud of to say that, yes, I will apply for the position, become a clinic manager of the institution." (V7)

"We have never been exposed, even like me. We do not know what is happening at higher levels. If you…a post comes out, there is no way that I will know what is expected of me. I am just going with the theory but practical-wise I know nothing." (Y3)

"… think there are no opportunities because you have to create for yourself the opportunities. "You will have to go to a superior and ask […] Or even when you

ask, he will, eh…they will tell you it is not your responsibility. So, there are no opportunities at all." (Y3)

4.5 SUMMARY

In this chapter, the researcher discussed themes, categories, and subcategories that emerged from the assistant and operational managers' interviews on clinical leadership mentoring in mental health care settings. Theme one on personal characteristics of an effective clinical mentor was outlined with its categories of interpersonal and intrapersonal qualities conducive to leadership, theme two of clinical-leadership mentorship was outlined with its experiences of being mentored and factors facilitating effective mentoring, theme three of the challenge experienced during clinical leadership mentoring, with its categories of institutional and professional challenges experienced by a mentor, challenges encountered in the mentorship of the novice leaders and, mentorship strategies were discussed and the fourth theme of opportunities of clinical leadership positions, where opportunities available, lack of opportunities and promotional leadership opportunities were discussed. In the next chapter, the researcher will outline the discussion of the presented results to existing literature.

CHAPTER 5
DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The chapter outlines a thorough analysis of the results, as an essential part of the inquiry and framework for mentoring for clinical leadership in mental health care nurse settings. The complex and extensive data gathered is discussed and interpreted in this chapter.

The research study investigated how the participants' perceptions of mentoring for clinical leadership fit into clinical leadership in mental health. The results will match or differ from what is already known and believed concerning mentoring for leadership in mental health clinical settings.

Four themes were derived as the most important for mentoring for clinical leadership. The themes outlined the personal characteristics of an effective clinical nurse leader and mentor, mentoring for clinical leadership, challenges experienced during mentoring for clinical leadership and opportunities for clinical leadership positions.

This chapter does more than discuss the results; it skilfully weaves them into a story that shows how they relate to leadership in mental health care. The analytically driven discussion will also give the field of mental health nursing helpful information and ideas on leadership.

5.2 DEMOGRAPHICS OF THE PARTICIPANTS

The varied demographics of the participants indicated the prevailing narrative in nursing as a field that women have historically dominated. Eighty-four percent of the participants were female and 16% were male. The World Health Organisation (WHO) in its State of the World's Nursing (2022:4), argues that 90% of the nursing and midwifery workforce is women and only 25% are in leadership positions.

The participant's age distribution, mainly in the 50–60-year range, raises concerns about the looming shortage of experienced leadership in mental health nursing. The aging nurse generation is a concern for future leadership (Darbyshire et al 2020:2). A strong framework is needed to train the next generation of nurses to be leaders. The skilled nurse leaders already in place have a wealth of knowledge on leadership and can guide the newcomers.

In terms of work experience, it is evident that most participants, fifty-five percent of whom have worked in the mental healthcare setting for more than seventeen years. These are seasoned professionals with years of experience and have a solid foundation in leadership roles.

The distribution of titles further clarifies the understanding that most participants serve as operational managers and a few as assistant nursing managers. This points to a management structure that is well-versed in the complexities of mental healthcare. Most operational managers will be unable to be in a leadership position as an assistant nurse manager.

5.3 THEME ONE: PERSONAL CHARACTERISTICS OF AN EFFECTIVE CLINICAL NURSE LEADER AND MENTOR

Effective nursing leadership is an essential aspect of the transformation of healthcare. The nurse managers are the first-line leaders who build or break the workforce. The novice leaders are the recipients of expert leaders' behaviours and personal characteristics can instil positivity or break the need to learn to lead in the novice leader (Kostich, Lasiter & Gorrell 2020:293; Warshawsky, Caramanica & Cramer 2020:154). The emotional and social components of interpersonal skills enrich the work of nurse leaders and mentors. Not just what they do matters, but also how they affect people's emotions.

Transformational leadership views the leader as an individual who can attract, influence, inspire and engage followers to have an energetic pursuit for career development and relate to growth and strategic changes in the work environment, as

there is shared decision-making and capacity-building through role-modeling and promotion of collective interests (Pattison & Corser 2022:946). Bandura's SLT emphasised acquisition of new knowledge and skills by paying attention, observing, and reproducing what was observed and becoming motivated to continue in the newly learned behaviour (Yarberry & Sims 2021:240).

5.3.1 Category 1: Interpersonal skills

Effective clinical leadership and mentoring need interpersonal skills, particularly in the emotionally charged hallways of mental health treatment. These talents include a variety of competencies essential for constructive relationships. Human beings are social beings, and relationships with others are part of an interpersonal perspective (Hooley, Nock & Butcher 2021:96). In the mental health arena, where vulnerability and crises are commonplace, nurse leaders' and mentors' interpersonal skills become not only highly valued but also vital.

Participants in this study indicated that the ideal mentor and leader can live and speak the talk. Being a good role model means doing the work and demonstrating how things are done daily rather than bragging. The participants emphasised that effective communication involves giving clear instructions, listening empathetically, comprehending without prejudice, and communicating politely and clearly. Respect is gained by a leader who upholds justice and moral principles and is fair and challenging instead of using authoritarianism.

Jack, Bianchi, Costa, Grinberg, Harnett, Luiking, Nilsson and Scammell (2022:2) point out that interpersonal skills build interpersonal competence where one develops self-awareness and competence. In SLT, interaction with others, socialisation and connecting with others, builds career commitment and development (Yarberry & Sims 2021:240).

5.3.1.1 Sub-category 1: Being a positive role model

Being a good role model is essential in the field of clinical leadership. The participants emphasised that the responsibility of leading by example comes with the mantle and that actions speak louder than words.

Van Diggele et al (2020:3) outlined those leaders as role-models encouraging followership and stepping forward to lend meaningful support to the mentees by leading by example and walking the talk. A mental health nurse leader is responsible for role modelling expert leadership skills that will enhance the commitment and accountable leadership of the upcoming nurse leaders. Modelling can be done in the form of words and/or actions.

Mentees look up to their mentors. When being a role model, mentees listen to what you say and treat you with respect as you carry yourself with poise and confidence, as imitation is the highest form of flattery (Koenig 2019:5a4). Others observe positive role model, and the actions are retained. A leader must strive to inspire and still be relatable.

Jack et al (2022:3) established that being a role model in clinical leadership requires insight and congruence with personal and professional values. Role modelling develops an upcoming leader's coping, personal, and resilience skills. Self-efficacy is also reinforced by role modelling. The concept of learning through role-modelling is based on attention, retention, motivation, and production, which is outlined in Bandura's SLT (Yarberry & Sims 2021:241; Khushk et al 2022:41).

5.3.1.2 Sub-category 2: Communication skills

Communication is the essential rhythm that maintains the beautiful flow of mentoring complexities in the high stress of mental health care setting. The participants consistently emphasised this point, referring to the essence of mentoring in which words serve as bridges rather than only to convey information between the mentor

and mentee. As participants pointed out, effective communication promotes understanding and trust, two things that the mentoring relationship is built around.

Van Diggele et al (2020:6) described this idea well, stressing that a leader's speech should constantly promote respect and appreciation of the accomplishments of others. It is about leaders tailoring their words to the audience.

Listening is just as important to effective communication as speaking. This idea was put out by one of the participants who pointed out that good leaders must have good listening skills. A leader may hear the needs that are not being expressed, and those that are, in the silent moments of listening. Hagqvist et al (2020:6) propose that engaging in active listening through paying close attention to the mentee, is important in mentoring as it promotes motivation to communicate and engage.

Patient communication provides the time for deep learning and for knowledge's roots to penetrate understanding's rich soil. It is about providing the mentee with the safety of a mentor's advice while allowing them to develop, breathe, and discover their voice. Varcarolis and Fosbre's (2021:90) affectionate portrayal of communication as the exchange of ideas and messages between individuals, reflects this feeling. The hidden power that underpins communication skills is the leader's emotional intelligence, which Harahap, Sutrisno, Mahendika, Suherlan and Ausat (2023:354) described as the ability to recognise, regulate, and comprehend one's own emotions and those of others. An emotionally intelligent leader can manipulate the teams' emotions to their advantage, allowing them to execute efficiently even when confronted with the most difficult tasks.

5.3.1.3 Sub-category 3: Fair but firm

Each nurse leader needs a complex set of skills to strike a balance between being fair and being firm. According to the participants, mentoring is all about being there for your mentee when they need an encouraging shoulder and sound advice. One participant pointed out that being firm and always fair goes beyond being just a directive but incorporates a concept that underpins mental health nursing leadership.

Another participant indicated clearly how confidence and kindness are inherently at odds with each other. Being fair means being equal and just, not accepting. Being strong does not mean being rigid. It means sticking to values that protect the purity of care. Nurse leaders should be able to take chances in their leadership without needing approval from others. This shows assertiveness. Mikkonen, Tomietto, Cicolini, Kaucic, Filej, Riklikiene, Juskauskiene, Vizcaya-Moreno, Pérez-Cañaveras, De Raeve and Kääriäinen (2020:6) confirmed that an open organisational climate that is open and collaborative, fosters learning opportunities.

5.3.1.4 Sub-category 4: Consistency

Leadership and management are reciprocal elements for the achievement of organisational goals. Van Diggele et al (2020:1) indicated that order and consistency in management enable the leader to accomplish organisational goals. Consistency in leadership enables the leader to achieve the mentoring goals. If the leader, as a manager, is not consistent, then organisational and mentoring goals will not be achieved.

5.3.1.5 Sub-category 5: Understanding the mentees

In mental health settings, it is not enough to look at a peer on the surface; but one must dig deep into one's humanity, self-awareness, and inner drive. This fact, as well as the complexity of mentoring in this field, was illuminated by the participants' comments.

Participants claimed that a mentor should understand different personalities and accommodate those personalities. This captures the essence of tailored leadership and care. The best thing for mentors to do is to see their mentees as the complicated people they are, with their own experiences, skills, and weaknesses. The goal of this understanding is not just to change the way mentoring is done, but also to create an environment where each mentee feels valued, understood, and supported. Van Diggele et al (2020:3) construes that self-awareness is essential in developing leadership skills. SLT considers cognitive factors, where the mentee will construct

updated thought processes of knowledge and understanding through interaction with the mentor (Khushk et al 2022:41).

The current study revealed that it is important for the leaders to know the strength and weakness of their subordinates. Leaders should investigate what makes each team member unique. Creating a space where everyone's skills are valued and supported is related to this which is important for good leadership. Human traits should influence leadership techniques. Keltner and Steele (2019:111) point out, that knowing oneself is the starting point for knowing others. Self-aware leaders can better guide followers as their ideals, strengths, and shortcomings are known. Self-awareness enables those in leadership roles to guide others with authenticity and empathy. This reflective process is essential to effective leadership and should not be considered as a luxury but a necessity.

5.3.1.6 Sub-category 6: Motivational and non-judgemental attitudes

Breed, Downing and Ally (2020:6) explored the idea of intrinsic motivation and how it drives leaders to build relationships and achieve organisational goals. Intrinsically driven leaders can guide and empower others as they are enthusiastic about work and values.

Being able to help and lead people without making assumptions about them is one of the most important skills for leaders. The participants alluded that a leader should not judge the mentee during the mentoring process. This is a poignant reminder of the delicate balance leaders must maintain in guiding without imposing their biases. Suliman and Warshawski (2022:3) and Yildirim et al (2020:1366) attested that interpersonal relationships that are built by non-judgemental attitudes, built resilience and SLT attests those reactions expressed by others, are shaped by how they are perceived by the mentors.

Participants alluded that a good leader must create an environment that helps others to grow and stay healthy by being calm, having a non-judgmental attitude and focusing on recognising the mentee's qualities. This will assist the mentees in showcasing their

exceptional skills. Deng et al (2023:630) alluded that self-awareness, understanding one's strengths and weaknesses, and how one makes sense of the world influences authentic leadership.

Internal and external factors of motivation are important in clinical leadership, as Breed et al (2020:5) noted. Motivation harnesses the power of positive reinforcement from others while also sparking inner desire. Creating a work atmosphere where mentees feel inspired and motivated requires this two-pronged strategy. According to Koenig (2019:1), a mentor's role is to provide example and guidance. Mentors can inspire mentees by sharing their infectious enthusiasm and positive outlook.

5.3.2 Category 2: Intrapersonal qualities conducive to clinical leadership

When asked to list the intrapersonal qualities essential for clinical leadership, participants emphasised the importance of good decision-making, critical thinking skills, compassion, and respect for others' values.

The development of self-esteem, confidence, and self-efficacy is facilitated by intrapersonal communication, defined by van Raalte, Vincent, Dickens and Brewer (2019:14) as the involvement of self-talk and self-reflection. This internal monologue affects the leader's interactions and behaviours with others outside the group. According to Weiss, Tappen and Grimley (2019:59), leadership trust management is crucial, and reliability and consistency are cornerstones of this concept. Trust as the foundation of the mentor-mentee relationship is paramount.

A transformational leader can sometimes take the qualities of a good rebel leader who is described as a creative and capable leader who is not afraid to experiment on new challenges and taking up new roles of leadership for the advancement of an organisation (de Kok, Weggelaar, Reede, Schoonhoven & Lalleman 2023:2).

5.3.2.1 Sub-category 1: Not forcing one's own beliefs and values on others

The participants reported that effective mentorship was conducive where the mentor did not force their values on the mentees. James, Watkins and Carrier (2022:4) supported the statement by alluding that aligning values and cultural milieus develop experiential learning. Hagqvist et al (2020:3) shared the same sentiments and alluded that the same values and beliefs communicate seamlessly on the premise of shared understanding. The mentor and mentee must relate and interact with respect with one another concerning cultural identities. As a mentor, allowing the mentee to have their own beliefs and values will assist in a mutual understanding of the roles played.

5.3.2.2 Sub-category 2: Making and taking decisions

An accountable and responsible leader must be able to make decisions and live with the consequences thereof. Participants indicated they valued a mentor who was confident in making decisions and being accountable. The participants also indicated that they wanted the mentor to allow them to make decisions for their confidence to grow. Mannix and Jones (2020:37) attested that the autonomy to make decisions and not always follow others' decisions builds confidence and fulfilment in a mentee. Transformational leaders are not afraid to make decisions as they are concerned with organisational outcomes, increased innovation, capacity building, development, and implementation of change (Poels, Verschueren, Milisen & Vlaeyen 2020:2).

5.3.2.3 Sub-category 3: Being compassionate and understanding

Participants highlighted being compassionate and understanding as one of the qualities of a good mentor. Van de Mortel, Needham and Henderson (2021:5) supported the statement by identifying the qualities perceived to increase the success of the mentor-mentee relationship as being approachable, motivated, and showing initiative. An approachable person is understanding. Darbyshire et al (2020:3) alluded to the statement by indicating that compassion, thoughtfulness, ethical comportment, empathy, creativity, and problem-solving abilities are expected from a nurse, including a nurse leader and mentor. Firmansyah and Saepuloh (2023:299) posited that SLT,

emphasised the dynamic interaction between people, environment, and behaviour and that attitudes and emotions influenced learning.

5.4 THEME TWO: MENTORING FOR CLINICAL LEADERSHIP

The role of clinical leadership is to facilitate service improvement in healthcare and different approaches can be implemented, including mentoring upcoming nurse leaders. Healthcare services globally recommend frontline managers to be effective healthcare delivery, and leadership is viewed as a contextually situated process of a collective group and not the actions of an individual (Grove et al 2020:104). In this context, mentoring for clinical leadership is an important aspect of improving healthcare delivery.

5.4.1 Category 1: Experiences of being mentored

The participants shared positive and negative experiences of being mentored. Mentoring for clinical leadership approach enables the mentee to grow as a leader. The experiences differed from one participant to the other, and it was clear that the process was not experienced the same way by all.

Sabbah, Ibrahim, Khamis, Bakhour, Sabbah, Droubi and Sabbah (2020:2) indicated that transformative leaders inspire followers, offer assistance and motivation, share a vision, and arouse feelings of affiliation and utilise rules, enforcement, remedial actions, and rewards to motivate others to achieve shared objectives. SLT

5.4.1.1 Sub-category 1: Positive experiences

Participants shared how their seniors approached mentoring for leadership as an important growth process and how enthusiastic they were in shaping the leadership environment. The quotes captured the mentor-mentee connection where both parties shared information to improve leadership skills.

The participants remarked that the willingness of the senior managers to mentor them gave them important insights. The direct guidance helped the mentees to deal with emergencies and solve problems in the clinical setting. Through these experiences, the mentees not only picked up new skills but also got better at being leaders. James et al (2022:6) viewed positive role modelling experiences within the clinical practice as an inspiration and support for the mentee, and negative experiences were mostly because of the reluctance of the mentor. Good nursing leaders set the mentoring process in motion for the mentees, to pass on the knowledge that one cannot take when retiring (Koenig 2019:55).

According to constructivism, individuals learn by doing and by observation and can build their knowledge and comprehension by participating and evaluating the outcomes (Khushk et al 2022:42). This learning can be positively or negatively experienced, depending on the mentor or the mentee.

5.4.1.2 Sub-category 2: Informal mentoring

Most participants pointed out that they were mentored informally which was also helpful. Participants described how learning happened through casual interactions with the mentor. Idubor and Adekunle (2022:74) distinguished between formal and informal mentoring. In formal mentoring, specific and clear goals are set, to have a successful outcome for another mentor. The process is well-managed and usually occurs on a one-to-one basis for a clear outcome.

In informal mentoring, there is little or no structure, and no specific goals are set. The informal mentoring process is not controlled to achieve a predetermined goal as the mentoring relationship is created spontaneously, due to chemistry between two people, without the active involvement of the institution. The mentor takes an interest in the mentee and expresses the desire to mentor. The process lasts for an exceptionally long time and is not based on job rank or hierarchy. Formal and informal mentoring approaches provide a feeling of purpose and satisfaction for the mentor who aspires to grow future leaders through mentorship.

5.4.1.3 Sub-category 3: Insufficient mentoring

Leadership comes with its own set of challenges. The lack of guidance or training on mentorship was highlighted by the participants. The mentors were willing to take the mentoring for leadership roles without training.

Davis et al (2022:1070) indicated the negative impact of mentoring that was caused by insufficient organisational support of mentoring and the difficulty in finding mentors. The development of competent clinical leaders can take place if appropriate mentors are sought to lead the process. Ineffective mentoring hurts an institution, which can be identified by the negative decline in productivity, increase in stress, loss of valuable and talented leaders and lack of responsibility in leading (Idubor & Adekunle 2022:78).

5.4.1.4 Sub-category 4: Trial and error learning

The participants indicated that learning by making mistakes can happen when there is not enough guidance. The trial-and-error plan for leadership growth shows how persistent and determined the mentors are to impart knowledge and skills to the mentees. The assistant nurse managers showed strength and determination in mentoring. Learning by doing has positive outcomes.

Warshawsky et al (2020:254) posit that most nurse managers are new or poorly trained leaders who must wing it when it comes to taking care of patients and leading in the units. The authors confirmed that nurse managers often assume vital leadership roles with little to no leadership knowledge and education and are forced to learn on the fly through experience rather than through intentional role preparation. The young and upcoming nurse leader does not have to learn through trial and error how to lead but needs reassurance from the older leader regarding being taken through the process of leadership.

Kostich et al (2020:293) talked about how important nurse managers are for training future leaders. Nurse managers are pressured to take care of delegated responsibilities as well as accountability of the people they are overseeing forgetting

the need to care for themselves. Furthermore, Kostich et al (2020:296) added that giving steady, positive feedback is one of the most important parts of being a good guide. For mentoring to be effective, the leader must be present to care, give support, and talk about the challenges of being a leader.

5.4.2 Category 2: Factors facilitating effective mentoring

The qualities and capabilities of the mentor, have a big effect on how well the challenging task of mentoring for clinical leadership unfolds. The participants indicated opinions that shed light on crucial factors that make the mentoring process successful and outlined the importance of having knowledgeable and experienced mentors who can share this knowledge in a useful way. To help nurse managers develop effective leadership skills, mentors' practical knowledge and experience are highly valuable. Nurse leaders are required to work as a workforce that can provide mentoring, prolonged guidance, and consistent support to impart knowledge and skills necessary for effective leadership in the clinical working environments (Moran, Hansen & Schweiss 2018:469).

Li, Hong and Craig (2023:1) attested that SLT is a theoretical framework that sheds light on social learning behaviors where engagement, collaboration, teamwork, guidance, engagement, and support from a knowledge person, builds the confidence of a less knowledgeable person to learn to lead.

5.4.2.1 Sub-category 1: Knowledgeable and experienced mentors

The preliminary selection process is crucial when it comes to deciding the fate of future leaders in the nursing profession. The study by White, Heitzler, Anderson, Yearwood, McLaughlin and Fall-Dickson (2018:108) stated that mentees gain confidence and a drive for personal growth when mentors lead them compassionately while providing constructive criticism. Warshawsky et al (2020:254), established that nurse managers learn through experience rather than through intentional role preparation.

According to Bvumbwe and Mtshali (2018:225), it is crucial to identify potential leaders early. The authors stressed the importance of aligning recruitment processes with the institution's aims and strategic goals. The participants indicated that it is vital to seize talent before it disappears, by identifying and developing potential leaders. This is aligned with the South African National Strategic Direction for Nursing and Midwifery Education and Practice: A road map for Strengthening Nursing and Midwifery in South Africa (2020/21-2025/26:19), Goal 1 (one), which states that mentoring and specialist training can improve leadership abilities.

SLT, constructivism, and transformational leadership are all about active participation in the creation of knowledge and experience, sharing of ideas and development of others by role-modelling, motivation, and support (Khushk et al 2022:42; Davis et al 2022:1063).

5.4.2.2 Sub-category 2: The right candidate with leadership potential

Leadership is a skill, and individuals who have the quality need to be allowed to lead within the mental health clinical setting. Avcı and Kaya (2021:4) confirmed this statement in their study by stating that stated that individuals with self-leadership skills are potential candidates who can be effective leaders and be able to control themselves, manage their own behaviour, and cope with the stressors relating to leadership. This is supported by Davis et al (2022:1072), who indicated that the challenge of finding appropriate mentors may be related to the inability of a mentee to find a mentor with whom they may have a shared identity.

Another challenge may be that an individual who has been identified as a mentor, might not be interested in mentoring but is delegated the task due to the position held.

5.4.2.3 Sub-category 3: Open-door policy

The feedback from participants highlighted the need for mentors to be approachable to facilitate effective mentoring. Mentors may assist their mentees in developing a supportive mentoring environment by establishing an open-door policy that allows

them to seek help in a casual setting. According to Breed et al (2020:4), mentors' positivity and accessibility inspire mentees to overcome obstacles and build self-confidence, White et al (2018:109) alluded by stating that positive attitudes from the mentors, inspire the mentees to overcome obstacles and feel confident, knowing that there is someone open and approachable to assist and talk to about challenges faced.

5.4.2.4 Sub-category 4: Support of seniors, managers, and colleagues, and having a formidable team.

Participants indicated that having the backing of upper-level management and peers is vital when mentoring new employees. An effective mentoring relationship requires a cohesive team dynamic in which all members work together to reach shared goals. According to Cross, Lee, Bridgman, Thapa, Cleary and Kornhaber (2019:22) and Chisengantambu, Robinson and Evans (2018:193), a supportive environment increases the self-confidence of future leaders, which in turn boosts their job satisfaction and leadership self-assurance. Emotional and informational support from a senior person, enhances trust and motivation for a junior person to actively participate in learning (Li et al 2023:18).

5.4.3 Category 3: Mentorship strategies

Strong mentoring programmes are crucial to the growth of mental health nursing leadership. The experiences that research participants shared shed light on the benefits of intentional and well-planned techniques, as they illustrated the diverse methods and problems of mentoring.

As an initial step in the mentoring process, participants stressed the significance of established protocols, orientation, and introduction and how crucial it is for mentees to fully grasp the role of leadership and all its obligations. Lindfors, Meretoja, Kaunonen and Paavilainen (2018:259) agreed, listing enthusiasm and commitment as two of the most crucial factors in a successful orientation. It is important to provide participants with appropriate and unambiguous guidance, as they pointed out, as there can be challenges if that is not done.

5.4.3.1 Sub-category 1: Induction, orientation, and written protocols

A successful orientation process in a working environment requires the following elements: commitment to the orientation process, cheerful outlook to the orientation process, collective engagement with the process, professional competence and adequate knowledge and skills (Lindfors et al 2018:259). Hagqvist et al (2020:7) alluded that employers must provide all mentors with an appropriate orientation.

5.4.3.2 Sub-category 2: Guidance and development through accompaniment

Participants indicated how beneficial it was to be accompanied in the leadership journey, as that fostered confidence and practical learning. The importance of mentors being supportive, involved, and knowledgeable beyond their specialisation is emphasised by Cross et al (2019:120) and Weiss Tappen and Grimley (2019:66), emphasis the value of mentors having a shared interest and actively participating in mentoring.

5.4.3.3 Sub-category 3: Exposing mentees to the demands of the next level manager management

Participants reported that it felt good to be exposed to the demands of the next-level manager as that prepared them to have an idea of what leadership entailed within the mental health clinical environment.

It is crucial to expose mentees to more complex activities to foster growth, as this approach aligns with distributed leadership models, as discussed by Varcarolis and Fosbre (2021:29) and Dunn (2021:563), that place a focus on decision-making and collaboration. No leader can work as an island.

5.4.3.4 Sub-category 4: Learning by standing in for or relieving superiors

Mentoring provides mentees with real-world leadership experience, as detailed by the participants, who indicated that the process of mentees taking on the role of their superiors-built confidence in leadership.

Breed et al (2020:7), in their study, supported the statement of standing in or relieving supervisors by explaining that nurse leaders who are permitted to prove that they can do certain tasks successfully should be encouraged and shown appreciation and be given feedback on the task performed. The mentee will not learn if not given a chance to act in the leadership position.

5.4.3.5 Sub-category 5: Continuous, ongoing mentorship and training

Participants indicated that learning is a process as one cannot grasp everything learned at one time. A continuous process of teaching and learning was emphasised. In-service education plays a key role in an organisation as it serves as a platform for ongoing development, where individuals can acquire skills to maintain and increase their competencies. Small group teachings, project work, experiential learning, and reflective practice are desired methods for improving and developing leadership skills in upcoming leaders (Sadowski, Cantrell, Barelski, O'Malley & Hartzell 2018:138). This was supported by Dunn (2021:562), who alluded that devoting substantial time to course development and categorising effective educational leadership development activities will build a competent clinical leader.

5.4.3.6 Sub-category 6: Adequate monitoring and feedback

Participants reported that mentoring for leadership will improve if proper feedback on their performance as mentors or mentees can be given. The mentees preferred to be monitored, supervised, observed, and given constructive feedback by the mentor.

In the process of communication, the manner of feedback will entail whether the receiver well interpreted the message and whether the person transmitting the

information was clear and relevant (Varcarolis & Fosbre 2021:90). The expert leader must ensure that information is given to the novice leader is clear and understandable. Feedback must be given in a positive and non-threatening manner. Constructive feedback will enable the novice leader to be willing and accommodating to improve where there is still a lack of leadership skills. Engaged individuals will seek to improve performance efficiency and achieve organisational productivity as they feel encouraged to hear the supervisor engaging them and giving feedback on the progress of development and advice on what was achieved and what needs to be improved (Amah 2018:2).

5.4.3.7 Sub-category 7: Presenting as a developmental tool

According to the participants, ongoing instruction and in-service training were crucial for long-term learning and the advancement of leadership skills. For the development of leadership skills, Dunn (2021:563) posits that a clinical competency model can be used where the demonstration of skills is built, and the performance of skills is evaluated in a classroom. Though the competency model relates to simulations, this practice can be used where the mentor can give a presentation on leadership and its requirements to the mentee.

Putting leadership into practice by being given responsibilities to lead, brainstorming, and allowing giving input into the profession, are important as this gives one constant improvement in the ability to lead (Busari, Yaldiz, Gans & Duits 2020:793). Given an opportunity and capacity to lead by collaborating with others in clinical leadership development, willingness to take risks gives a sense of empowerment to lead and develop in the leadership role (Hofmann & Vermunt 2021:254).

5.4.3.8 Sub-category 8: A culture of mentorship

Participants reported that mentoring should not only be practised by the assistant nurse managers with the operational managers but should be a culture practised in the institution by all categories of nurses. It should however not be assumed that all individuals know how to mentor.

This statement is supported by Idubor and Adekunle (2022:74), who indicated that the mentoring relationship involves technical, interpersonal, and political skills that are taught by the more experienced person to the less experienced person and is a reciprocal relationship that enables the mentor to reproduce self in the mentee. The mentee can even surpass the mentor in the field of expertise. White et al (2018:108) confirmed by indicating that mentorship is a reciprocal relationship between the mentor and the mentee that and the attitude of care in role-modelling, positivity and motivation play a key role in this reciprocal role.

5.5 THEME THREE: CHALLENGES EXPERIENCED DURING CLINICAL LEADERSHIP MENTORING

Clinical leaders encounter a multitude of institutional and professional obstacles within the intricate and rigorous domain of mental health care. The challenges faced by the participants were illuminated, yielding valuable insights into the complex nature of these issues. Participants highlighted the scope of practice for nurses by the South African Nursing Council (SANC) as one of the obstacles. In the absence of such guidelines, the mentoring responsibilities of nurse leaders are devoid of direction.

Participants also highlighted that the leaders' ability to mentor effectively was affected by resource constraints. Due to the increased workloads and disruptions caused by insufficient human, material, and technological resources, mentoring takes a back seat in the hierarchy of priorities.

The mentorship procedure adds another layer of complexity to the already heavy administrative burden and night shift responsibilities. There were missed chances to offer advice and support since leaders could not devote as much time to mentoring due to the demands of these duties.

5.5.1 Category 1: Institutional and professional challenges experienced by leaders

The institutional challenges were highlighted as the following by participants; no scope of practice determined for nurses in mental health. A shortage of resources put pressure on the leaders. Administrative and night duty responsibilities and lack of authority or autonomy in decision-making. The discussions are outlined below.

5.5.5.1 Sub-category 1: No scope of practice determined for nurses in mental health

Leaders cannot effectively teach subordinates and create a supportive mental health workplace due to a lack of proper direction. Establishing a clear scope of practice in mental health is crucial because it will provide nurse leaders with the tools they need to mentor effectively. Both the National Health Service (NHS) Leadership Academy in its Clinical Leadership Competency Framework (2011:34) and the International Council of Nurses (ICN) Code of Ethics (2021:12) stress the need for institutions to provide leaders with the necessary tools for their jobs and the maintenance of clinical competence.

The International Council of Nurses (ICN) Code of Ethics (2021:12) requires nurses to take responsibility and accountability for ethical nursing practice and maintain competence when accepting delegated responsibilities. It further emphasises that competence is achieved through continuous professional development and lifelong learning.

Leadership Competency Framework domains indicate that leadership and the mentoring process contribute to the organisation's superior performance in leadership. The domains are namely: demonstrating personal qualities, establishing direction and vision for the organisation, improving patient care and safety, managing resources and teamwork (Dunn 2021:561).

5.5.1.2 Sub-category 2: Shortage of resources that put pressure on the leader

The stress of unit management, along with limited resources, creates an environment where mentorship is often disregarded. Participants highlighted that the lofty expectations placed on nurse leaders when the focus shifts from offering direction to efficiently resolving pressing operational issues, exacerbate the situation.

Busari et al (2020:792) indicated that human resources, material, and financial resources impact on mentoring. Understaffing in institutions contributes to an insufficient workforce. Time management, availability of resources and resource utilisation, contribute to ineffective mentoring (Abrahams, Tahni & Kahn 2022:70; Mai, Newton, Farrell, Mullan & Kapoor 2022:2). Chang, Chiu, Hsu, Liao and Lin (2019:78) added that resource provision as a supportive strategy in the clinical field and were supported by Clochesy, Visovsky and Munro (2019:63) who indicated that the shortage of professional nurses, disadvantages the functioning of clinical units and puts the nursing profession at stake.

5.5.1.3 Sub-category 3: Administrative and night duty responsibilities

Participants highlighted the challenge of dedicating enough time to developing new leaders due to other professional duties and demands of the leadership role. The World Health Organization (WHO) (2020:59), emphasises that strong nursing leadership and governance requires nurturing and the development of nationally supported programmes on leadership, research, and policy literacy skills. Upcoming leaders can make mistakes and easily become frustrated if there is a lack of leadership education and mentoring during a transition process (Sherman & Saifman 2018:355). Devoted and uninterrupted, consistent time for mentoring partnership makes the mentee feel confident of the mentors; commitment to mentoring success (Morrison-Beedy, Tzeng & Abraim-Yago 2018:10).

5.5.1.4 Sub-category 4: Lack of authority and autonomy in decision-making

Participants bemoaned a lack of agency in decision-making despite their caregiving duties. In their remarks, they voiced a wish for more say in important decisions. The inability to implement suggested adjustments or solutions hinders effective leadership and institutional participation. Autonomy in leadership is crucial, according to Breed et al (2020:3) since it allows managers to make strategic decisions and act independently. Gaining expertise and self-assurance as a leader requires this independence.

5.5.1.5 Sub-category 5: Insufficient support from superiors

Middle managers felt alone and unsupported in their duties when they did not receive assistance from higher-ranking workers, as other participants mentioned. As a result, leaders had feelings of being overwhelmed and unsure, which impacted their mentoring relationships. According to Varcarolis and Fosbre (2021:7), mentor-mentee relationships thrive when both parties show empathy and understanding. On a similar note, Chisengantambu, Robinson and Evans (2018:193) stressed the positive impacts of supportive leaders on teamwork and professional relationships.

5.5.2 Category 2: Challenges encountered in the mentorship of novice leaders

There are unique challenges to mentoring emerging leaders in the field of mental health nursing, and many of these challenges stem from the mindset and actions of the mentees themselves. Seasoned leaders in this research voiced these concerns, highlighting the difficulty of training future leaders.

The assistant nurse managers indicated that the major challenge for mentors was when mentees were unwilling to participate in the mentoring process. Some operational managers, as pointed out did not seem to care about climbing the corporate ladder and even rejected the idea that they could be prepared for higher-level roles if given the chance. The negative attitudes hindered the mentoring efforts. How people respond to mentorship is influenced by their attitudes, which are formed

by their past experiences (Keltner & Steele 2019:484). Mentoring relationships thrive when the mentor and mentee bring a good mindset, suggested White et al (2018:109). After giving it, some thought, mentoring new leaders in mental health nursing is a tricky balance of understanding, persistence, and bravery. People who mentor others oversee changing their mentees' thoughts and actions so that they help create a safe, helpful, and learning-friendly space. This way teaches new skills, changes attitudes, makes people more accountable, and builds a culture of respect and professionalism among nurse leaders.

5.5.2.1 Sub-category 1: Reluctance to be mentored

The challenge of finding appropriate mentors may be related to the inability of a mentee to find a mentor with whom they may have a shared identity. The identification of an individual to mentor, who might not be interested in mentoring, is a delegated task, due to the position held (Davis et al 2022:1072). In this instance, the assistant directors were to mentor the operational managers, and some may not be interested in taking up that role.

5.5.2.2 Sub-category 2: Disrespect for the knowledge, authority, and position of superiors

The assistant managers pointed out that they felt disrespected regarding their knowledge of leadership and authority delegated to them as overseers. This lack of respect broke the bond between them as mentors and the operational managers as mentees. makes. This challenge made it harder for leaders to create a decent work setting and to make mentoring programmes effective.

Problems with interpersonal relationships, evidenced by disrespect, and negative attitudes are obstacles and setbacks for effective mentoring relationships. A positive attitude will enhance mentoring. Respect for the mentoring relationship is crucial for quality mentoring (White et al 2019:109).

5.5.2.3 Sub-category 3: A lack of seriousness and responsibility toward duties

Participants indicated that the mentees were not dedicated or accountable for their work, making the mentoring process even more challenging. To successfully teach leadership skills, teachers need to deal with interested or motivated mentees. Warshawsky et al (2020:259), emphasised that training programmes should be set up to help individuals who want to be leaders, to help them get used to being leaders.

5.5.2.4 Sub-category 4: Ethos and unethical behaviour

Maintaining professional ethics and moral behaviour is challenging in mental health care clinical leadership. The participants pointed out experiences of what was not expected of nurses in terms of ethics. The lack of work ethic and duty consciousness affected the ability to mentor upcoming leaders.

The ICN Code of Ethics for Nurses (2021:2) outlines the standards of ethical conduct of the nurse and the profession as well as of the nurse and co-workers. Creating positive-practice environments, professional knowledge, and taking appropriate actions to support and guide subordinates to advance ethical conduct are outlined as a code of ethics. In leadership mentoring, these aspects can be incorporated by the mentor for the empowerment of the mentee. Ethics committee and in-service training and continuous professional development on ethics are needed according to some participants. Setting up ethical groups and teaching employees how to behave professionally while they are on the job should get institutional support. Mentors play a crucial role in instilling a sense of professional responsibility in their mentees and serving as role models for ethical conduct.

5.5.2.5 Sub-category 5: Motivated by reward rather than a vocation

Participants highlighted the challenge that some mentees were motivated by money rather than a real love for nursing as a career. Participants felt that for them to, mentor others, a monetary reward was to be considered. This attitude could make mentoring impossible as it makes individuals less interested in and dedicated to job growth.

Van Diggele et al (2020:3), attest that some institutions achieve organisational goals through a reward system and positive reinforcement, however, the individuals who are driven by this reward system may lack the motivation to perform beyond what is expected. Monetary value works as a reinforcer for other individuals to perform competently. Some leaders mentor others, not because of the monetary value, but because of their passion and love for the job. Mentors and mentees need to be taught to value diligent care over money.

5.5.2.6 Sub-category 6 and 7: Difficulties with discipline and interference of labour unions

Participants reported the interference of labour unions when having to delegate the mentoring responsibility to managers and difficulty when having to discipline. This is confirmed by Nene, Ally and Nkosi (2020:5), who alluded that bureaucratic management and union influence interfere with leadership roles.

According to Chapter 5 of the Labour Relations Act (Republic of South Africa 1995), workplace forums are allowed to promote the interests of employees, increase efficiency in the workplace, and collective bargaining engagement with management regarding conduct, behaviour, and protection of employees. It is an unfortunate circumstance were labour unions give orders to the employer instead of coming to the negotiation table on behalf of employees. Employees should also not use the labour unions as a scapegoat for any misconduct and unacceptable behaviour. Leaders in the unit should be allowed to practice their nurturing and caring attitude of mentorship and be comfortable disciplining subordinates where a need arises, without fear. Nene et al (2020:7), alluded that unions play a critical role in, representing members, protecting their rights, and promoting their members' interests., however, that influence is too strong, and it challenges leadership roles.

5.5.2.7 Sub-category 8: New versus old school of nursing

The advancement in technology has placed more pressure on leaders within clinical settings. Participants felt the old type of nurse cannot mentor the new type of nurse due to the challenge of not being familiar with the technological advancements in the job.

Avcı and Kaya (2021:1), confirmed that the developing science and technology, though useful, has created a competitive working environment amongst employees and has created stress in some individuals. The WHO in the Digital education for building health workforce capacity (2021:10) also identified the digital health workforce as a strengthening capacity that will enhance competence and skills development.
The “Baby Boomer” nurse leaders have more experience in the leadership position than the “Millennial” nurse leaders who are in the preparation role to replace them (Warshawsky et al 2020:254).

The “Baby-boomers” and Generation Xers are the driving force of healthcare but will soon be outnumbered by the millennials who are influencing healthcare using technology and online resources as the new way to go (Vogenberg & Santilli 2018:48). It is of paramount importance for these generations to work together, to impart knowledge and skills to one another in the leadership-mentoring process.

5.6 THEME FOUR: OPPORTUNITIES FOR CLINICAL LEADERSHIP POSITIONS

The discussion of opportunities available and the lack of opportunities are discussed in detail below.

5.6.1 Category 1: Opportunities available

Leading in the field of mental health nursing has its challenges, but it also presents numerous opportunities of development. This is in line with the opinions expressed in

by the participants who reported how opportunities provided by the healthcare system made mentoring or leadership possible and encouraged leadership development.

As an example of a career trajectory in this field, one participant moved from the position of a junior professional nurse to that of an operational manager This gave a positive outlook on a leadership journey and leadership skills.

5.6.1.1 Sub-category 1: Mentoring courses

Structured education courses which cover leadership, financial management, and other important topics, can assist nurse leaders in gaining the information and skills needed to be leaders.

The University of Fort Hare has established an Albertina Sisulu Executive Leadership Programme in Health, which serves as a major effort to improve the leadership skills of executives in the healthcare field. This programme aims to assist the most senior healthcare managers in becoming better leaders.

Hofmann and Vermunt (2021:254) alluded that clinical leadership development courses make learning much better for individuals and organisations. Not only do these courses teach future leaders' important aspects about what institutions need in a leader, but also give leaders chances to network.

Moran, Hansen and Schweiss (2018:469), mentioned hospital-based preceptorship and mentorship initiatives as additional proof of the commitment to developing future leaders. These classes are essential for preparing mentees for leadership and unit management positions and for understanding the processes involved in making clinical decisions.

Considering these opportunities, one can conclude that mentoring for leadership in mental health settings is rich with fantastic possibilities for individual development. Structured programs, specialised positions, and institutional support create an environment where future leaders can grow professionally and personally. The variety

of leadership development programmes and positions available gives a positive outlook for the mentoring for leadership nursing leadership in mental health.

5.6.2 Category 2: Lack of opportunities

One of the main challenges for the development of clinical leadership in mental health care is the belief that there are limited opportunities for advancement in leadership positions. This was the general sentiment among participants, who expressed concern that pre-existing mindsets and institutional barriers were stunting the growth of future leaders. The participants indicated that aspiring leaders may be unable to do well in this kind of setting because there are insufficient support systems and mentors.

5.6.2.1 Sub-category 1: Limited advancement to leadership positions

Based on what the participants said, there is a strong link between teaching and getting promoted to top roles. A participant indicated that they were appointed as operational managers for an extended period and have not seen progress in being promoted to a senior leadership level. This idea stresses that mentorship is not just teaching but includes getting mentees ready to be leaders in the future, even at a senior level. Mentoring supports professional growth and career development of the mentee (Pandey & Sharma 2022:168).

5.6.3 Category 3: Lack of opportunities

Lack of exposure to the leadership position robs the mentee of development and competence in leadership skills. Participants highlighted the importance of being exposed to leading in the units, for them to grow in the leadership role.

5.6.3.1 Sub-category 1: Exposure to high-ranking leadership positions

The mentee can be paired with the mentor, for an opportunity to be given feedback on the performance of learning to lead When addressing the issue of competency in clinical mentoring, Raletooane, du Plessis and van Wyk (2022:4), highlighted that lack

of exposing mentees to procedures which may include leadership and management, making mentees feel underequipped. Mentees, however, want to take an elevated level of responsibility without an experienced mentor, to assess their capability of leading.

5.7 SUMMARY

This chapter presented a discussion of the findings of the data collected on mentoring for leadership in mental health clinical settings. The information from the participants and the literature related to the information was outlined.

It was clear that there were positive and negative aspects relating to mentoring for clinical leadership. The study indicated that the culture and structure of an institution play a key role in mentoring schemes and the chances for nurse managers to move up the leadership ladder. Structural and educational changes need to be implemented for effective mentoring. These changes are of utmost importance to create a platform where future leaders can grow and be properly prepared for the leadership role.

Ethics and technological advancement need to be considered and aspiring leaders need to be committed to the change for reasons other than making money. Well-planned courses, support, and a guidance system that works will promote the effectiveness of leadership for mentoring in the mental healthcare settings.

CHAPTER 6
DEVELOPMENT, EVALUATION AND VALIDATION OF FRAMEWORK

6.1 INTRODUCTION

This chapter will outline a clinical leadership-mentoring framework for nurse managers in the mental health clinical setting based on the findings from the focus group interviews with the assistant and operational managers. The framework will be developed with relevant concepts relating to leadership and mentoring. A survey list of Dickoff and James (1968:197) will be followed to develop the framework.

6.2 CONCEPTUAL FRAMEWORK

The term ‘concept’ can be described as a building block of a phenomenon, a mental formulation of experience, or a conceived idea (Chinn et al 2022:164; Gray & Grove 2021:170). A conceptual framework outlines how research objectives and the research process come together to draw coherent conclusions. It provides structure, gives guidance, and assists the researcher in identifying concepts and how they relate to each other, thus serving as a foundation and an anchor for the study (Lobiondo-Wood & Haber 2018:69; Creswell et al 2021:82).

A conceptual framework serves as a structured justification of why a study is conducted, guides an understanding of what is known about a particular subject, helps identify gaps in the problem, and outlines the systematic structure of addressing a research problem, to contribute to what is already known (Varpio, Paradis, Uijtdehaage & Young 2020:990). The researcher developed a mental health clinical leadership-mentoring framework based on the survey list by Dickoff and James (1968:197).

6.3 DEVELOPMENT OF A CONCEPTUAL FRAMEWORK

The survey list by Dickoff and James (1968:184) outlines the six aspects used to develop a conceptual framework: an agent, recipient, context, dynamics, procedures, and terminus (refer to **Table 6.1**).

Table 6.1: Components of the conceptual framework proposed by Dickoff and James (1968:197)

Component	Activity
Agent	Who or what performs the activity?
Recipient	Who or what is the recipient of the activity?
Context	In what context is the activity performed?
Dynamic	What is the energy source for the activity?
Procedure	What is the guiding procedure, technique, or protocol of the activity?
Terminus	What is the endpoint of the activity?

Firstly, the "agent" in this context denotes assistant nursing managers, who are recognised authorities in leadership, while the "recipient" signifies operational nursing managers, who are individuals comparatively inexperienced in leadership. The "context" pertains to the mental health clinical setting, specifically the units to which operational managers are assigned and overseen by assistant managers. "Dynamic" refers to motivational factors influencing both assistant and operational managers. The "procedure" encompasses the leadership-mentoring process, and the "terminus" represents the envisioned outcome – in this study, the cultivation of confident, knowledgeable, and skilled operational managers in leadership roles.

6.4 DISCUSSION OF THE CONCEPTUAL FRAMEWORK

In pursuit of advancing the field of nursing management within the unique context of mental health clinical settings, this study's overarching aims and objectives were dedicated to developing a comprehensive clinical leadership mentoring framework

explicitly tailored for nurse managers. Rooted in the imperative need for effective leadership in mental health care, the researcher embarked on a journey to conceptualise this framework and to provide a visual representation that enhances clarity and accessibility in understanding the intricate phenomena under investigation. This discussion delves into the intricacies of the developed conceptual framework, shedding light on its essential components and elucidating their significance in fostering leadership excellence among nurse managers in mental health clinical settings.

6.4.1 Agent

The assistant managers are responsible for supervising, mentoring, and guiding the operational managers to their leadership roles within their assigned mental health units. The assistant managers attested that mentoring is paramount for the upcoming leaders to be confident in leadership. The mentoring process was outlined as a reciprocal process, where the mentor and the mentee had to take responsibility for the process to unfold.

The mentor was perceived as an individual with interpersonal and intrapersonal characteristics: knowledgeable and skilled individual, non-judgmental attitude, and fair but firm (refer to **Figure 6.1**).

Figure 6.1: Agent

6.4.1.1 Knowledge and skills

Knowledge in leadership entails a leader's skills to guide and lead a group. The Merriam-Webster (n.d) dictionary defines knowledge as information, facts, and skills that an individual acquires through experience, education, or training. The clinical leader gains knowledge through experience in the leadership role and association with other leaders.

The knowledge and skills of a mentor form the basis of effective mentoring. In this process, the assistant manager is expected to be the expert in the mentoring process, be knowledgeable about the organisational issues and job requirements, and have the capacity to lead (Hofmann & Vermunt 2021:254). The mentoring process can be effectively achieved by being a positive role model to the operational manager, with a non-judgmental attitude. Koenig (2019:54) and Leino-Kilpi and Henderson (2022:2105), attest that a positive role model will take time to listen to those around, be someone one will look up to have a sense of integrity in their ethical behaviours, be self-motivated and be willing to inspire others to manage emotions effectively.

Mentors should model a commitment to lifelong learning and encourage their mentees to stay updated with the latest developments in healthcare. A mentor in clinical leadership should possess a blend of clinical knowledge, leadership expertise and interpersonal skills that will enable the impartation of knowledge that will foster the professional and personal growth of the mentee. The possession of knowledge and skills by the mentor in the structure and process of the mentoring relationship will enhance an understanding of the roles and responsibilities in clinical leadership to the mentee (Hamer, Hansoti, Prabhakaran, Huffman, Nxumalo, Fox, Gopal, Oberhelman, Mwananyanda, Vwalika & Rispel 2019:16).

As a mentor, one is traditionally envisaged as a more experienced senior individual who shares their wisdom, knowledge, and skills with a more junior or less experienced individual to support the growth that will result in skills development, maximising of potential to lead (Scerri, Presbury & Goh 2020:144). Laukka, Hammarén, Pölkki and Kanste (2022:2775) illustrated the leadership qualities, roles, and behaviours that

leaders should possess, and the participants confirmed these as they indicated that an individual considering to be a mentor should be knowledgeable about mentoring, be experienced in being a mentor, have leadership potential, and be able to build and support upcoming leaders.

6.4.1.2 Non-judgemental attitude and understanding

Davis et al (2022:1065) pointed out that mentoring is established by establishing strong, supportive relationships of emotional support between the mentor and the mentee, which seek to bring development. Strong and effective leadership-mentoring relations can be built by a non-judgmental mentor who understands others. A non-judgmental attitude enables honest and open conversations and prevents negative criticisms about others.

A mentor who seeks to understand others puts oneself in their boots and is willing to listen attentively to others' concerns and experiences. Operational managers articulated that a non-judgmental and understanding mentor will make leadership role-taking an easier path for them. The mentor must maintain a work culture that promotes harmony, collective relationships, and fair and selfless care for the mentee and avoid any toxic leadership behaviour (Guo et al 2022:3257).

6.4.1.3 Fair and firm

Participants outlined that being a firm and fair leader enhances the development of a competent and assertive leader. Positive and effective healthcare environments are created by balancing fairness and firmness in leadership, creating cohesion. Markey, Moloney, Doody and Robinson (2022:2237), indicated that fairness forms part of integrity in taking responsibility in practice and owning up to leadership decisions.

Making effective clinical leadership decisions involves clinical knowledge, collaboration, communication, and commitment. A clinical leader with control over work decisions, enhances work-related well-being (Niinihuhta Terkamo-Moisio, Kvist & Häggman-Laitila 2022:2792). Julnes, Myrvang, Reitan, Rønning and Vatne

(2022:2747), further point out that the responsibility of competence development relies on different management competencies that involve effective decision-making as part of a leadership style to execute decisions effectively.

Putting decisions into action by the clinical leaders and closely monitoring their implementation, develops a character of responsibility taking in the novice leader. This process can be refined and improved over time.

6.4.2 Recipient

The operational managers are novice leaders who depend on the mentor, the assistant manager, for guidance and support. Positive and negative mentoring experiences, and factors that will enhance effective mentoring and strategies for mentoring were outlined. The responsibility of mentoring was not only left to the assistant manager, but the operational managers had a responsibility to ensure that mentoring took place.

The participants indicated that it is not only the mentor who is responsible for the mentoring process. Their attitudes, and willingness to learn from the mentor, show positivity and eagerness to learn to lead (Mantzourani, Chang, Desselle, Canedo & Fleming 2022:2500). The operational managers, who in this study are the mentees, have a responsibility in the mentoring relationships for the development of their leadership.

Active involvement in the mentoring relationship, setting up clear goals, being accountable, maintaining open communication, being self-directed and prepared to learn, and being reflective of their own behaviour and practices during the mentoring process will enhance effective mentoring (Mantzourani et al 2022:2500) (refer to **Figure 6.2**).

Figure 6.2: Recipient

6.4.2.1 Self-directedness

Self-directed learning (SDL) entails individuals assuming initiative and accountability for their education by taking initiative and responsibility for their own learning and judging what to learn in the available opportunities. An individual has control over the goals and management of the learning experience (Loeng 2020:2). The mentee is responsible to take an active role in their mentoring relationship and development learning. A self-directed mentee is active, involved, and motivated and does not rely only on the mentor. The mentee takes control of their development, and the mentor provides guidance and support. It is a collaborative and mutual effort. The mentee must be prepared to initiate sessions with the mentee for discussions, outlining challenges, identifying areas for improvement, assessing progress, receiving feedback, and seeking development opportunities. The mentee must be determined to have a clear understanding of their own goals and set up measurable and achievable objectives to achieve them.

Self-directedness allows the mentee to take ownership of decisions based on the guidance received from the mentor, be a continuous learner, and be willing to adjust and adapt to new changes. Mohamad et al (2021:2), attested that in SDL, individuals select what and how they will learn with the mentor's guidance, individually or in a group. SDL increases self-confidence, independence, motivation, and ability for lifelong learning. Siahaan (2022:4284) confirmed that SDL assists an individual the capacity to autonomously design learning programmes, choose appropriate learning models, monitor, and assess learning results regularly.

6.4.2.2 Goal orientation

In the mentoring for leadership, setting up clear goals is essential for the mentor and mentee as clearly understand what they aim to achieve through the mentoring relationship. Setting clear goals provides direction, focus and a basis for measuring progress. Clear and well-defined goals serve as a roadmap for the mentoring journey and assist in having a productive, focused and aligned role for the mentor and the mentee (Banja, Ndhlovu & Mulendema 2021:6; Hayes & Mahfouz 2020:733). The mentor needs to first identify objectives that are specific, measurable, attainable, relevant, and time-bound, but still enquire from the mentee what they want to achieve in the mentoring relationship (Dreer 2021:103; Pryce et al 2021:46).

6.4.2.3 Involvement

Effective involvement in a mentoring relationship is vital for the mentor and the mentee to make the most of the experience. Both parties should commit to learning, growth and a beneficial relationship that is respected and appreciated and upholds professionalism (Skjevik et al 2020:278).

6.4.2.4 Preparedness

As a mentee, one must show interest in what is being taught. The mentee is responsible for being prepared to learn from the mentor. Being prepared is a two-way street. The mentor contributes to providing guidance, insight, and experience, while the mentee becomes actively involved as a participant committed to being mentored. Bandura's SLT purports that individual behaviours are developed through role modelling, identification, and interaction. Individuals learn through internal reinforcement and observation (Varcarolis & Fosbre 2021:342; Hooley, Nock & Butcher 2021:100). An individual pays attention to what the other person is doing, imitates and practices the behaviour modelled by the other, and with motivation, continuously reinforces the learned behaviour. In mentoring for leadership, the mentee

imitates and practices the behaviour modelled by the mentor, and with motivation, masters the learned behaviour.

6.4.3 Context

A context can be defined as an environment or a condition in which something exists (Melnyk & Fineout-Overholt 2019:751). In clinical leadership, the context can be referred to as a specific environment within which clinical leaders operate and make decisions. Leadership practices, strategies and healthcare delivery systems influence this context. In this study, the mentoring process occurs within a unit in a mental health clinical setting, where the operational manager is allocated, and the assistant manager is to oversee the running of that unit. Kim, Lee and Lee (2022:2217), attest that clinical leadership in nursing is created within a context where the nurse leader is influenced to improve the quality of nursing care and is motivated and empowered through a clear organisational vision. The assistant managers experienced institutional and professional challenges that interfered with their mentoring role. Factors beyond the organisation's control included interference by labour unions, material and human resources, lack of mentoring and promotional leadership opportunities.

The forces that the assistant manager and the operational manager had no control over, included involvement of labour unions, material, and human resources, mentoring opportunities, and promotional leadership opportunities (refer to **Figure 6.3**).

Figure 6.3: Context

6.4.3.1 Labour union involvement

Labour unions in healthcare, are responsible for advocating for worker's rights and negotiating with employers on working conditions, wages, work benefits and job security issues. The interaction between labour unions and clinical leadership in healthcare settings may present challenges and opportunities. Nene and Nkosi (2020:2), attested that the unions' voices are louder than those of the nurse managers and this interferes with decision-making in the clinical leadership environment. The unions may have rules that the leaders may need to follow, and collaborative partnerships and building a platform for sharing ideas must be established to avoid conflicts.

6.4.3.2 Material and human resources

A shortage of nurses is a phenomenon that has been around for a long period (Turale & Meechamnan 2022:372). The rising factors of the ageing population in nursing, which creates an increasing shortage of nurses and additional administrative duties that the clinical leader is tasked to take charge of, interfere with leadership training (Roth, Breckner, Wensing, Mahler, Krug & Berger 2023:2).

The lack of material resources within the health care setting contributes to poor implementation of the leadership role as material resources like computers are required to provide some interventions in caring and leadership (Alatawi, Aljuhani, Alsufiany, Aleid, Rawah, Aljanabi & Banakhar 2020:39).

6.4.3.3 Mentoring opportunities

Mentoring for leadership opportunities plays a vital role in the development of the clinical leadership skills of healthcare leaders of the future (James. Watkins & Carrier 2022:1). Assorted opportunities need to be explored for mentoring leadership opportunities and this may include engaging in peer mentoring relationships, where the mentor can support the mentee in the leadership journey (Templeton, Jeong & Pugliese 2021:3; King & Upadhyay 2022:1156).

6.4.3.3.1 Formal organisational mentorship programmes

Most healthcare institutions have formal mentoring programmes in place for clinical leaders. An experienced leader is paired with an emerging leader who facilitates structured mentorship. Participating in such programmes can connect you with experienced mentors while also providing valuable leadership education (Davis, Jones, Settles & Russel 2022:1072).

6.4.3.3.2 Professional associations

Some professional healthcare and clinical leadership organisations, often provide mentoring opportunities. In some cases, clinical leaders can engage in peer mentoring relationships. This involves colleagues with similar experiences supporting each other in their leadership journey. Davis and Morley (2022:227) attest that professional associations play a vital role in the success of a profession as quality assurance bodies for advocacy and change.

6.4.3.3.3 Academic institutions

A healthcare professional pursuing an advanced degree in healthcare management, leadership or a related field in an academic institution may have mentoring programmes or institutional members that can provide guidance. Engaging the services of an executive coach who specialises in healthcare leadership can be an advantage. An executive coach can provide valuable guidance and support in the leadership journey, even if not being a traditional mentor (Davis & Morley 2022:227).

6.4.3.3.4 Online mentorship platforms

Several online platforms like LinkedIn, or mentorship websites, offer opportunities for individuals to connect with experienced clinical leaders who may be willing to be mentors (Andersen & West 2020:261). One can find such platforms to find mentors or offer mentoring services. Online communities and social media platforms dedicated to healthcare leadership discussions can provide a platform for mentorship connections.

Goodrich (2021:261), posited that online mentoring, is a medium that offers educational opportunities, guidance, support, encouragement, promotion, and modelling that is qualitatively distinct from conventional in-person mentoring. Engaging in the networks of healthcare professionals dealing with mentoring online, expands mentoring networking (Ahmed, Johnson, Latif, Kennedy, Javier, Stinson & Vishwanatha 2021:502).

6.4.3.3.5 Reverse mentoring

The prospect of engaging in reverse mentoring is one that the mentees highlighted when referring to being allowed to teach/mentor the experienced mentor on some advancement in technological-related issues as the mentee is younger and more advanced when it comes to technological advancements. Madhavanprabhakaran, Francis and Labrague (2022:472) attested that millennials are tech-savvy and bring fresh, creative ideas and talents to an organisation. The reverse mentoring approach ensures a reciprocal exchange of knowledge and experiences, enriching the professional development of both parties involved in the mentoring relationship where the mentee can share experiences with the mentor (Khattak, Rahman, Zafar Saleem, Fayaz & Iqbal 2021:248). Mentoring is a two-way street where both mentor and mentee stand to gain valuable insights and experiences from one another.

To harness the full potential of mentoring, it is essential to identify the right person as a mentor. Wissemann, Bloxsome, De Leo and Bayes (2022:9) attest to the importance of having the right match and person to establish a successful mentor-mentee relationship. By doing so, the mentor and mentee will benefit from a mutually enriching experience that contributes to the continuous improvement of clinical leadership practices.

6.4.3.3.6 The mentoring processes

The mentoring process in Sokari (2019:116), is explained as an avenue for a less experienced person to obtain professional skills, competencies, and career development, formally or informally, from an experienced person. The process unfolds

through a series of distinct stages, ensuring a systematic and effective approach to mentoring, namely:

- Identifying a need for mentoring: At the outset, individuals recognise the need for mentoring, typically driven by a desire for personal or professional development. This stage involves self-reflection and acknowledging areas where guidance and support are sought (Davis et al 2020:1071).
- Selection of a mentor: Once the need for mentoring is identified, the next step involves selecting a suitable mentor. Mentors must be well-established, experienced, accomplished, experienced, career specialists, have up-to-date information and value excellence and quality (Idubor & Adekunle 2022:83; Nimmons, Giny & Rosenthal 2019:117). Wissemann et al (2022:9), posit that a good mentor is important for a mentor-mentee relationship as this will bring about a successful mentoring programme.
- Orientation and goals setting: To ensure alignment and clarity in the mentoring relationship, an orientation phase is crucial as goals, expectations values and beliefs will be clarified. Where there is no orientation, goal setting or induction, the mentees feel thrown into the deep as they are not used to the routine, workplace challenges, and environment (Raletooane, du Plessis & van Wyk 2022:4).
- Development and support: The mentoring process's core involves the mentee's active development and support. Davis et al (2022:1074), align this with psychosocial support where the mentee acts as a role-model for the mentee, and shows warmth, friendliness, respect, support, and encouragement. Blake-Beard, Shapiro and Ingols (2021:9), emphasised that mentors can learn and better themselves in the mentor-mentee relationship if they acknowledge that they do not know everything.
- Feedback and evaluation: Regular feedback and evaluation sessions are integral to mentoring. For a mentee to develop competence in this relationship, feedback and mentee-centred evaluation must be the focus (Tuomikoski, Ruotsalainene, Mikkonen & Kääriäinenbo 2018:82). Constant feedback impacts both sides. The mentor may be interested in knowing whether they were misinterpreted during the mentoring process and whether their mentoring was effective and may build

reciprocity into the relationship. The mentee may be resistant to giving feedback taking into consideration the impact it might have on promotional opportunities but may also be interested in knowing how they are progressing in learning the leadership roles (Blake-Beard et al 2021:8).

- Completion and transition: The mentoring relationship enters a completion phase as the mentee progresses and achieves the established goals. Mentors reach a self-actualisation role after building the next generation of leaders who will surpass them in the leadership role even when not present physically (Idubor & Adekunle 2022:83).
- Sustaining the relationship: Even after the formal mentoring process concludes, sustaining the relationship remains essential. Stanley, Watson, Reyes and Varela (2019:261) commented on collaborative relationships in departments where best practices are shared for improvement and change in leadership. These shared relationships can be copied into the mentoring for the clinical leadership process to advance upcoming leaders.

6.4.4 Dynamic

In this study, the dynamic of mentoring refers to the enabling factors of mentoring and or strategies for effective mentoring, on a meta-level: clear goals and expectations, a structured framework, training and support, and resource availability. The enabling factors of mentoring may include goals and expectations, availability of resources, training, and support, as well as a structured framework refer to **Figure 6.4**.

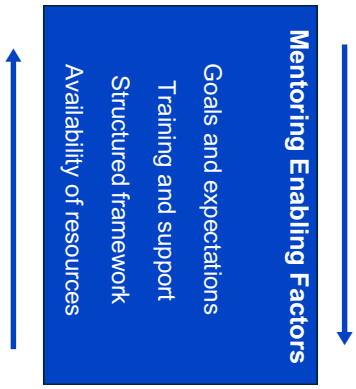


Figure 6.4: Dynamics

6.4.4.1 Setting clear goals and expectations

Establishing clear goals and expectations is akin to identifying a guiding star in the academic journey. Stanley et al (2019:256), emphasised the need to align expectations with institutional strategic plans to foster a culture of accountability and integration of institutional aims. Having clear goals and expectations in a mentoring relationship fosters the commitment of the mentor and mentee to achieve success and collaboration. The goals and expectations will enhance collaborative strategies between the mentor and mentee through communication skills, openness, and transparency (Busari et al 2020:793).

6.4.4.2 Structured framework

The structured framework serves as the roadmap guiding the academic journey. According to Chinn, Kramer and Sitzman (2022:267), the theoretical framework organises interconnected notions to create a meaningful and intricate scenario. Adaptability ensures the framework remains relevant and supportive, providing a robust structure for academic endeavours.

6.4.4.3 Availability of resources

The availability of resources serves as the logistical foundation for a well-functioning clinical nursing environment. Busari et al (2020:792) and Vauhkonen et al (2024:2) attested that the unavailability/insufficiency of human and material resources impacted on clinical leadership improvement and professional competence.

6.4.4.4 Training and support

Considered the essential tools and resources, training and support are pivotal components within a synergistically aligned academic system. Toh et al (2022:5), posit that mentoring supports and motivates the mentee in personal and career goals, beliefs, and values, and boosts confidence and self-efficacy. The synergy ensures that training programmes and support mechanisms are not generic but rather intricately designed to enhance the academic journey, nurturing a continuous learning and development culture.

6.4.5 Procedure

In this study, the "procedure" encompasses the mentoring processes for leadership that can be practiced for effective mentoring. The primary objective of the mentoring for leadership programme within the mental health clinical setting is to cultivate the development of operational managers, nurturing them to become competent, knowledgeable, and skilled leaders in the field. This comprehensive process involves active participation and commitment from both mentors and mentees, where assistant managers serve as mentors, guiding operational managers as mentees through their leadership journey.

In mentoring the mentee relies on the mentor as a reliable person, who, in the mentoring environment and process, will impart the knowledge and skills required of a nurse leader.

The mentoring for leadership programme is strategically designed to expose mentees to the challenges associated with higher managerial roles. Through a deliberate process of learning by standing in for or relieving superiors, operational managers gain first-hand experience and insights into the complexities of upper-level management (Breed, Downing & Ally 2020:8). This exposure is fundamental for their professional growth, allowing them to develop the necessary competencies to navigate the multifaceted responsibilities of leadership within mental health clinical settings.

Continuous and ongoing mentorship forms a cornerstone of the mentoring for the leadership programme. Assistant managers, in their role as mentors, provide sustained guidance, support, and feedback to operational managers throughout their developmental journey Blake-Beard et al (2021:8) confirmed that feedback, whether casually or formally, plays a vital role in learning between the giver and the receiver. This commitment to continuous mentorship ensures that mentees receive valuable insights, learnings, and personalised support tailored to their evolving leadership needs.

A parallel emphasis on a dynamic and continuous training process is integrated into the mentoring programme. Training sessions have an impact on performance, organisational culture, and skills competencies (Maenhout, Billiet, Sijmons & Beeckman 2021:6; Stanley et al 2020:262; Jeon, Park, Choi & Kim 2018:34). This approach ensures that mentees are equipped with the latest knowledge, skills, and best practices, enhancing their leadership capabilities (Refer to **Figure 6.5**).

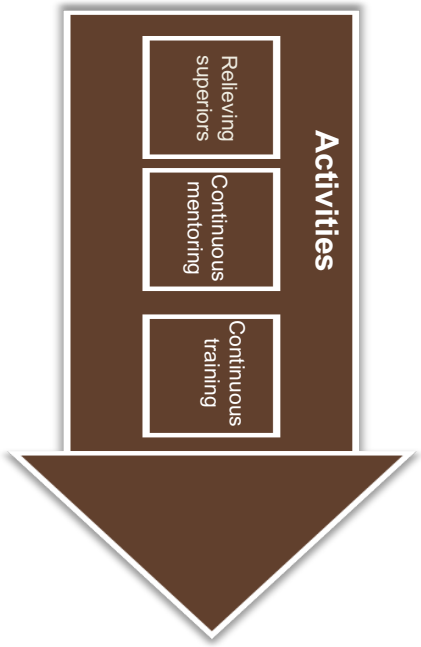


Figure 6.5: Procedures

6.4.5.1 Relieving superiors

Relieving superiors is a crucial aspect within the proposed clinical leadership-mentoring framework for nurse managers in the mental health clinical setting. This component acknowledges the significance of creating a supportive environment for nurse managers by addressing the challenges associated with their role. According to Breed et al (2020:8), autonomous motivation happens when nurse leaders are allowed to make decisions and complete tasks as they deem fit which assists in developing decision-making skills in leadership.

The findings from the interviews with assistant managers and operational managers emphasised the overwhelming responsibilities that nurse managers in mental health clinical settings often face. These responsibilities include administrative tasks and extend to managing the complex dynamics of mental health care units. Mentors are challenged with stress and are not immune, as they navigate the dynamics of work-related responsibilities and the mentoring role (Blake-Beard et al 2021:13). By incorporating the concept of relieving superiors into the framework, the aim is to

streamline managerial tasks, allowing nurse managers to focus on mentorship and leadership development.

To operationalise relieving superiors, the framework will propose mechanisms such as redistributing administrative tasks, implementing efficient communication channels, and fostering a culture of collaboration among the nursing staff. These strategies balance managerial responsibilities and the mentorship role, improving the nurse managers' ability to guide and support their teams effectively.

6.4.5.2 Continuous mentoring

Continuous mentoring is a foundational element in the proposed framework, recognising that mentorship is an ongoing process crucial for the professional development of nurse managers in mental health clinical settings. Blake-Beard et al (2019:9) pointed out that the mentoring role can be used as an effective retention strategy and can increase the mentor’s job satisfaction, organisational commitment, and career success. The framework will draw on the insights from the interviews, highlighting the need for sustained mentorship to address the unique challenges and complexities inherent in mental health nursing management. The concept of continuous mentoring within the framework extends beyond traditional, sporadic mentorship sessions. It involves establishing structured mentorship programmes, regular feedback mechanisms, and opportunities for nurse managers to engage in reflective practices.

The framework will emphasise the importance of mentorship as a reciprocal relationship, where mentors and mentees contribute to each other's professional growth. By incorporating continuous mentoring, the aim is to create a supportive network that enables nurse managers to navigate the complexities of mental health nursing leadership while fostering a culture of shared learning and development.

6.4.5.3 Continuous training

Continuous training emerges as a critical component within the proposed framework, recognising the rapidly evolving nature of healthcare and mental health nursing practices. The interviews with assistant and operational managers highlighted the need for nurse managers to stay abreast of the latest clinical developments, leadership strategies, and mental health interventions.

Drawing on the insights gathered, the framework will propose a structured approach to continuous training encompassing clinical and leadership competencies. Clinical leadership development should aim to develop clinical competencies, which should be included in the curriculum for all healthcare disciplines (Dunn 2021:566). Upcoming leaders should also be encouraged to attend workshops, in-service training, and leadership conferences. The framework will also underscore the importance of leveraging technology for ongoing professional development, such as online courses and virtual simulations.

6.4.6 Terminus

The definition of the "terminus" indicated that it represents an envisaged outcome, which is the cultivation of confident, knowledgeable, and skilled operational nursing managers who are prepared to take up the leadership role.

The mentoring for leadership framework, will outline how this process can unfold. Mentoring for leadership involves creating a structured approach, where the operational manager will be supported, mentored, guided, and supervised by the assistant nursing manager, to reach the potential of a competent clinical leader. The mentoring for clinical leadership framework will enhance the mentoring relationship within the mental health clinical setting. It outlined the systematic and supportive approach for the skills development, growth, and continuous learning of clinical nurse leaders in a structured and organised manner (refer to **Figure 6.6**).

Figure 6.6: Terminus

In conclusion, the framework will serve as a guide that outlines how the clinical leaders can effectively mentor, guide and support the upcoming leaders.

6.5 DESCRIPTION AND VISUALISATION OF A CONCEPTUAL FRAMEWORK

The aims and objectives of this study were to develop a clinical leadership mentoring framework for nurse managers in a mental health clinical setting. Furthermore, the researcher visualised the developed conceptual framework to offer a clear and accessible representation of the phenomena under investigation. This illustration used different colour codes as directed by Colour Psychology (2008). The researcher developed the clinical leadership-mentoring framework using six components of activity as proposed by Dickoff and James (1968:184) (refer to **Figure 6.7**).

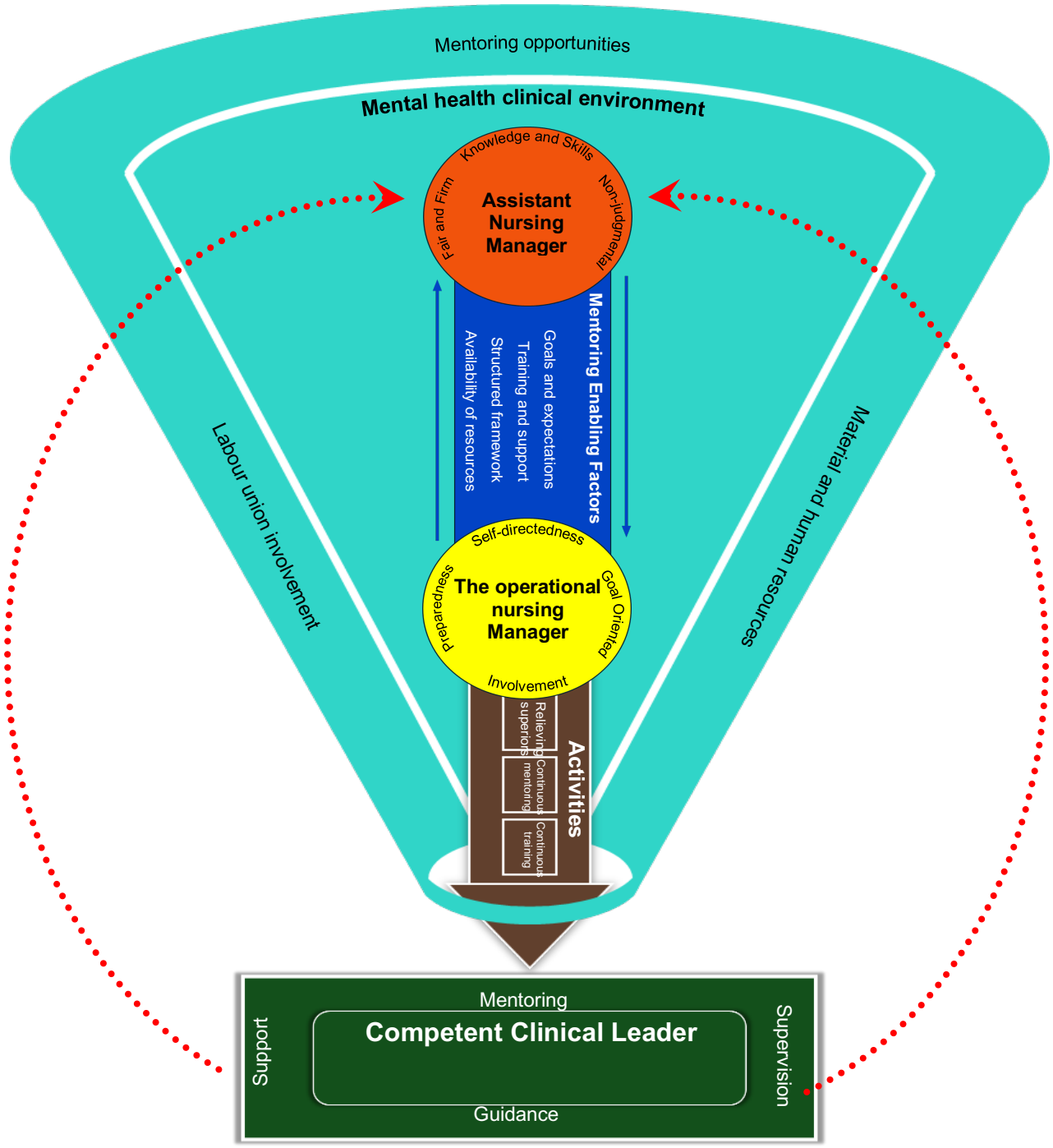


Figure 6.7: Mental health clinical leadership-mentoring framework for nurse managers

Author's conceptual framework

The researcher pointed out the following colour meanings in the framework:

- Orange depicts creativity, success, determination, importance, and energy (the agent). As an agent, the assistant manager should be creative, determined, and energetic, and see the importance of mentoring the future leader. The orange colour reflects these traits (Colour Psychology 2008).
- Yellow is a colour for intellect, enthusiasm, positivity, and optimism (the recipient). As the recipient, the operational manager is reflected in yellow as an individual who must show enthusiasm, positivity, and optimism to learn (Colour Psychology 2008).
- Turquoise represents tranquillity, relaxation, and protection (the context). The learning environment should be accommodative, protective, relaxed, and tranquil to ensure effective teaching and learning (Colour Psychology 2008).
- Blue relates to security, communication, trust, safety, loyalty, and wisdom (dynamics). Trust, loyalty, and effective communication between the agent and recipient should exist. The agent should teach the recipient with wisdom (Colour Psychology 2008).
- Brown depicts retro, lasting, and durable (procedures). The mentoring process follows a specific method. The procedure must be reliable, durable, and lasting. New ideas should be brought into the mentoring for leadership (Colour Psychology, 2008).
- Green is associated with calmness, growth, stability, freshness, and motivation (terminus). The end product of mentoring should be a recipient that reflects freshness, growth, and stability in leadership. Based on this trait, the terminus is reflected in green (Colour Psychology, 2008).

Red signifies strength, power, confidence, and vibrance (Colour Psychology 2008). After a rigorous exercise of mentoring, the operational manager gains power and strength to lead and becomes confident to take the leadership role of the assistant nursing manager.

6.6 FRAMEWORK EVALUATION

The evaluation of the developed framework incorporates the established criteria suggested by Chinn et al (2022:264). The evaluation criteria as proposed included transparency, simplicity, generalisation, accessibility, and importance (Chinn et al 2022:264). The evaluation was conducted by a panel of experts consisting of two senior lecturers from higher education institutions, two operational managers, and two assistant nursing managers from mental health care institutions (Döringer 2021:12). The evaluation and analysis of theories about models or frameworks provide clinicians and academicians with valuable insights into the functioning of these concepts (Risjord 2019:1). The panel of experts were provided with checklist and model for evaluation through the email. The experts were given a consent form to sign for agreeing to evaluate the framework and were allowed to call the researcher for presentation or for clarifications if the questions given were not clear. The evaluation process happened between December 2023 and January 2024.Feedback based on the evaluation checklist demonstrated a consensus among the experts who unanimously affirmed that the framework had transparency, simplicity, transferability, accessibility, and importance. These criterion elements are discussed as follows based on the feedback from the panel of experts:

- **Transparency:** It was a central consideration, ensuring the framework's inner workings and processes were clear and easily understandable. The framework concepts were extracted from gathered data and the literature review provided detailed methodologies to ensure transparency.
- The framework's **simplicity** was assessed to measure its level of complexity, with a particular focus on creating a design that is easy for users to navigate. **Figure 6.7** clearly illustrates the concepts and their connections that contribute to the overall simplicity of the framework, making it easy to understand and identify.
- **Generalisation:** An analysis was conducted to assess the framework's applicability, verifying its suitability for various scenarios, and confirming its significance beyond specific use cases. This framework was developed based on the participants' experiences in specific contexts in GP during their clinical

leadership. However, it can be transferable to other contexts where clinical-leadership mentoring is required.

- **Accessibility** was a crucial criterion, emphasising the ease with which individuals, including subject matter experts, can access and utilise the framework. The framework will be disseminated to all participants through presentations at the mental healthcare institutions where the data was gathered. In addition, the document will be accessible in digital format via the UNISA online library, while a physical copy will be stored in the physical library. Furthermore, the articles will be compiled and submitted to academic journals for publication, thus expanding their accessibility to a broader audience of scholars.
- **Importance:** the significance of the framework in effectively addressing central themes and obstacles within the subject matter was carefully examined. The findings of this study may improve the clinical leadership of nurse managers in mental health care institutions. The following section discusses the framework validation.

6.7 FRAMEWORK VALIDATION

Initial validation was conducted by the study supervisor during framework development through scrutiny and feedback for amendments. The researcher shared the framework with the supervisor for review and approval. The first draft was revised after considering the feedback received, and the second draft went through additional review and validation. After the second assessment, the framework was edited and sent to a graphic designer for technical visualisation. The final product of the illustration was reviewed and approved by the supervisor.

Secondly, the same panel used for the evaluation process assessed the validation of the developed framework using a face validity checklist derived from the work of Bölenius et al (2012:3), and content validity according to the criteria outlined by Sangoseni, Hellman and Hill (2013:2). The validation was done concurrently with the framework evaluation.

The face validity criteria included relevance, importance, purpose, appropriateness, and intuitiveness (Bölenius et al 2012:3), which are described below based on the feedback from the panel:

- **Relevance:** The panel unanimously concluded that the framework is relevant and suitable for effectively addressing the intended aims and problems within the subject matter.
- **Importance:** This framework is expected to be beneficial as it will enhance the skills, expertise, and abilities of mentors (assistant nursing managers) and mentees (operational managers and clinical nurses). All panel members agreed it will foster growth and knowledge in a mental health clinical leadership environment.
- **Purpose:** This study aimed to develop a mentoring for clinical leadership framework for nurse managers in mental healthcare settings to foster leadership skills and knowledge. The panel members uniformly agreed that the framework effectively targeted its intended objectives.
- **Appropriateness:** The panel agreed that the content of this framework seems appropriate for the targeted audience (assistant managers and operational managers) and purpose (enhancing mentoring for clinical leadership).
- **Intuitiveness:** The panel verified that the framework effectively captured and represented the underlying topic being examined or addressed, including its components, variables, and approaches. The six activities outlined by Dickoff and James (1968:197), effectively captured the variables utilised to create the framework.

The content validity criteria comprised comprehensiveness, the relevance of items, representativeness, agreement of experts, and alignment with objectives (Sangoseni et al 2013), as presented below based on the feedback from the panel:

- **Comprehensiveness:** The framework was conceptualised based on the survey list presented by Dickoff and James (1968:197). The panel agreed that the survey list facilitated the researcher to comprehensively capture all the fundamental characteristics of the phenomena.

- **Relevance of items:** The panel concurred that every individual component within the framework is specifically relevant to the broader content domain and makes a substantial contribution to addressing the clinical leadership mentoring primary concerns.
- **Representativeness:** The researcher assembled all the six survey lists/activities proposed by Dickoff and James (1968:197), which the panel agreed, aided the framework, encompassing the complete spectrum of information within the mentoring for clinical leadership.
- **Agreement of experts:** The panel were confident that the experts in the field will concur with and understand the content selection and scope of the framework. The validation from experts endorsed the framework's significance and usefulness, hence this might increase its acceptance and implementation among professionals.
- **Alignment with objectives:** The panel concurred that the study's primary objectives were based on the survey's conclusions, as outlined in the proposed framework. The researcher ensured that the framework's goals were clearly defined and effectively communicated (Chapter 1).

6.8 SUMMARY

In this chapter, the researcher discussed the framework for clinical leadership mentoring in the mental health clinical setting as directed by the findings of the study, using the Dickoff and James (1968:197) survey list. The next chapter will address the summary of the key findings, evaluation of the framework, and provision of conclusions and recommendations.

CHAPTER 7
SUMMARY, CONTRIBUTIONS, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION OF THE STUDY

7.1 INTRODUCTION

The current research study was conducted in three phases. Phase one explored and described the mentoring for leadership opportunities and challenges that novice and expert clinical nurse leaders face in mental health care (outlined in detail in **Chapter 4** and further discussed in **Chapter 5**). Phase two developed a mentoring for leadership conceptual framework for nurse managers within mental health clinical settings for continuous improvement, leadership development, and effective succession planning in leadership (referred to **Chapter 6**). Lastly, phase three detailed the evaluation and validation of the developed conceptual framework, outlined in **Chapter 6**.

This chapter summarises the research design and method, followed by a summary and interpretation of the study's findings, recommendations, contributions, and limitations. Finally, the chapter concludes by presenting the overall conclusions drawn from the study.

7.2 RESEARCH DESIGN AND METHOD

Each phase of the study has its methodology. **Phase one** of the study employed a qualitative grounded theory methodology using focus group interviews with fifteen operational nursing managers and twelve assistant nursing managers separately. This phase was conducted in two public mental health care institutions in Gauteng Province to outline perspectives on mentoring for leadership experiences and to foster growth in mental health leadership.

Phase two involved the development of the conceptual framework, drawing guidance from the six survey activities proposed by Dickoff and James (1968:201). These

survey activities were a template for developing the conceptual model, focusing on the agent, recipient, context, dynamic, procedure, and terminus. Furthermore, the critical findings from phase one were integrated to provide a real-world basis or practical foundation for the conceptual model.

Phase three evaluated the developed framework using evaluation criteria by Chinn et al (2022:170) to ensure that the framework complied with rigorous standards and was suitable for its intended application within academic and practical settings. The evaluation criteria included clarity, simplicity, generality, accessibility, and importance. This phase involved six participants, four from mental health care institutions and two from higher education institutions in Gauteng Province. Furthermore, phase three validated the framework through face and content validity by subject matter experts. The steps for all the phases were described in detail in chapter three. The summary and interpretation of the research findings are provided below.

7.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

This section delineates the research questions of each phase, presents the overview of primary findings, and outlines the scientific linkage and contributions of each phase to another in developing a clinical leadership-mentoring framework for nurse managers in mental health care settings.

7.3.1 Phase one: Situational analysis (exploration and description of the mentoring for leadership opportunities and challenges that novice and expert clinical nurse leaders face in mental health care settings)

The research questions for phase one were:

- What mentoring for leadership opportunities and challenges are novice clinical nurse leaders facing in mental health care settings?
- What mentoring for leadership opportunities and challenges do establish clinical nurse leaders face in mental health care settings?

- What are the mentoring leadership characteristics of a clinical nurse leader in a mental health setting?

The participants' responses to the research questions in phase one, as gathered from focus group interviews, yielded the following key findings:

- The personal characteristics of an effective clinical nurse leader and mentor incorporate interpersonal and intrapersonal characteristics.
- Mentorship for clinical leadership dealt with mentored experiences, the factors for facilitating effective mentoring, and mentoring strategies to consider during the mentorship process.
- The challenges experienced during mentoring for clinical leadership in the clinical context incorporated institutional and personal-related attributes.
- The opportunities for clinical leadership positions outlined a lack of or availability of leadership opportunities and the possibility of being promoted to a senior or leadership position.

7.3.1.1 The personal characteristics of an effective clinical nurse leader and mentor

The participants reported that an effective clinical mentor must have both interpersonal and intrapersonal qualities to be an effective mentor. Being a positive role model, motivating, being non-judgmental and knowing how to communicate with the mentee, are effective characteristics of a mentor. The participants added that a fair but firm and consistent mentor, when dealing with the mentees, makes the mentoring process a success. The participants also highlighted that a mentor who takes time to understand the mentee, does not force their own beliefs and values on them, and is confident when making decisions, which play an essential role in the mentoring for the leadership process.

The participants outlined positive and negative experiences of mentoring for leadership. The participants reported that some form of informal mentoring was taking place and trial and error for learning was present. Participants also reported insufficient

mentoring as some mentors were not knowledgeable and experienced regarding the mentoring process. Some mentorship strategies and factors that could bring about an effective mentoring process were reported, namely, having the right candidate with leadership potential, having induction and orientation programmes and written protocols for mentoring for leadership, and having the support of the senior managers and the team in the unit.

7.3.1.2 The challenges experienced during mentoring for clinical leadership

Mentoring for leadership has not been a smooth sailing process as participants reported the challenges experienced during the process. Institutional and professional difficulties were reported. The challenges included the human and material resources shortage that impeded with the assistant managers' responsibility to mentor the operational managers. Day and night administrative duties allocated to the operational managers, with no scope of mentorship determined for the mental health nurse leaders, the lack of authority and autonomy for decision making, and the support from the assistant managers, negatively impacted the mentoring for leadership roles.

7.3.1.3 Opportunities for clinical leadership positions

For effective mentoring for leadership in mental health settings, the participants highlighted that opportunities like mentoring courses for operational and assistant managers must be made available. The other negatively highlights reported were that operational managers lack the opportunities to be future nurse leaders, as there is little or no advancement to leadership positions. The operational managers felt that they were stagnant in their positions and would only have an opportunity for an assistant manager's position if an assistant manager retired or went on pension. The role of mentoring did not create exposure to high-ranking leadership positions; hence, some operational and assistant managers did not value the process.

Overall, the findings of the first phase have significantly contributed to addressing the research questions by providing contextualised leadership opportunities and

challenges based on novice and expert clinical nurse leaders' experiences in mental health care settings, which served as fundamental building blocks for the development of the conceptual model in phase two. The summary of phase two is outlined in the next section.

7.3.2 Phase two: Framework development (clinical leadership-mentoring framework for a mental health care setting)

The second phase presented the development of a clinical leadership-mentoring framework for mental health care. The research question for phase one was:

- What should a mentoring for clinical leadership framework for nurse managers in mental health care consist of?

To address the above research question, researchers employed six components or activities to guide the development of the conceptual model as proposed by Dickoff and James (1968:201), namely: context, recipients, procedures, dynamics, agents, and terminus. These components were described in detail in **Chapter 6** using the empiric findings obtained in Phase One (**Chapter 4**). The exploration of each element was conducted on an individual level, focusing on the mentoring process. Relevant concepts were then identified based on the findings and existing literature. The concepts were consolidated to form links based on the components for developing the mentoring for clinical leadership framework.

The product of phase two contributed uniquely to the mental health clinical field by developing a conceptual model or framework that may assist in improving the positivity and confidence of upcoming nurse leaders as strategies to enhance and strengthen leadership development. The following section summarises the evaluation and validation of the developed conceptual framework.

7.3.3 Phase three: Evaluation and validation of developed conceptual framework

The third phase described evaluating and validating mentoring for clinical leadership framework for mental health care. The research questions in this phase were:

- What is the efficacy of the existing mentoring clinical leadership framework in improving leadership abilities among mental health care professionals?
- How do subject matter experts perceive the developed framework through structured questionnaires, to validate the effectiveness and relevance of the framework?

A panel of key stakeholders (two assistant nursing managers, operational managers, and senior lecturers) reviewed and validated the developed conceptual framework. A checklist detailing the theory evaluation criteria proposed by Chinn et al (2022:264), was used to achieve this evaluation. The theory evaluation criteria included clarity, simplicity, generality, accessibility, and importance. The comments indicated that no significant modifications or adaptations were necessary for the framework. Overall, the panel members, who represented the whole nursing profession, positively approached the framework.

Initially, the supervisor iteratively reviewed the framework. Based on the feedback, the research refined the framework until both parties agreed that it accurately captured the phenomenon being studied. Then the framework was submitted to the same panel of experts that evaluated the validation assessment. The panel validated the developed framework through a face validity checklist derived from the work of Bölenius, Brulin, Grankvist, Lindkvist and Söderberg (2012:3) and content validity according to the criteria outlined by Sangoseni, Hellman and Hill (2013:4). The feedback pointed out that the framework required no substantial alterations or adjustments.

Phase three of the study, evaluation, and validation of the developed framework, played a crucial role in ensuring the production of dependable, accurate, and

applicable models that effectively contribute to comprehending and addressing the phenomena under investigation.

7.4 CONTRIBUTION OF THE STUDY

This study provided valuable insights into enhancing clinical leadership in mental health nursing by highlighting specific perspectives and experiences of both novice and expert leaders, offering practical guidance for future initiatives in this area. Furthermore, the study has contributed to the nursing field by developing a framework for clinical leadership mentoring in mental health care settings, addressing challenges faced by assistant nursing managers and operational nursing managers.

7.5 RECOMMENDATIONS

This section presents the recommendations for enhancing clinical leadership in mental health care settings.

7.5.1 Recommendations for practice

The operational managers and assistant nursing managers highlighted a need for training for the mentorship role. The recommendations for practice are:

- The institutions should consider having structured mentorship programmes to address the plight of the managers. Training programmes should be developed to equip mentors with the necessary skills and knowledge. By providing mentors with the relevant tools, they can enhance their mentoring abilities and create a conducive learning environment for their mentees.
- The institutions can consider the appointment of mentors within each unit, who will work hand in hand with the Skills Development Section and the Clinical Education and Training Units to concentrate specifically on the mentoring programmes. The training units can arrange training on communication skills, decision-making, and inter- and intra-personal skills to contribute to an effective mentee-mentor relationship.

- The appointment of suitable individuals capable of taking up the mentoring role within the units can be considered. The pairing of the mentor and the mentee, taking into consideration personal characteristics, should also form part of the criteria.
- A formal process should be implemented to assess the needs and goals of the mentees, ensuring alignment with the skills and expertise of potential mentors. Regular evaluations and feedback sessions are vital to assessing the compatibility and effectiveness of mentor-mentee matches.
- The implementation of the mentoring frameworks and models in the institutions can be taken into consideration. Healthcare organisations should establish mentorship frameworks that outline the objectives, responsibilities, and guidelines for effective mentoring. These frameworks serve as a reference point for mentors, providing them with a structured approach to supporting their mentees. On the other hand, these institutions can establish partnerships with private organisations that offer training programmes on mentorship for further training.
- The new leaders were concerned about staying current with nursing trends and receiving mentoring from more experienced leaders who might not be as knowledgeable about emerging technologies and trends. The use of technological gadgets to source new and additional information on mentoring can be encouraged among old and novice leaders. Access to relevant literature, workshops, and online platforms can enhance their knowledge and assist in navigating complex clinical scenarios. Regular review and update of these resources will ensure their alignment with evidence-based practices and emerging trends in clinical leadership.
- Fostering a mentoring culture within the organisation is crucial. It is possible to achieve this through various channels, such as internal communications, leadership endorsements, and success stories from mentees and mentors. A supportive culture cultivates an environment where mentorship is embraced and encourages managers to participate actively.
- Giving the researcher an opportunity to give a presentation on the study results and the framework which will enhance the use of the framework, thus contributing to leadership for mentoring in the mental health care settings.

7.5.2 Recommendations for policy development

The participants raised concern regarding the need for relevant policies for guidance and implementation of the mentorship role in mental health care settings. The recommendations for policy development are:

- Beginning by conducting a comprehensive analysis of the existing policies related to mentoring and leadership development within mental health clinical settings.
- Identification of the gaps or areas that need improvement to ensure effective mentoring programme implementation for managers. Based on the findings from the policy analysis, development of evidence-based policy guidelines specifically focused on implementing and sustaining a mentoring model for managers will be an advantage. These guidelines should outline the mentoring programme's objectives, roles, responsibilities, and expected outcomes.
- Engagement of key stakeholders, including policymakers, healthcare administrators, managers, and professional associations, to gather input and support for developing and implementing the mentoring policy. This collaboration will help ensure alignment with organisational goals and enhance the policy's effectiveness.
- Determining of the necessary resources, such as funding, staffing, training materials, and technological infrastructure, required to support the successful implementation of the mentoring programme. The mental healthcare managers should advocate for adequate resource allocation and securing of funding through strategic partnerships or budget reallocation to sustain the mentorship programme in the long term.
- Establishment of mechanisms to monitor the implementation of the mentoring policies and evaluation of its effectiveness. This includes defining performance indicators, data collection methods, and assessment tools to measure the impact of the mentoring programme on managerial development, clinical outcomes, and organisational performance.

- Ensuring accountability and quality assurance by having defined clear roles and responsibilities for programme coordinators, mentors, and mentees, highlighting their accountability for adhering to the mentoring policy guidelines.
- Implementation of quality assurance measures, such as regular evaluations and feedback mechanisms, that will ensure the ongoing improvement and effectiveness of the mentoring programme.

7.5.3 Recommendations for education

Participants were concerned about lack of education or not being at par with the other counterparts who are in academia when coming to any educational advancements that will assist them in effective mentorship. The recommendations for education are:

- The designing of educational programmes that equip managers with the knowledge and skills to become influential mentors. This may include mentoring theory, communication, leadership development, and clinical expertise modules.
- Collaboration with educational institutions, professional organisations, and experienced mentors to develop comprehensive and tailored training programmes on mentorship.
- Incorporation of experiential learning by including opportunities for managers to participate in hands-on learning activities that simulate real-world mentoring scenarios. These can involve role-playing exercises, case studies, or mentorship practicums, allowing managers to apply their knowledge in a supportive and controlled environment.
- Mental healthcare institution executives should create a learning community among managers by establishing monthly forums, discussion boards, or peer-to-peer networks. This will enable the managers to share their experiences and best practices, seek guidance from experienced mentors, and engage in collaborative learning. Encouragement of active participation by managers and provision of support to ensure the community remains vibrant and valued.
- Integration of mentoring into the management curriculum by collaborating with educational institutions offering management programmes to integrate mentoring

into their curricula. This integration will ensure that future managers have the necessary knowledge and skills to become influential mentors This can be done through dedicated courses, workshops, or assignments focusing on mentoring and its role in leadership development.

- Offering of continuous professional development opportunities for mentors to enhance their mentoring skills and stay updated with the latest research and best practices. This can include seminars, conferences, webinars, or mentorship symposiums that provide mentors with opportunities to gain experience from experts in the field and share their experiences.
- Implementation of evaluation and assessment strategies to measure the effectiveness of the educational programmes. This may involve collecting feedback from participants, analysing pre- and post-training assessments, and conducting follow-up surveys to evaluate the impact of the education and training programmes on the managerial abilities of mentors.

7.5.4 Recommendations for future research

The researcher conducted the study at only two public mental health care institutions in Gauteng Province. The following is recommended for future research:

- Consideration of doing more research within the other public and private mental health care clinical facilities and not only in Gauteng Province is recommended.
- The current study was conducted with the operational and assistant nursing managers only; therefore, future research that includes mental health and other registered nurses is recommended.
- The researcher investigated the development of a mentoring for leadership framework, and future research may consider developing strategies to enhance effective mentoring for leadership in mental health care settings.
- The testing of the proposed framework at the larger scale of the population of leaders in other health care settings and not only in the mental health care settings.

7.6 LIMITATIONS OF THE STUDY

The following subsections present a comprehensive overview of the limitations encountered in each of the three phases of the study.

7.6.1 Phase One: Limitations

The researcher conducted the study at two public mental health care institutions in Gauteng Province and did not include the other public and private mental health care institutions in Gauteng Province. This could limit the applicability of the developed mentoring model to similar contexts. The results can therefore not be generalised to other institutions, locally and internationally but may be transferable to other contexts. A mentoring model that addresses the needs of managers within a specific practice domain may not be suitable for those who operate in different settings or under different scopes of practice, thus limiting the universality of the research findings. Further research that includes all provinces, and other countries is recommended.

The active involvement of the researcher in data collecting, which is a defining aspect of qualitative research, brings about the possibility of exerting influence on the participants' responses. This influence identified through alterations in participant conduct or viewpoints resulting from the consciousness of being observed or the effects of the researcher-participant relationship. Furthermore, it is imperative to acknowledge that the primary investigator's unconscious biases and subjective opinions may have influenced the data analysis.

A technique called bracketing was used to mitigate and reduce this impact. Bracketing entails deliberately suspending the researcher's previous beliefs, experiences, and biases to approach the data with a neutral and impartial viewpoint. This rigorous method seeks to reduce the influence of the researcher's personal bias on the analysis, thus enhancing the objectivity and credibility of the study.

7.6.2 Phase Two: Limitations

It was challenging to capture all identified relevant building blocks within a single conceptual framework. This incompleteness can limit the model's ability to fully represent the complexity of the studied phenomenon. However, the key findings were incorporated into the model development to comprehensively represent the phenomena under investigation.

The generalisability of the developed framework is limited by the qualitative nature of phase one, which played a pivotal role in shaping the framework. However, while its applicability may be context-specific, there is potential for consideration in other provinces within South Africa or internationally. The extent to which the framework can be applied in diverse settings may need modification to ensure suitability and practicality. Additionally, the developed framework has not undergone testing, therefore; it is recommended that testing of the model in post-doctoral studies be conducted. Despite not being tested; the developed framework still contributes to the body of knowledge in the mental health care context.

7.6.3 Phase Three: Limitations

Evaluation and validation entailed the exercise of human judgements, adding the possibility of subjectivity and bias. The findings were influenced by the inputs provided by subject expert panel, making them potentially susceptible to the specific individuals involved in the panel and the various stages of the process. To mitigate these limitations, the researcher used structured evaluations as proposed by Chinn et al (2022:264) to ensure the consistency of the evaluation.

7.7 CONCLUDING REMARKS

The purpose of this study was to develop a clinical leadership-mentoring framework for nurse managers in mental healthcare, to foster growth in mental health leadership. Overall, the findings outlined novice and established clinical nurse leaders' challenges during mentoring. No clear guidelines are put in place, nor is training on mentorship

given to both, which makes it difficult for the mentor and mentee relationship. The developed framework envisages establishing an overview of what it takes to have an effective mentorship process in the clinical area and how beneficial it will be for an institution to take mentoring seriously to develop competent confident upcoming nurse leaders. If implemented effectively, mentoring novice leaders will improve patient care, organisational standards, and build on staff retention.

7.8 PERSONAL REFLECTIONS

The researcher embarked on a doctoral study that aimed at developing mentoring for clinical leadership in mental health settings, seeing this as an important aspect when coming to competent clinical leadership in mental health care setting. The researcher is a mental health nurse, passionate about competence in mental health, hence the research study concentrated on mental health nursing.

The research journey was incredibly challenging for the researcher, considering that masters' studies were completed ten years ago. The researcher had to adjust to a new journey of studying, researching, and realigning one to advanced research-related requirements. The acceptance of the research proposal boosted the researcher's confidence to continue with the studies. A change of job opportunities, ill health, and the loss of a parent were some of the challenges the researcher faced while embarking on this study journey, which brought uncertainty about whether this study would be completed.

The researcher in some instances wanted to quit, as anxiety and frustrations occurred when getting feedback from the supervisor. The capability to conduct research was tested as whispers of discouragement sounded louder, but encouragement from the research supervisor, family, friends, and colleagues knocked back the sense to pursue the studies. The researcher mastered the courage to walk this journey of studying with pride, patience, and confidence.

The researcher has developed tremendously in literature search, academic writing skills, and critical analysis of research articles. Developing a mentoring for clinical

leadership framework made the researcher tap on the creative skills in designing and networking. The researcher posits that the established framework will provide guidance for mentorship in the areas of clinical leadership, policy formation, nursing education, and future research.

7.9 SUMMARY

The final chapter summarises the study, outlining its contributions, recommendations, limitations, and conclusion. This research focused on developing a clinical leadership-mentoring framework for nurse managers in mental health care, aiming to enhance leadership capabilities in this field. No previous research had established such a framework. The data, collected from assistant nurse managers and operational managers at two public mental health care institutions in Gauteng Province, informed the development of this framework. Conclusions were drawn from the findings, and recommendations were proposed for practice, policy development, education, and future research.

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LIST OF ANNEXURES

Annexure A: Ethical Clearance certificate from Research Ethics Committee: Department of Health Studies, UNISA

UNISA university of south africa

RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES
REC-012714-039 (NHERC)

1 November 2017

Dear Mrs Moleboge Antonia Chabedi

Decision: Ethics Approval

HSHDC/748/2017
Mrs Moleboge Antonia Chabedi
Student No:61158844
Supervisor: -Prof JE Maritz
Qualification: D Cur
Joint Supervisor: -

Name: Mrs Moleboge Antonia Chabedi
Proposal A clinical leadership-mentoring model for nurse managers in the mental health care settings

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 1 November 2017 to 1 November 2022.

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on 2 August 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
www.unisa.ac.za

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 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 Gauteng Department of Health: Gauteng Province

Student Number: 61158844
Ms. MA Chabedi
For Attention: The Deputy Director
Department of Health
Nursing Education Department
Private Bag X085
MARSHALLTOWN
2107

RE: PERMISSION TO CONDUCT RESEARCH WITH ASSISTANT MANAGERS AND OPERATIONAL MANAGERS AT THE INSTITUTION

I, Moleboge Antonia Chabedi, a doctoral student at the University of South Africa (UNISA), hereby request permission to conduct research at the healthcare institution.

Title of the study: A clinical leadership-mentoring model for nurse managers in mental health care settings.

Objectives of the study:

Phase 1: Situation analysis

- To explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders are faced with in mental health care settings.
- To explore and describe leadership-mentoring opportunities and challenges that established clinical nurse leaders are faced with in mental health care settings.
- To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting.

Phase 2: Model development

- To develop a clinical leadership-mentoring model for a mental health care setting.

Phase 3: Model evaluation

- To evaluate the clinical leadership-mentoring model for a mental health care setting.

Research instrument and data collection

Focus group interviews will be conducted with the participants and the interviews will be tape-recorded. Field notes and reflective notes will also be taken during the interviews.

Ethical considerations

Participants will be invited to participate voluntarily. Participants will be given an information leaflet to familiarise themselves with the title and background of the study, purpose, procedure, benefits, risks, and issues regarding to confidentiality and anonymity.

The researcher will conduct the study on receipt of approval from the UNISA Research Ethics Committee.

Significance of the study

Finding of the study will contribute to the advancement and improvement of clinical leadership in mental healthcare settings.

The researcher undertakes to provide the institutions involved with a research report, and present the findings to the institutional managers. The research articles will be published in accredited journals for other institutions to learn from the outcomes for improvement of clinical leadership in their own clinical settings.

For any further information that may be required, please feel free to contact me or my supervisor on the following contact details:

Researcher: Mrs. MA Chabedi
Email address: lebo.chabedi123@gmail.com
Telephone details: 0835038655 or 0125213755/5750
Supervisor: Prof Jeanette Maritz
University of South Africa
Tel: 012429 6534
maritjie@unisa.ac.za

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.

Yours sincerely
Ms. Moleboge Antonia Chabedi (Researcher)
Doctoral student: UNISA
Signature:……

Annexure C: Approval letter from Gauteng Department of Health: Gauteng Province

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. Robert Oyedipe
Tel: +27 12 451 9036
E-mail: Robert.Oyedipe@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

MEETING: 11/2017
PROJECT NUMBER: 32/2018
NHRD REFERENCE NUMBER: GP_201801_009

TOPIC: A clinical leadership-mentoring model for nurse managers in mental health care settings

Principal investigator:	Mrs. Moleboge Antonia Chabedi
Supervisor:	Prof. J. Maritz
Facility:	Cullinan Care and Rehabilitation Center Weskoppies Hospital
Name of the Department:	UNISA

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Dr. Robert Oyedipe
Acting Chairperson: Tshwane Research Committee
Date: 25/04/2018

.....
Mr. Pitsi Mothomone
Chief Director: Tshwane District Health
Date: 2018-04-26

Annexure D: Permission request from Weskoppies Hospital

Student Number: 61158844
Ms. MA Chabedi
For Attention: Chief Executive Officer
Weskoppies Hospital
Private Bag X113
PRETORIA
0001

RE: PERMISSION TO CONDUCT RESEARCH WITH ASSISTANT MANAGERS AND OPERATIONAL MANAGERS AT THE INSTITUTION

I, Moleboge Antonia Chabedi, a doctoral student at the University of South Africa (UNISA), hereby request permission to conduct research at the healthcare institution.

Title of the study: A clinical leadership-mentoring model for nurse managers in mental health care settings.

Objectives of the study:

Phase 1: Situation analysis

- To explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders are faced with in mental health care settings.
- To explore and describe leadership-mentoring opportunities and challenges that established clinical nurse leaders are faced with in mental health care settings.
- To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting.

Phase 2: Model development

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Phase 3: Model evaluation

- To evaluate the clinical leadership-mentoring model for a mental health care setting.

Research instrument and data collection

Focus group interviews will be conducted with the participants and the interviews will be tape-recorded. Field notes and reflective notes will also be taken during the interviews.

Ethical considerations

Participants will be invited to participate voluntarily. Participants will be given an information leaflet to familiarise themselves with the title and background of the study, purpose, procedure, benefits, risks, and issues regarding to confidentiality and anonymity.

The researcher will conduct the study on receipt of approval from the UNISA Research Ethics Committee.

Significance of the study

Finding of the study will contribute to the advancement and improvement of clinical leadership in mental healthcare settings.

The researcher undertakes to provide the institutions involved with a research report, and present the findings to the institutional managers. The research articles will be published in accredited journals for other institutions to learn from the outcomes for improvement of clinical leadership in their own clinical settings.

For any further information that may be required, please feel free to contact me or my supervisor on the following contact details:

Researcher: Mrs. MA Chabedi
Email address: lebo.chabedi123@gmail.com
Telephone details: 0835038655 or 0125213755/5750
Supervisor: Prof Jeanette Maritz
University of South Africa
Tel: 012429 6534
maritjie@unisa.ac.za

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.

Yours sincerely
Ms. Moleboge Antonia Chabedi (Researcher)
Doctoral student: UNISA
Signature:.....

Annexure E: Approval letter from Weskoppies Hospital

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Weskoppies Hospital facility Research approval

The approval is subject to approval by the Ethics Committee of the University of South Africa (UNISA)

APPROVAL BY HOSPTAL CHIEF EXECUTIVE OFFICER

I **Mrs. M.A. Mabena** Chief Executive Officer / Superintendent of **Weskoppies Hospital**, hereby agree that this research/evaluation be conducted in **Weskoppies hospital**.

The officer conducting the trail will be: **MOLEBOGE ANTONIA CHABEDI**

Research title: **A CLINICAL LEADERSHIP-MENTORING MODEL FOR NURSE MANAGERS IN THE MENTAL CARE SETTINGS .**

Institution: **WESKOPPIES HOSPITAL**

Supervisor: **: PROF JEANETTE MARITZ**

HOSPITAL CEO / Superintendent			Date		
Signature	Initial(s)	Surname	Day	Month	Year
	MA	**Mabena**	**19**	**01**	**2018**

Annexure F: Permission request from Cullinan Care and Rehabilitation Centre

Student Number: 61158844
Ms. MA Chabedi
For Attention: Chief Executive Officer
Cullinan Care and Rehabilitation Centre
Private Bag X1005
CULLINAN
0001

RE: PERMISSION TO CONDUCT RESEARCH WITH ASSISTANT MANAGERS AND OPERATIONAL MANAGERS AT THE INSTITUTION

I, Moleboge Antonia Chabedi, a doctoral student at the University of South Africa (UNISA), hereby request permission to conduct research at the healthcare institution.

Title of the study: A clinical leadership-mentoring model for nurse managers in mental health care settings.

Objectives of the study:

Phase 1: Situation analysis

- To explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders are faced with in mental health care settings.
- To explore and describe leadership-mentoring opportunities and challenges that established clinical nurse leaders are faced with in mental health care settings.
- To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health setting.

Phase 2: Model development

- To develop a clinical leadership-mentoring model for a mental health care setting.

Phase 3: Model evaluation

- To evaluate the clinical leadership-mentoring model for a mental health care setting.

Research instrument and data collection

Focus group interviews will be conducted with the participants and the interviews will be tape-recorded. Field notes and reflective notes will also be taken during the interviews.

Ethical considerations

Participants will be invited to participate voluntarily. Participants will be given an information leaflet to familiarise themselves with the title and background of the study, purpose, procedure, benefits, risks, and issues regarding to confidentiality and anonymity.

The researcher will conduct the study on receipt of approval from the UNISA Research Ethics Committee.

Significance of the study

Finding of the study will contribute to the advancement and improvement of clinical leadership in mental healthcare settings.

The researcher undertakes to provide the institutions involved with a research report, and present the findings to the institutional managers. The research articles will be published in accredited journals for other institutions to learn from the outcomes for improvement of clinical leadership in their own clinical settings.

For any further information that may be required, please feel free to contact me or my supervisor on the following contact details:

Researcher: Mrs. MA Chabedi
Email address: lebo.chabedi123@gmail.com
Telephone details: 0835038655 or 0125213755/5750
Supervisor: Prof Jeanette Maritz
University of South Africa
Tel: 012429 6534
maritjie@unisa.ac.za

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.

Yours sincerely
Ms. Moleboge Antonia Chabedi (Researcher)
Doctoral student: UNISA
Signature:.....

Annexure G: Approval letter from Cullinan Care and Rehabilitation Centre

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Annexure 1

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to Ms. Moleboge Antonia Chabedi to do her research on

"A clinical leadership mentoring model for nurse managers in the mental health care settings"

at Cullinan Care and Rehabilitation Centre.

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:

Flow of services must not be compromised.

pp

Signature
Clinic Manager/CHC Manager/CEO

24/04/2018
Date

Annexure H: Confidentiality clause: UNISA

[redacted]

61158844 Chabedi

Declaration of confidentiality regarding security and confidentiality of data and identifiable information

I, Moleboge Antonia Chabedi with Id. Number: 680209028906 will be conducting research on the topic: "A clinical leadership-mentoring model for nurse managers in mental health care settings"

I hereby declare that all data and identifiable information collected for this research project will be used only for the required topic under study and not for any other purpose.

Data and identifiable information will be kept until the research under study is completed. The data and identifiable information will then be permanently deleted from my tape recorder and computer files.

The following will be adhered to:

- All files containing data and identifiable information for this study will be kept on a hard drive, under lock and key in a secure area. No files will be kept on a central server.
- All files containing data and identifiable information for this study will only be sent by email to the supervisor and co-coder.
- Any possible breach of security will be reported in full to the participants and supervisor.

I understand the importance of security and confidentiality of the data and identifiable information of this study and agree to the terms stated above.

Signed at Pretoria on this 10th day of October 2017.

Ms. MA Chabedi.

.....

1

Annexure I: Information leaflet

INFORMATION LEAFLET AND INFORMED CONSENT

TITLE: A CLINICAL LEADERSHIP-MENTORING MODEL FOR NURSE MANAGERS IN THE MENTAL HEALTH CARE SETTINGS

Primary researcher: Mrs. MA Chabedi (Student Number: 61158844)

Supervisor: Prof. JE Maritz

Dear Participant

You are invited to participate in a research study that forms part of a doctoral study undertaken by Moleboge Antonia Chabedi at the University of South Africa. This is an information leaflet that contains information pertaining to the study and you are requested to familiarise yourself with its contents prior to agreeing to participate in the study.

WHAT IS THE PURPOSE OF THE STUDY?

The researcher aims to develop a clinical leadership-mentoring model for a mental health care settings using the data that will be collected from focus group interviews, and the model will be evaluated.

WHAT WILL BE EXPECTED OF YOU?

As a participant, you need to understand what the study is all about and give permission to take part in the study by signing a consent form. You are requested to take part in the focus group interviews that will be conducted at the mental health care institution where you are working. The interviews will take approximately forty-five to sixty minutes. The interviews will be tape-recorded and field notes will be taken during the interviews.

WHAT ARE THE RISKS INVOLVED IN THE STUDY?

There are no foreseeable risks involved in taking part in this study. You may not answer a question if you feel uncomfortable and you may withdraw participation in the study anytime.

WHAT ARE THE POTENTIAL BENEFITS THAT MAY COME FROM THE STUDY?

You will not receive any payment for taking part in the study. Your taking part in the study will contribute to the development of a clinical leadership-mentoring model for mental health care settings that might assist in improvement of nursing leadership and mentoring in the future.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT IN THE STUDY?

Your participation is voluntary and you have the right to withdraw at any stage without being penalized. You have a right not to provide any reasons for your withdrawal. You also have the right to be informed about the results of this study.

HOW WILL CONFIDENTIALITY AND ANONIMITY BE ENSURED?

All information recorded will be kept strictly confidential. No information will be linked to your name. You will be identified by a number or alphabet in the study and your identity will not be revealed even during reporting of the study in the thesis, conference presentations or scientific journals. Information provided will be safely kept under lock and key during and after data analysis.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study has received approval from the following institutions:

The Research and Ethics Committee of the Department of Health Studies at the University of South Africa (UNISA), The Gauteng Department of Health and the mental healthcare institution where you are working.

DECLARATION OF CONFLICT OF INTEREST

There is no conflict of interest that may influence conduction of the study.

CONTACT PERSON REGARDING THE STUDY?

Researcher: Mrs. MA Chabedi
Email address: lebo.chabedi123@gmail.com
Telephone: 0835038655 or 0125214477

Supervisor: Prof Jeanette Maritz
Email address: maritjie@unisa.ac.za
Telephone: 012429 6534

Annexure J: Informed consent form

INFORMED CONSENT

TITLE: A CLINICAL LEADERSHIP-MENTORING MODEL FOR NURSE MANAGERS IN THE MENTAL HEALTH CARE SETTINGS

Primary researcher: Mrs MA Chabedi (Student Number: 61158844)

Supervisor: Prof. JE Maritz

I the undersigned Mr., Ms., Mrs.,……..hereby confirm that I have read the participation information leaflet and freely and voluntarily agree to participate in the study. The information about the study purpose, risks, benefits, anonymity and confidentiality was clearly outlined to me in a language I understood.. I understand that my name will not be used in any part of the study; and that I may at any stage withdraw from the study without giving any reasons and that will not be used against me in the future.

Printed name of participant:	Signature of participant	Date:
Printed name of researcher:	Signature of researcher	Date:
Printed name of Witness:	Signature of Witness:	Date:

3

Annexure K: Participants' demographic information

DEMOGRAPHIC DATA/BACKGROUND INFORMATION OF PARTICIPANT

TITLE: A CLINICAL LEADERSHIP-MENTORING MODEL FOR NURSE MANAGERS IN THE MENTAL HEALTH CARE SETTINGS

Primary researcher: Mrs. MA Chabedi (Student Number: 61158844)
Supervisor: Prof. JE Maritz

Please indicate the most appropriate information applicable to you by crossing (X) in the relevant block.

EXAMPLE: Employment Status

Employed	**X**
Unemployed	

1. **Age**

20-29	
30-39	
40-49	
50-59	
60+	

2. **Gender**

Female	
Male	
Other	

3. **Race**

African	
Coloured	
White	
Indian	
Other (Specify)	

4. **Educational background (Management)**

Certificate	
Diploma	
Degree	

Other (Specify)	

5. Number of years working at a mental health care institution

0-10	
11-20	
21-30	
31-40	
41-50	
50+	

6. Number of years working as an operational manager

0-10	
11-20	
21-30	
31-40	
41-50	
50+	
N/A	

7. Number of years working as an assistant nurse manager

0-10	
11-20	
21-30	
31-40	
41-50	
50+	
N/A	

Printed name of participant	Signature of participant	Date
Printed name of researcher	Signature of researcher	Date

Annexure L: Interview guide

INTERVIEW GUIDE FOR FOCUS GROUP INTERVIEWS	
HEADINGS	**INTERVIEW QUESTIONS**
Definitions	- How would you define clinical leadership? - How would you define mentorship in clinical leadership?
Enhancement of clinical leadership mentoring?	- What enhances mentoring in clinical leadership? - What do you expect from a mentor in clinical leadership? - How do you mentor the upcoming leader into the clinical leadership position?
Characteristics of a mentor/mentee	- What characteristics do you envisage from a clinical leader/mentor? - What characteristics do you envisage from a mentee in clinical leadership mentoring?
Experiences	- What are your experiences in clinical leadership as a mentor or mentee? - How were you mentored for the clinical leadership position?
Challenges	- What challenges are experienced by the mentor/mentee in a clinical leadership mentoring process?
Recommendations	- What recommendations can you give regarding clinical leadership mentoring?
Any other input?	- What other inputs would you like to add regarding mentoring in clinical leadership?

To explore and describe the leadership-mentoring opportunities and challenges that novice clinical nurse leaders are faced with in the mental health care settings.

To explore and describe leadership-mentoring opportunities and challenges that established clinical nurse leaders are faced with in mental health care settings.

To identify the leadership-mentoring characteristics of a clinical nurse leader in a mental health settings.

1

Annexure M: Co-coder's certificate

QUALITATIVE DATA ANALYSIS

CO-CODING CERTIFICATE

For

Moleboge Chabedi

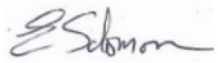
For the study titled

A clinical leadership-mentoring model for nurse managers in the mental health care settings.

This is to certify that

I, Dr EM Solomon, am an experienced co-coder and have co-coded and analysed the data from focus group interviews related to this study. After conferring with Ms Chabedi, it can be confirm that consensus was reached with regards to the major themes and categories arising from the research interviews.

In accordance with ethical standards, all information related to the co-coding and analysis of the above study remains strictly confidential and any information related to the study will be destroyed upon completion of the process.



Dr E.M. Solomon (D.Tech:Hom UJ)

20th May 2021

Transcripts were coded doing line by line analysis as suggested by Rapley (2011:274-275) and Creswell (2013:193-225

Rapley, T. (2011). Some Pragmatics of Data Analysis "in" Silverman, D. Ed. *Qualitative Research 3rd Edition*. Sage Publications. Chapter 15.

Creswell, J.W., (2013). *Qualitative inquiry and research design. Choosing among five traditions*. Third ed. Sage Publications.

Annexure N: Framework evaluation request and participant's informed consent

61158844: Chabedi MA

RE: REQUEST TO EVALUATE A CLINICAL LEADERSHIP MENTORING MODEL FOR NURSE MANAGERS IN MENTAL HEALTH CARE SETTINGS

Dear Prof/Dr/ Mr/ Ms

I Moleboge Antonia Chabedi, a doctoral student at the University of South Africa, is requesting for your expert evaluation of my framework developed as part of the finalised stages of the research conducted. The model is based on a grounded theory design and was developed from data collected during focus group interviews held with operational managers and assistant nurse managers on mentoring for clinical leadership from two public psychiatric institutions in Gauteng Province.

The researcher developed a framework for mentoring for clinical leadership as the outcome of the research study and your evaluation is requested to check on the validity and relevance of this model. Mentoring for clinical leadership aims at building the upcoming nurse leaders to be confident and equipped to take up leadership roles in psychiatric clinical settings. Implementation of the framework can benefit the institutions and improve leadership skills for the upcoming nurse leaders. An evaluation form is attached to this request letter for you to complete, with an assessment criterion that requires you to look into the following aspects of the framework: its transparency, simplicity, generalisability, accessibility and importance. An explanation on the evaluation of the components is added to the evaluation form and additional comments are acceptable.

Your participation in this evaluation is voluntary, with no financial compensation and you have the right to withdraw at any time without giving reason. No physical or psychological harm is foreseen by the researcher during the evaluation process. The evaluation process may take between thirty to forty minutes to complete. All information obtained in the evaluation will be treated as strictly confidential and no information will be linked to your name in the dissemination of the thesis or reports in publications.

For any clarifications, the researcher Ms. MA Chabedi can be contacted on these numbers during office hours: (011 696 8312/8300) or on cellphone numbers: 0855038655/0713825924 and email address: lebo.chabedi123@gmail.com or 61158844@mylife.unisa.ac.za. The supervisor Prof J. Maritz may be contacted during office hours at: 012 429 6534.

I request that you send back the consent form, should you agree to my request to evaluate. The completed evaluation document and the consent form can be sent to the researcher via email.

Your participation will be highly appreciated.
Yours sincerely
Ms. MA Chabedi (Researcher)

61158844 Chabedi MA

PARTICIPANT'S INFORMED CONSENT

Study title: A clinical leadership-mentoring model for nurse managers in mental health care settings

I, (Prof./Dr./Mr./Mrs./Ms.) .....have received, read and understood the participation information leaflet that indicated the nature, benefits, and risks of the evaluation.

I understand that my participation is voluntary and that I may withdraw at any stage, should I not want to continue with the evaluation of the framework, without penalty. I hereby declare freely that I consent to and agree to take part in the evaluation of the framework. I have been informed that no information given will be linked to my name in the thesis or any publications.

Participant' s signature_____ Date: _____

Annexure O: Checklist for evaluating the developed framework

61158844 Chabedi MA

CHECKLIST FOR EVALUATING THE DEVELOPED FRAMEWORK

Research title: Clinical leadership-mentoring model for nurse managers in the psychiatric clinical settings

Researcher: Moleboge Antonia Chabedi

1. DEMOGRAPHIC DATA OF EVALUATORS (Tick the applicable item)

Current Occupation	Assistant Nurse Manager	
	Operational Manager	
	Lecturer	
	Other (Specify)	
Employer	College	
	University	
	Clinical Facility	
Highest Qualification	Diploma	
	Degree	
	Other (Specify)	
Field of expertise	Education	
	Management	
	Other (e.g Model expert, Psychiatric Nursing, Midwifery, Trauma Nurse)	

2. GUIDELINES FOR EVALUATION

2.1. Transparency: Is the framework clear?

This question addresses whether the concepts used for the framework are relevant, appropriate and related.

2.2. Simplicity: Is the framework easy/simple to understand?

The question addresses whether the framework is confusing, or complex or its steps can be easily followed.

2.3. Generalisation: Can the framework be generalised?

The question addresses whether the framework can be used or adapted in any other psychiatric clinical settings except where the research study was undertaken.

2.4. Accessibility: Is the framework available and accessible to stakeholders?

The question addresses whether the framework can be accessible to clinical nurse managers to adopt and use for mentoring purposes in psychiatric settings.

2.5. Importance: Is the framework important?

The question addresses whether the framework is practical and whether it addresses the main idea of mentoring for clinical leadership for clinical managers in psychiatric settings.
Is the framework important for clinical practice, education and research?

3. EVALUATION TABLE (Select yes or no and comment if needed)

Evaluation criteria	Evaluating question	Yes/ No	Comments if needed?
1. Transparency	Is the framework clear?		
2. Simplicity	Is the framework easy/simple to understand?		
3. Generalisation	Can the framework be generalised?		
4. Accessibility	Is the framework available to the participants and stakeholders?		
5. Importance	Is the framework important?		

Overall thoughts and additional comments

.....
.....
.....
.....
.....
.....

Thank you for participating in this evaluation.

Annexure P: Validation questionnaire

VALIDATION QUESTIONNAIRES

Research title: Clinical leadership-mentoring model for managers in the psychiatric clinical settings

Researcher: Moleboge Antonia Chabedi

		Yes	No
FACE VALIDITY			
Relevance	Does the framework appear to be relevant to you on a superficial level?		
Importance	In your opinion, does this framework seem important in capturing the intended content or skills?		
Purpose	Based on a brief overview, do you think this framework effectively adress what it is intended to adress?		
Appropriateness	From your perspective, does the content of this framework seem appropriate for the targeted audience or purpose?		
Intuitiveness	Does the framework's content align with your understanding of the intended construct?		
CONTENT VALIDITY			
Comprehensiveness	Do you believe that the content of the assessment covers all relevant aspects of the targeted domain or skill set?		
Relevance of Items	Do the individual component in the framework align with the broader content domain it aims to adress?		
Representativeness	Do you think the framework represent the entire range of content within the clinical-leadership mentoring?		
Expert Agreement	Are you confident that experts in the field would agree with the content selection and coverage of this framework?		
Alignment with Objectives	Considering the objectives of the framework, do you believe that the content adequately addresses the intended goals?		

Comments……
……
……
……
……

Thank you for participation.

Annexure Q: Sample of interview transcript with operational managers

INTERVIEW WITH OPERATIONAL MANAGERS: 19 FEBRUARY 2020

Interviewer Good afternoon, participants, and thank you for taking your time to be part of this, eh, research study. Kindly take note, I'm aware that you've made yourself acquainted with the information book…uh, leaflet. And I'm not going to be calling you by name. I'm just going to be indicating that you are participant one or two or three, so don't be surprised that I'm not calling you by name because that's what you agreed upon in the information leaflet. I'm going to start with the first question and my question to you would be: how would you define leadership mentoring in mental health? Anybody can feel free to start. There's no queue. How would you define mentoring in leadership?

Participant 1 I can say it's to, eh…as…as…as a leader yourself, eh, you'll be mentoring, eh…like, you'll be teaching young ones, eh, the upcoming leaders, on…on leadership, on how to lead.

Interviewer Anybody would like to add?

Participant 2 Maybe because we are talking about clinical –

Female Mm.

Participant 2 …maybe it's part and parcel of dealing with clinical staff and leadership and mentoring. It's not only about you, like, teaching also the…the young ones, yes, it is included, but I also basically feel that you are…we are…also have to be mentored maybe to be leaders because I think leadership has got some stages where…or some levels where you reach. So, basically, it covers that as well, that, eh, we are heading to one direction of being leaders and being able to mentor the upcoming young generation that are to take up in the future.

Interviewer If I may ask another question: what do you view as the characteristics of a good leader and mentor?

Participant 3 I think a good leader has to be a person who has good listening skills and also can communicate [INDISTINCT – VOICE CLARITY – 00:03:05] with whoever, it's either the subordinates, the person in charge, or above.

Interviewer [INDISTINCT – VOICE CLARITY], participant fi…five, you nodded your head. Do you want to say something?

Participant 5 I'm…actually I'm agreeing with what she's saying about listening skill and communication.

Participant 3 Communication.

Participant 5 I think that's a basic –

Female Ja.

Participant 5 …and it's very, very important.

Female Ja.

Participant 3 And also you should be a…you should be a…a…a good [INDISTINCT – VOICE CLARITY] should be a good exemplary to others.

Participant 6 Mm. Role model.

Participant 3 Your conduct and, you know, performance also –

Female Mm.

Participant 3 …need to be exemplary to others so that they can follow the good that you are presenting to…to [INDISTINCT – VOICE CLARITY – 00:04:04].

Interviewer If I may ask –

Participant 1 [CROSSTALK] –

Interviewer Yes.

Participant 1 …also to, uh, make decisions –

Female Ja.

Participant 1 …to…to take decisions and follow up on those decisions.

Interviewer Thank you.

Participant 4 And, again, fairness, yeah, being fair when coming to, eh, dealing with situations.

Participant 6 And to add on that, you can also be responsible and accountable for your actions –

[CROSSTALK]

Participant 6 …and behaviour.

Participant 2 And positive attitude as well.

Female Mm.

Interviewer Thank you.

Participant 6 I also wanted to add as much as she was saying about communication and listening skills when dealing…also on what she said re the clinical [INDISTINCT – VOICE CLARITY – 00:05:04], I get it will be your conduct and then after those communications and listening skills towards the…the…the people that I may say you are mentoring, they must also…you have a character that you can say that you brought change. It must be in like terms of a change agent as in towards them.

Interviewer I heard that you're saying you are operational managers and I wanted to know what leadership mentoring opportunities, eh, are available for operational managers at the institution?

Participant 2 Here?

Interviewer Yes.

Participant 2 Or personal?

Interviewer Here at your institution---

[CROSSTALK]

Interviewer …what leadership opportunities are there for you as operational managers?

Participant 5 Re men…re mentoring or [CROSSTALK – 00:06:04]?

Interviewer Yes, you…as operational managers, have you been mentored in this position that you are in?

Participant 2 I mean, to be honest, I was. Because when I came, I found one of the…I don't want to mention name but there was an A-S-D here in the ward who mentored me for s…for three months just to show me around and then orientate me in the ward. Ja. I mean, now with me, I think I was, even if it was for the three months. But I was…because I was basically new in this place. So, I found somebody in the ward. Ja.

Participant 6 Okay. I was also mentored by a co-manager because I al…we were placed in the same ward, sa…same unit. So, she has been a manager for…for a long time. So, she's the one who mentored me during my placement in that particular ward.

Participant 3 I was also [INDISTINCT – VOICE CLARITY – 00:07:10] fortunately [INDISTINCT – VOICE CLARITY] when we started, after…when we were in…appointed as new operational managers, I was placed under the assistant director who really, you know, mentored…mentored me with everything because we were starting a new ward also. So, I…I was fortunate enough to be mentored [INDISTINCT – VOICE CLARITY].

Participant 4 Uh…uh, I was mentored and still in the process of mentoring on how to handle situations like in general –

[INDISTINCT – VOICE CLARITY]

Participant 4 …like how to deal with situations when you face them. Mm.

Participant 6 Ja, I forgot, I also…I was also mentored by, mm, an A-S-D while we were opening ward thirty.

Interviewer Okay.

Participant 6 Mm.

Participant 2 Ja, so, I think in general, [INDISTINCT – VOICE CLARITY – 00:08:22] we've got –

Participant 6 They do mentor us.

Participant 2 Mm. Opportunities to be mentored.

Group Mm.

Interviewer Thank you. If what…I may ask, what are the challenges that you experience as an…a leader, an operational manager?

Female Yoh.

Participant 5 Mine was…e…especially I…when you start as a new manager, you have the…you have people who have attitude that you are a manager, you are younger, you have just been…maybe you are –

Female [INDISTINCT – VOICE CLARITY].

Participant 5 …you don't have a long service in the institution, so, you know –

[CROSSTALK]

Participant 5 …doesn't go well with them.

Participant 3 Negative attitude.

Participant 4 Negative attitude.

Participant 5 Ja, negative attitude. So, but at least you have to cope and bring them back –

Participant 4 Ja, even –

[CROSSTALK – 00:09:15]

Participant 4 …teamwork.

Participant 5 …and understand you. Mm.

Participant 4 [INDISTINCT – VOICE CLARITY] teamwork.

Participant 2 I mean; I want to be specific. I had a…a sort of a shop steward which was very bad. So, basically, I feel that, um, as much as, like, people, they represent the employees, but employees are more mis…mislead by the representatives in terms of doing what is right and what he's doing what is wrong. So, I had…I had that, which was very difficult.

Participant 6 Ja. And it makes the situation worse.

Participant 2 Mm.

Participant 1 At least you had that. I'm going through that.

Participant 2 You are going through that?

Participant 1 Ja.

Participant 2 [INDISTINCT – VOICE CLARITY].

Participant 5 Ja.

Participant 1 Ja. Negative influences.

Female Ja.

Participant 6 Ja, it's true. Attitude plays a big role. The challenges that I had personally is like finding yourself in that position as being, eh, appointed as a new manager. Because you still…yes you will…you did have that [INDISTINCT – VOICE CLARITY – 00:10:27] opportunities when you were orientated, you were mentored, but being there and then, mm, you know, finding yourself with staff that still challenges [VERNACULAR], ai, she's still new –

Female Mm.

Participant 6 …and then it's like now they are judging are you doing it right? And then you find yourself a…as a…at a position where you want to do your best and, you know, there's –

Female Mm.

Participant 6 …there's also, like, in terms of emotional things that you are going through. At times, we will like not that much support when it comes –

Female Mm.

Participant 6 …to maybe your supervisor, depending on who's there to…to…to lead you further.

Female Ja.

Participant 6 I think those are the main challenges. And it ends…end up, you know, personally I feel like whether you are coming or going in terms of what you want to prove…not necessarily prove but do your best in terms of your…your leadership role, as much as we said we should be [INDISTINCT – VOICE CLARITY – 00:11:24] lead by example.

Female Mm.

Interviewer So, the other issue that I wanted to know from you its what challenge do you think are being faced by the experienced person when they've got to mentor this inexperienced person or the leader? The challenges that can be, you know, faced by the experienced leader –

Participant 6 By the mentor [CROSSTALK].

Interviewer …who's the mentor. Yes.

Participant 6 Okay.

Participant 2 The attitude –

[CROSSTALK]

Participant 5 If the person does…is not willing to want to learn, then the mentor is going to experience a challenge –

Female Mm.

Participant 5 …on how to mentor that particular person. And then even comparing, mm…mm –

Participant 6 Comparison.

Participant 5 Comparison, like, I did mentor this one, this one was like this and this one, and we are too slow or what-what.

Female Ja.

Participant 5 So, you see that it demoralises you if you…you are comparing with someone else.

Female Mm.

Participant 5 I mean, we are different, unique, and then ob…obviously our performance is going to be different. But if you are compared to someone else, then it's going to be a problem and you are going to develop an attitude towards that particular person and then the relationship then –

Participant 3 Becomes a struggle.

Participant 5 Ja.

Interviewer So, then, how do you think the leadership mentoring can be improved?

Participant 2 I think if we can preach about attitude and we preach it, we preach it. Like in the church, we preach it until it gets into people's… And the other thing is that, um, when we…we…we ourselves por…uh, portrays a pot…s positive attitude, people also learn from that. What I've realised is that when people, um…most of the time when I'm working with the staff who's got, uh, negative attitude and then you'll find that there's an incident that is happening and that improves the person. If you bring them back with love, sometimes they…they change –

Female Mm.

Participant 2 …their attitude –

Female Mm.

Participant 2 …towards you or you want to show them that, you see, this is what you did, this is what you did, this is what is leading us, and all that. So, sometimes, like, when the incident has happened, sometimes we've got this tendency to blame whereby people they become more rebellious. But if you give them the attitude of trying to develop them and show them that, um, they…they…they sort of like come back to you.

Female Mm.

Participant 2 That's what I've experienced most of the time, which I basically feel that sometimes I become fortunate when a person is having a negative attitude and then something just…will just happen onto that person. So, I will have a chance to confront the person and bring them back. And then after that they definitely change.

Female Mm.

Participant 3 And especially when you talk to [INDISTINCT – VOICE CLARITY – 00:14:38] privately without other people influencing –

Female Mm.

Participant 3 …then, you know, you…you sort of come to terms with that and that person come to terms with what you want, you know, him to…to know, her to know, and it be…becomes better that way. But if you maybe just say it in front of everybody –

Female Mm.

Participant 3 …there it's going to be a problem because they are going to be rebellious, more rebellious than before.

Participant 4 And adding on that, like, talking to a person privately is, eh…eh, looking at the…the tone of the voice when you talk.

Group Mm.

Participant 4 Ja. You have to talk with the person in a calm manner.

Female Mm.

Participant 4 And also encouraging that…that person, like, you're teaching them.

Female Mm.

Participant 4 Teach them, eh, give in-services so that –

Female Mm.

Participant 4 …that they will be able to understand.

Interviewer [INDISTINCT – VOICE CLARITY – 00:15:40] wanted to say something. Oh.

Participant 1 No. She…she…she said something that I wanted to say, that is why I [INDISTINCT – VOICE CLARITY].

Interviewer Oh. Okay. I heard that you said that you were being mentored in your position as operational managers, but I just want to hear from you how was it done? How were you mentored in this position?

Participant 1 Mine was…mine was through accompaniment [INDISTINCT – VOICE CLARITY].

Interviewer Would you elaborate as you say accompaniment [CROSSTALK]?

Participant 1 Ja. What happened is that when I became an operational manager, there was already…I was working with a [sic] assistant manager and actually it was [INDISTINCT – VOICE CLARITY] so that they…that person was my main mentor. She was just showing me how to do things as we went along.

Interviewer And, others, how were you mentored?

Participant 6 With me, when I was, like, appoint…appointed as a manager, fortunately there was another operational manager in the unit that I was, before I was, like, allocated a unit on my own. It was, like, a type of accompaniment. Whatever she was orientating me doing things, it was like I was looking at, like, in terms of being educ…I mean, given in-services on how to manage things, problem solve…solving, crisis management, in terms of looking at what she's doing and then also giving me opportunity to do that by myself.

Participant 3 And also by doing rounds. After I was appointed, and then in the new ward the…the…the manager, the assistant director, he [INDISTINCT – VOICE CLARITY – 00:17:39] came for rounds almost on daily basis and then, you know, just monitoring…mentoring that, you know, do this like this and do this like this. And then also when you did something that is maybe…you're not sure of, when you ask her, she could…she could, you know, come to the ward or call you to the office and then explain to you. That's why I say I was fortunate enough, but I can't…I can't mention the name of the person.

Female Mm.

Participant 3 That person, you know, was mentoring and was giving in-service, guiding, you know, properly.

Female Mm.

Participant 2 And also in terms of support and, I mean, I got a lot of support –

Female Ja.

Participant 2 …because it was so challenging for me. It was my first time being an operational manager. There goes the shop steward [INDISTINCT – BACKGROUND NOISE]. So, I got a lot of support from the…from the management part, from…from…from the person who was supervising me. And in terms of teaching me how to do things, I also had an A-S-D, I think maybe me and sister [INDISTINCT – VOICE CLARITY – 00:18:49] are talking about one person maybe in terms…who was very, very supportive and who was teaching me. He [INDISTINCT – VOICE CLARITY] for two hours, showing you that this is –

Female Mm.

Participant 2 …you know. Ja. So, basically support as well.

Interviewer Thank you. I just also wanted to ask from you, eh, what recommendations can you give regarding mentoring of leaders?

Participant 3 Come again.

Interviewer What, eh…eh, inputs…recommendations can you give? Do you have any recommendations that you can give regarding mentoring the leader in the institutions?

Participant 5 I think, firstly, when…if we can learn to be patience…patient. Because sometimes we'll find that…I mean, it's…to be a leader, maybe, eh, mm, if you, uh…it will take you long to understand something and then that particular mentor…mentorer [sic] should be able to be patient with you so that you can learn step by step and…until you…even though…even though you cannot take forever to teach someone but at least if we can also be patient.

Participant 2 Um, I also feel that clinic…I mean, mentoring, it should not be on, uh, managers only. It should be from auxiliary nurse to a [INDISTINCT – VOICE CLARITY – 00:20:40], enrolled nurse to an auxiliary nurse, professional nurse to an enrolled nurse. But the way it is happening, it is more on us, from our level to the A-S-D. Because when you go to the [INDISTINCT – VOICE CLARITY], okay, the operational manager will try and give support or mentor the professional nurse, but it also depends on their attitude.

Female Mm.

Participant 2 But then when it goes to the subordinates, now it becomes a problem. So, if we can put that also in our subordinates that they've got the responsibility to mentor people who are under them, like, um, P-N, enrolled, enrolled nurse to auxiliary nurse, then in that manner it eases the burden for the operational manager and you don't have to look for…I mean, mentor everybody in the ward because it…it's…there's a lot of rebel…the rebellion. But if people can be mentored accordingly, I think maybe there will be some improvement. And as an operational manager, I feel that it's not fair that you can mentor everybody in the ward. Yes, you've got your professional nurses, but the professional nurses must take it down to the enrolled nurses. Enrolled nurses must take it down to the auxiliary nurses. That…that…that's, ja, a recommendation.

Interviewer Any other input?

Participant 4 I think again i…if it can be continuously, because some other people…like, you can't grab a lot of things in…in a short period or what.

Female Mm.

Participant 4 So, if it can be continuously, it will be better.

Female Mm.

Interviewer Would you like to expatiate what you mean by saying about it should be continuous?

Participant 4 Like, i…i…i…it can be done e…e…e…each and every day [VERNACULAR – 00:22:33] …how can I put it? Like, eh, the…the week must not end wi…without, eh, teaching people something or what.

Participant 6 And in-service, like –

Participant 4 Ja.

Female Mm.

Participant 4 In an in-service form.

Female Mm.

Interviewer Thank you. Is there any other input that…oh, I saw you. You want to say something.

Participant 5 I wanted to add –

Interviewer Yes.

Participant 5 …mm, uh, there is this committee of ethics where we try to develop, I mean, our nurses to what professionalism, like, teaching them how to behave. Ethical issues that will prevent us from being…uh, to avoid litigations and what-what. So, we are trying to teach nurses about professionalism, how to behave as nurses, and then again that will also teach them how to become better leaders tomorrow…of tomorrow or future better leaders [INDISTINCT – VOICE CLARITY – 00:23:45].

Interviewer Is there any other thing that you would like to add regarding mentoring?

Participant 5 But sometimes you…you mentor a person who's…who's, mm, willing to learn. Sometimes it's difficult to for…to force someone to learn something that…because sometimes you'll…you'll arrange a…a…a climate me…I mean an in-service, people won't pitch. You find that you are in-servicing only two or three people meanwhile it's supposed to be a group of ten or twenty or… So, if at least people who can l…I think it will motivate people to come and…come for in-service training so that they can be developed, because you cannot force someone to…to learn if she is not or he is not willing to learn. But if you can encourage them. Hence, I'm saying we should be patient with them and…and continuous communication so that maybe they can understand or hear you one day…one day and come and learn and become better people. Because, you know, these days, it's…it's a problem, especially with these unions where

if…when you try to develop someone, the union will be…will be there. They'll…they'll even threaten you that they are going to report you to the unions. So, you are even afraid to discipline people because every time when we try to do something they will tell you about unions. Unions, unions. So, it's a challenge. It seems like people don't want to learn. People want…they don't…they want to do what…I mean, [VERNACULAR – 00:25:45] –

Participant 4 It's like if –

[CROSSTALK]

Participant 4 …if people can learn how to understand the policies and protocols, surely things will be easier because you…they end up doing things their own way.

Participant 5 Mm. Their own way, ja.

Participant 4 Ja. And a thing…they…like, those things end up being, like, personal.

Female Mm.

Participant 4 They do things personally. And then after sitting down with them, uh, eh, they understand the policies, the protocols, the procedures, that's when they…now they are aware of, eh, like, the things that we are doing is…it was [INDISTINCT – VOICE CLARITY].

Participant 5 But sometimes we…you can…you can even bring a protocol or policy but –

Female [INDISTINCT – BACKGROUND NOISE].

Participant 5 …as long as the union rep is not there, the person becomes so resistant and rebellious, so it is a problem. If we can also engage the union so that at least when they represent their…their…their –

Participant 2 But it depends when you engage unions if they are too representative of the union. Because sometimes people they claim that, um, this union…and then, remember, we need to understand one thing that being a shop steward it does not give you the power to bully people. You just –

Female Mm.

Participant 2 …a…a com…um, a person, a mediator, between the employer and the employee.

Female Mm.

Participant 2 If the employer's not doing right, you…you…you correct.

Female Mm.

Participant 2 If the employee is not going according to the policy…so, but it doesn't work like that. The in…the…the…the unions they are always right, and they are trying to prove the point –

Female Mm.

Participant 2 …that, um, we are just managers without any insight. I don't know but the basic. So, it depends even if when you engage those unions, are you engaging people who are fair? Are you engaging people who are willing to build? Are you engaging people who are willing to work?

Female Mm.

Participant 2 Because you can't be a shop steward in an environment where you are at home. You will become a shop steward…steward after signing the contract of employment. I'm sorry, my dear, ai, this union thing…

[INDISTINCT – VOICE CLARITY – 00:28:00]

Participant 6 So, on the other note, you…you know, like as you are saying, it's like now it's only that there's a lot of changes. Like this modern environment that we are…we are…we are living in, it's also bringing challenges in terms of, like, people think like they will use technology to do this, no more looking at things [INDISTINCT – VOICE CLARITY] based clinically so that they must, uh, [INDISTINCT – VOICE CLARITY] they must do according to what sister was saying, like, to understand what is happening around their environment. So, I…I mean, as, uh, leaders, as mentors, we must also, like in terms of acquaint ourselves [sic] to what people are…what challenges they are faced. I mean, as our…like, uh, those we are mentoring –

Female Mm.

Participant 6 …to check in terms of where they are. It can be as individuals or as in what is happening around them so that we also include [INDISTINCT – VOICE CLARITY] to be empowered with the understanding.

Female Mm.

Participant 6 Because when you look at it sometimes there's also a gap.

Female Ja.

Participant 6 They want to do it their way, especially even if those that come after us as professionals. It's like there is a gap in terms of us maybe now as leaders we are having…like, in terms of, you know, they will also give…like, labelling you as, like, you are from the old school, if ever you…you understand what I mean? They're coming with challenges of, like, things are done this way. So, when you come –

Female Mm.

Participant 6 …you want to mentor them [INDISTINCT – VOICE CLARITY – 00:29:30] so they challenge this thing. So, we need to also close that gap in terms of having a common understanding. Maybe the…the…the interaction and the…and the mentoring will come up where we…you know, we got the same sense of understanding so that it works better.

Participant 5 So, we…we must empower ourselves –

Participant 6 Also, again…not necessarily like we won't be knowledgeable. Just an understand on –

Female Mm.

Participant 6 …understanding, like, where are you coming from as –

Female Mm.

Participant 6 …like, a person that you are mentoring. Maybe we'll be also missing a point in terms of…that's why maybe there will be also sometimes of rebellious. I understand what you are saying also that there will, uh, you know, contribution of unions and things like that but more as an individual or that group that

whoever you'll be mentoring also, you know, understanding a background where we are coming from, what is your understanding? How can we meet others so that things can…we are able to achieve our objectives at the end? Equipping ourselves [sic] is also better –

Female Mm.

Participant 6 …. knowing more what is happening in the modern world.

Interviewer If there's nothing else, thank you for your inputs. I appreciate your time. And I think we have come to the end of this session. Thank you.

Group Thank you.

--- END OF AUDIO

Annexure R: Sample of interview transcript with assistant nurse managers

INTERVIEW WITH ASSISTANT NURSE MANAGERS: 03 MARCH 2020

Interviewer …have acquainted ourselves with the information leaflet. And take note that I'm going to be referring to you as participant A or B or C, as I have mentioned that your names are not going to be anywhere in this. I am going to be asking you a few questions and my first questions that I'm going to ask would be: how would you define leadership mentoring? Or maybe I put it in this way: how would you define mentoring in leadership? Anyone can start. I'm going to say it's participant A, B, C and then D, E, F. Participant E, you have –

Participant E It's providing…providing support, skill, and imparting knowledge to the subordinates [INDISTINCT – VOICE CLARITY – 00:01:10].

Interviewer Anyone wanted to add?

Participant F Providing guidance.

InterviewerThanks, participant F.

Participant F With regard to leadership skills.

Participant D I would say –

[CROSSTALK]

Interviewer…participant D.

Participant D …accompanying a new operational manager into the role as an operational manager, being the person that [INDISTINCT – VOICE CLARITY] practically to show her the ropes.

InterviewerParticipant C wanted to say something.

Participant C Yeah. I can say it's going through many process [sic] with the person, being there, supporting, and assisting and developing a person to be a leader.

InterviewerAnd what do you view as the characteristics or attributes of an effective leader and mentor?

Participant D He must be courageous.

InterviewerYes, participant D. Yes.

Participant F He must be knowledgeable.

InterviewerOkay. Yeah.

Participant A Enthusiastic. Knowledgeable.

Participant D Energetic.

Participant A Love what you do.

Participant C Patient.

Participant B Be a good listener.

InterviewerMay you repeat, participant D. I didn't hear.

Participant B To be a good listener.

InterviewerBe a good listener.

Participant C It should be somebody who's assertive and willing to walk the walk with the mentee.

Participant A It must be a motivating person.

InterviewerYes, A.

Participant A And your personality should be, um, very calm, um, have a non-judgemental attitude as a manager, be able…be open-minded, you know, in any situation. Um, very smart intellectually. And empower yourself with regards to management duties, management administrative, managing personalities. Because we as managers as well, we need to understand who we are in terms of our personality so that we understand other people's personalities and be able to manage situations.

Participant F And you must also be a good role model –

InterviewerYes, [CROSSTALK – 00:04:40].

Participant F …and a good communicator who is approachable and accessible because your…I don't know what to say. Should I say your, eh…the coming manager must be able to access you, must be there for you…or for them.

Female Mm.

InterviewerWhat leadership opportunities are available for the upcoming leaders in the institution?

Participant A I know the Sisulu [SP] one.

InterviewerYes, A.

Participant A On previously we used to have but now maybe the department will try and get something. But this…the Sisulu [SP] one can assist if all of us…especially the new ones and especially the operational managers, if they can attend such, um, programmes.

InterviewerIf I must ask, are you saying it is the one that is also available in the institution?

Participant A No. It's the one that is, um, conducted by the province.

InterviewerDo you want, participant D?

Participant D Do you want things that are available now in the institution?

InterviewerYes. You may add this…whatever is available in the institution.

Participant D In-service training programmes through our [INDISTINCT – VOICE CLARITY – 00:06:23].

Participant E There is one booked I think for next month with [INDISTINCT – VOICE CLARITY].

Participant B That is for mentoring.

Female Mm.

Participant B Ja, but it's something that… [INDISTINCT – VOICE CLARITY].

Participant F I think the other opportunity is, um, supervision of, like, students and other nursing categories at broad level.

InterviewerParticipant A, you wanted to say something before she added.

Participant A I think to be given an…the opportunity, you know, to present or to give in-service to others because as you do that you gain more knowledge in what you are presenting.

InterviewerIf I may ask how…oh, you wanted to…sorry. Participant E you wanted to add something. [CROSSTALK – 00:07:25].

Participant E Yeah, I also wanted to say that there's a platform where people who go and research come back and gave us feedback about their findings.

Participant F [INDISTINCT – VOICE CLARITY].

Participant E Ja, to conduct seminars.

Female Mm.

Participant F Oh.

Participant A And, actually, we need to have –

Female [CROSSTALK].

Participant A …um, something but it's something we have spoken in some of the people that we need to have been, um, allocated to do research in the hospital but it hasn't take off, but then maybe we need a group of people who have masters and then we can start it small and then people can present and be able to, mm…be able to be open or be able to communicate more often [INDISTINCT – VOICE CLARITY – 00:08:19] in presentation, you know, to grow their presentation skill [INDISTINCT – VOICE CLARITY]. 'Because I think it's what we need as managers to be very good in terms of presentation skills. Maybe it could be one of the characteristics that you would need as managers or the upcoming leaders.

Interviewer Thank you, participant A.

Participant D And also –

Participant E Uh, can I add also?

Interviewer Okay.

Participant D They are also [CROSSTALK] –

InterviewerLet D [INDISTINCT – VOICE CLARITY].

Participant D …platforms like, uh, morbidity and mortality as well as the, uh, serious adverse events where people that have cases in their wards present to anybody and new people that haven't been exposed [INDISTINCT – VOICE CLARITY] are invited to join such settings so that they can learn from people who have already, you know, experienced incidences in their wards. That is also a platform for development of, um, a new manager.

Female Mm.

Interviewer[CROSSTALK – 00:09:35] –

Participant E I wanted to also say the opportunity of taking over when the senior manager is not there, the relieving. The upcoming mana…the upcoming manager can take over when the senior manager is not present.

Female Mm.

Participant E And over the weekend and after four.

Participant D After hours.

Participant E There is…there is a manager who's always with the operational manager, working together, um, imparting knowledge and skills to the operating manager that you [INDISTINCT – VOICE CLARITY].

Female Mm.

InterviewerThank you. How were you mentored for the leadership position that you are in?

Participant D I was accompanied by a senior A-S-D for a period of say from July to April the following year, working together with her, doing rounds together in the wards, before I could be left to do things on my own and that exposed me to a lot of things. After about two months, she left me to do things on my own and I was reporting back to her.

InterviewerParticipant F, I saw you wanted to say something. Thank you.

Female Um.

InterviewerYes, participant B?

Participant B From my side, um, I think mentorship I got it, um, from my supervisor when, um, whether I submit something or something like, um, maybe the stats or…ja. And then, eh, I would be corrected, we will sit down, and I will learn from that. But, um, as to accompaniment, there was never, um, like, [INDISTINCT – VOICE CLARITY – 00:11:47] like going with my supervisor for a certain period. I was never.

Participant F I would say –

InterviewerYes.

Participant F I was…I was [INDISTINCT – VOICE CLARITY] I was actually mentored even before I will get to the…the post because I was given opportunity to relieve my senior when…in the absence of my senior. And, uh, when I'm in the position and they are always there for me to get guidance as question if where I don't understand so that I can know what I'm doing, so that I can be sure of what I'm doing.

InterviewerParticipant C, you wanted to add something. Oh.

Participant A I can just add to that, um –

Interviewer[CROSSTALK].

Participant A …I attended the hospital management course for…it was a six months' course, but it was more like a three-year course with the University of Wits, and I learnt a lot of things from there, leadership, leader management, finance management. A lot of, um, information that you go through in that course is very good. I wish the department can actually bring it back. But I think the Sisulu [SP] is similar to that one. And you get to present, you get to do homeworks [sic]. And I also…I was…I had an opportunity to be…have a mentor that worked with me for a year period. And ja, I learned more from that. But I'm talking about fifteen years story, if it's…it's information. [INDISTINCT – VOICE CLARITY – 00:13:54].

InterviewerThank you. What challenges are you experiencing in the leadership position that you are in? Yes, participant D.

Participant D Lately there is a lot of conflict between us and the people at the operational level due to interference of union members, so much so that what you say as

a manager is viewed sceptically until they hear from the…from the union rep. So, that's a recent challenge.

InterviewerIs that the only challenge that [CROSSTALK].

Participant E And there's also, uh, negative attitudes towards us.

InterviewerAre you saying negative attitude from you?

Participant E From the staff.

Interviewer[CROSSTALK]. Okay.

Participant E From the staff.

InterviewerCan you elaborate starting by the attitude from the staff, participant E.

Participant E Uh, as…as ma'am has said, maybe if be…if…if you go to the ward to supervise, if something's not done, let's say maybe something has happened in the ward and you try to correct the behaviour or what-what, the next thing is that the union member will be calling you, um. Like…like, whatever correction that you they took it as though you are punishing them. Like, most of the duties they don't think that it's theirs. They…they actually not sure of what they here for.

Participant D Uh, this interference of the unions, basically, [INDISTINCT – VOICE CLARITY – 00:16:05] a feeling of them and the us. We are no longer like in the past like a group of people working in these groups. There are them and the [INDISTINCT – VOICE CLARITY] and the us. So, so much so that that's…there's information that is according to them relevant to them and not for our ears. And that creates a lot of problems if there is…there are disciplinary cases that should be handled, that's where now you find that people are misinformed as far as procedures are supposed to be done in this hospital.

InterviewerMm. Thank you. As the assistant nurse managers, what are the challenges that you are facing regarding mentoring the upcoming leaders?

Female Okay.

Participant F I…I may say –

InterviewerYes, participant F

Participant F …some of managers, even if you want to empower them, they will feel that it is not their duty. They do not want to be empowered with the next level of employment. They will…they have this thing of it's not their duty which makes us to feel that, okay, they don't want to be empowered.

Participant C And the other thing is –

InterviewerYes, participant C.

Participant C …lack of information. Some of the managers are just working without knowledge of systems that are available. So, you…you have to guide somebody. It's like you start from the scratch. The systems that are available in the hospital are not known. Simple things like record-keeping, people don't know how to keep the records and if the manager cannot keep the records, it becomes a problem. How will the staff be able to keep these records?

Participant B I think, um –

InterviewerParticipant B.

Participant B …the lack of, um, [INDISTINCT – VOICE CLARITY – 00:18:28], uh, from the managers at times. Mm, because, eh, they will tell you about the mistakes that the subordinates are doing and, like, if you tell them that you…they need to discipline them then it becomes a challenge because of, uh, they can't tell them straight that you have did…done a mistake here, so I will discipline you. Because, you know, I…I think they are too much befriending the subordinates. So, ja.

InterviewerThank you. So, how can the mentoring in leadership, eh, be improved?

Participant C I think the best thing is consistency –

InterviewerYes, C.

Participant C … [CROSSTALK – 00:19:24] we…we…we are doing similar things, things that are consistent, unlike, uh, each one of us have got their own perspective on what they're doing. Because then it becomes a problem if you are to mentor a person and then next time whatever you went through with when he goes somewhere it's not the same as that. If we can have consistency with most of the things that we are supposed to do with our subordinates.

Interviewer[INDISTINCT – VOICE CLARITY] would you like to add something?

Participant A I think there's, um –

Interviewer[INDISTINCT – VOICE CLARITY].

Participant A …there's a light at the end of the tunnel when you look at the way things are done now. There's more of in-service training than, um, meetings whe…whereby we would have no activity logs, whereby we…we need to have interventions of what we've communicated. But now there's more of in-service training and they are more helpful in terms of that as a group, as managers, we go together and we talk the same language, we do the same procedure. So, it's…I think it…it is helping for the hospital. So, there's more mentoring. If there's more education than meetings, it actually elevates the…the understanding, the procedures, the…you know, us talking the same language as managers because we are a…a group of same people playing the same role. That's my understanding.

Participant F I think also –

InterviewerYes –

[CROSSTALK – 00:21:35]

Participant F …communication between the managers.

InterviewerThank you. Is there anything else that you would like to add regarding leadership mentoring? Yes, participant D.

Participant D No, I would say it's journey. It's not something that can happen overnight, and it needs a lot of commitment and a lot of patience from you as the mentor and a positive attitude on the part of the mentee.

InterviewerAnything else?

Participant A If you are –

InterviewerParticipant A.

Participant A …well-motivated, loving what you are doing, I think really, we can achieve our goals as managers working together, communicating, being consistent,

having same under…having the same understanding in terms of procedures, policies, you know, you will be able to work towards a common goal.

Participant C I think given –

[CROSSTALK – 00:23:35]

Participant C …that would be utilised universally by all of us, it may assist us in accomplishing the mentoring issue.

Participant E And I think that all –

[CROSSTALK]

Participant E …being mentored, we have to have feedback just to hear, um, how far am I being mentored? Am I getting there or not? Have some sort of a meeting together between a mentee and a mentor, just to check. And accept –

Interviewer[CROSSTALK] –

P1 …and maybe accept also constructive criticism either to a mentor or a mentee. It must be both ways.

InterviewerThank you for the inputs. If there's nothing else, I think we've come to the end of our session and thank you for your time.

Group Thank you.

--- END OF AUDIO ---

Annexure S: Language editing certificate

Exalt Strategic Consulting

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27 Feb 2024

To whom it may concern

This letter serves to certify that Ms. Moleboge Antonia Chabedi has submitted her thesis for professional language proofreading and editing. The work submitted by Ms. MA Chabedi has been thoroughly edited and proofread for language and clarity.

We recommend aligning the thesis with the institution's referencing style and formatting guidelines

Professor Claudia Sigamoney
0828224786

Annexure T: Technical editing certificate

Between the lines editing

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3 June 2024

To whom it may concern:

I hereby confirm that I formatted the layout of the thesis titled: "A CLINICAL LEADERSHIP-MENTORING FRAMEWORK FOR NURSE MANAGERS IN MENTAL HEALTH CARE SETTINGS". Any amendments introduced by the author hereafter are not covered by this confirmation. The author is responsible for ensuring the accuracy of the references and its consistency based on the department's style guidelines.

Leatitia Romero

Affiliations

PEG: Professional Editors Group (ROM001) – Accredited Text Editor
SATI: South African Translators' Institute (1003002)
REASA: Research Ethics Committee Association of Southern Africa (104)

Annexure U:Turnitin report

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