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SCHOOL OF NURSING

An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape

A minor dissertation submitted in partial fulfilment of the requirements for the degree

MASTER'S IN NURSING EDUCATION (STRUCTURED)

UNIVERSITY of the
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Date: December 2022

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Declaration

I, Adam John Petersen, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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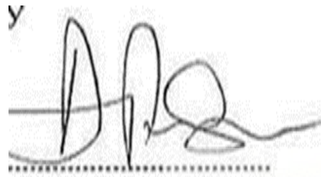

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Definitions and explanations of terms

Advanced Psychiatric Nurse

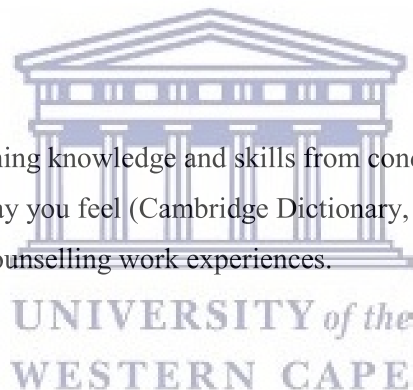
A nurse, registered with the SANC with an additional qualification in psychiatric nursing (South African Nursing Council, 2012). In this study, the APN will refer to psychiatric nurses who have completed a master's degree or post basic/postgraduate diploma in psychiatric nursing at a South African Higher Education Institution (HEI).

Counselling

Counselling, according to Peplau, is a process used by the APN to enable the person suffering from a mental disorder to fully understand and realise what at present is happening to him/her, in order for them to be integrated instead of being separated from life (Peplau, 1962). In this study, counselling will refer to psychotherapy and includes psychotherapeutic activities such as Cognitive Behavioural Therapy (CBT), Narrative Therapy, Group Therapy, Family Therapy, Gestalt Therapy, Motivational Interviewing, Structured Family Therapy, Parenting Skills Training, Assertiveness Training and Life Skills Training, where the APN incorporates Peplau's guiding principles through means of the nurse-patient relationship.

Work experiences

This refers to the process of obtaining knowledge and skills from conducting a particular task or from observation, that influences the way you feel (Cambridge Dictionary, 2019). In this study, work experiences refers to the APN's counselling work experiences.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List of abbreviations

APN:	Advanced Psychiatric Nurse
CBT:	Cognitive Behavioural Therapy
DOH:	Department of Health (National)
HEI:	Higher Education Institution
MDT	Multidisciplinary Team
P:	Participant
RN:	Registered Nurse
SANC:	South African Nursing Council
WCDOH:	Western Cape Department of Health

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// Abstract

Since the ground-breaking work of Hildegard Peplau, counselling is an essential competency of Advanced Psychiatric Nurses (APNs) all across the world. In South Africa, the teaching directives of the South African Nursing Council requires students to be competent in a number of therapeutic interventions, including specialised counselling techniques. Counselling is an essential job requirement of APNs in the Western Cape, and is much needed in the Western Cape, which has a high incidence of mental disorders, which cannot be met by psychologists in state psychiatric facilities. If they are properly utilised, APNs can provide counselling services to people who do not have access to these.

The aim of this study was to explore the counselling experiences of advanced psychiatric nurses, who have trained at HEIs in South Africa, working in state psychiatric facilities in the Western Cape.

Research design and methods

A qualitative research approach, through an exploratory descriptive design, was used. Through the non-probability sampling method, data was collected from participants, working at two tertiary psychiatric hospitals and two primary health care facilities in the greater Cape Town area. The data collected was analysed using content analysis to develop themes.

Ethical considerations

Ethical principles were strictly adhered to in this study as data was only collected once ethical clearance and permission had been obtained from relevant organisational entities. Participation in the study was voluntary and all information was kept confidential. Written informed consent was obtained and the right of withdrawal at any point explained. To ensure privacy and confidentiality, participants were anonymised and all personal information was delinked from the transcripts. All material was safely stored in a locked cabinet and on a password-protected computer, and will be destroyed after five years in accordance with the university data-management processes. Interviews occurred at a place and time when the APN was not required to engage in patient care. Support was available for any participant but was not required.

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Findings

Ten participants were interviewed, at which point data saturation was achieved. Four themes were generated: Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders; Institutional Barriers Affecting APN counselling experiences; Positive Experiences of APN Training Programme; and Positive Counselling Experiences, including six subthemes. Based on these findings, the researcher provided recommendations to Nurse Educational Institutions (NEIs).

Key words

Hildegard Peplau, Counselling, Qualitative Research, Advanced Psychiatric Nurse, Mental Health Nurses, Psychiatric Nursing, Psychotherapy, Biomedicalism

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To my colleagues, thank you for your support and flexibility. I am truly grateful.

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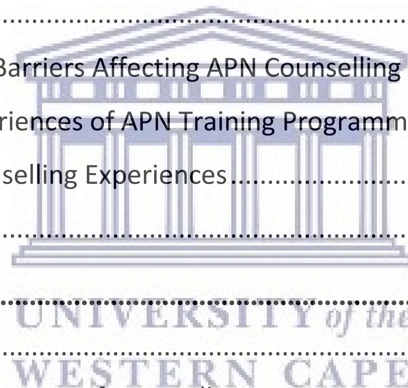
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Chapter 1
Introduction and Background

1.1 Introduction and background

Counselling has become a core function of mental health nurses worldwide, since the pioneering work of nurse theorist Hildegard Peplau in the 1950s (Wesemann, 2019). Peplau is recognised worldwide for her work in steering mental health nursing away from the custodial care model and in the direction of counselling, which garnered much respect and critique from other health professionals (Adams, 2017).

Traditionally, advanced psychiatric nurses (APNs) have placed a high priority on Peplau's therapy-based model as a framework for the nursing treatment of all mental health disorders (Peden, 2018). There is, however, growing concern among contemporary international mental health nursing scholars as to whether counselling remains at the core of advanced psychiatric nursing education and practice and whether there is an actual need for APNs in the health sector (Gabrielsson et al., 2020; Hemingway, 2016). These concerns are directly linked to the decrease in university-based training programs for APNs, confusing roles of the APN within the multidisciplinary team (MDT) (Terry, 2020), poor institutional management leadership (Lakeman & Molloy, 2018), biomedicalism and hostile political policies towards APNs (Hemingway, 2016). These issues impact the APN's core role of counselling (Lakeman & Molloy, 2018).

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Advanced Psychiatric Nurses (APNs) are mental health/psychiatric nurses who have further/advanced education and training in specialist skills such as different counselling approaches and in some countries have limited prescribing powers. APNs are referred to as Psychiatric-Mental Health Nurse Practitioners (PMHNPs) in the USA, Advanced Practice Psychiatric Nurses (APPNs) in Canada (Jackson, 2019) and Mental Health Nurses in the UK and Australia (Hemingway, 2016). Training also differs across countries (Hemingway, 2016).

1.2 Advanced Psychiatric Nursing in South Africa

In South Africa, counselling training was included in the one-year R212 post-registration in Advanced Psychiatric Nursing (SANC, 1993). Entry into a post-registration programme

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required registration as a professional nurse with SANC. Entry into a structured master's programme at HEIs was an alternative route to the qualification and required a bachelor's degree in nursing or honours degree (UWC, 2019). The master's programme offered students the benefit of master's degree with the additional Advanced Psychiatric Nursing qualification. Both groups could register with the SANC for an additional postgraduate qualification (SANC, 2018).

Counselling is an essential competency of APNs in South Africa. The SANC teaching directive for APN programmes requires students to be competent to conduct a number of therapeutic interventions, including individual and group therapy, case management and family therapy sessions (SANC, 2005).

The Western Cape has the highest 12-month and lifetime prevalence rate (39.4 percent) of all mental disorders in South Africa (Jacobs & Coetzee, 2018; SACAP, 2019). There are not enough clinical psychologists in the public sector to deal with this crisis. De Kock and Pillay (2016) reported that the national rate of clinical psychologists in the general population is 2.6 per 100 000). Only 43.4 percent of these clinical psychologists are employed in the public health sector (Bantjes et al., 2016). The estimated national rate of psychiatric nurses is 9.7 per 100 000 (De Kock & Pillay, 2016). There are therefore more psychiatric nurses employed in the public health sector compared to the number of clinical psychologists. In the Western Cape, there are currently only 265 professional nurses occupying advanced psychiatric nursing posts in state psychiatric facilities (Makie, 2020). The job description of these APNs in all three psychiatric hospitals in the Western Cape states that 30 percent of work activities must consist of therapies such as Family Therapy, Individual therapy, Gestalt Therapy, Narrative Therapy, Crisis intervention, the implementation of psycho-social rehabilitation (PSR) and Group Activities (Appendix F). Although their numbers are relatively small, if these APNs are used effectively, they can assist psychologists to address this need.

1.3 The researcher's personal interest in the study

As I embarked on this journey of completing a research study towards a master's degree, it was important for me to engage in a field of study that was relevant to me as an educator and advanced psychiatric nurse. Johnson et al., (2020) asserts that the formulation of a research question is prompted by the researcher's own experience or living environment. In my role as associate lecturer in the advanced psychiatric nursing programme at a Nursing Education

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Institution (NEI), I was curious as to whether graduates of APN programmes in the Western Cape had opportunities to conduct counselling in their workplace and what challenges were associated with counselling. This interest led to the current study, which aimed to describe the counselling work experiences of APNs employed at state mental health facilities in the Western Cape, who have obtained a post basic/postgraduate qualification in Advanced Psychiatric Nursing in South Africa.

1.4 Problem statement

There is a need for counselling in South Africa, especially the Western Cape. The specialised counselling training of APNs enables them to provide counselling services to lower income populations. Limited information about the counselling experiences of APNs exists in lower-middle income countries (LMIC) such as South Africa, and no published studies exist on the counselling practices of South African trained APNs working in government psychiatric facilities in the Western Cape.

1.5 Aim and objectives

The aim of this study was to explore the counselling experiences of advanced psychiatric nurses, who have trained at HEIs in South Africa, working in state psychiatric facilities in the Western Cape.

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Objectives

- To explore the counselling training of APNs
- To explore the self-reported counselling skills of APNs
- To establish APNs' experiences regarding opportunities in their workplace to do counselling
- To promote awareness of APNs' counselling experiences through the publication of findings

1.5.1 Research Question

What are the counselling experiences of advanced psychiatric nurses, who trained at HEIs in South Africa, working in state psychiatric facilities in the Western Cape?

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1.6 Significance of the study

As far as can be established, this study is the first conducted that has explored the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape. This study offers insight into APNs' experiences of their counselling practices and the challenges experienced related to counselling. The findings from this study may inform nursing management, APNs themselves and HEIs offering postgraduate programmes in mental health nursing.

1.7 Overview of the study

In **Chapter one**, the researcher provides the reader with an introduction to the study, background information related to the research topic, including the research aims and objectives. In **Chapter two**, the literature review focuses on international and national and literature pertaining to the research topic. **Chapter three** describes the research methodology: research design, research setting, study population and sampling, recruitment of participants, data collection and data analysis. Trustworthiness strategies and ethical considerations are also discussed.

Chapter four presents the reader with findings and the subsequent themes and sub-themes that emerged from the content analysis process. In **Chapter five**, the study findings are discussed in relation to the literature. **Chapter six** concludes the study with a summary of the main findings, study limitations and recommendations.

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1.8 Conclusion

This chapter provided background information to enable the reader to have an understanding of the origins of advanced psychiatric nursing, including factors that affect the profession locally and abroad. The problem statement, aims, objectives and significance of the study were also described to enable this process. The following chapter will provide more in-depth information of the research topic through a literature review.

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Chapter 2
Literature Review

2.1 Introduction

A literature search was conducted using the keywords: mental health nursing, advanced psychiatric nursing, psychiatry, counselling, Hildegard Peplau, biomedical, nurse patient relationship, interpersonal relations theory, mental health nurse education. Databases used were Google Scholar, Sagepub, Ebscohost, PubMed, Wiley Online Library, JSTOR, Semantics Scholar, Sage Journals and Europe PMC database. Key early seminal texts from the 1960s have been included in this review as these provide context and valuable background to the research topic. This narrative review is presented in themes.

2.2 Development of Advanced Psychiatric Nursing

Peplau's interpersonal relations nursing theory and the first master's programme for mental health nursing in the 1950s have engendered real change in this nursing speciality (Adams, 2017). Trained in psychotherapy, recognition from the American Psychiatric Association of these nurses as licenced psychotherapists soon followed, despite initial resistance from psychiatrists and psychologists (Wheeler, 2014). Psychotherapy or counselling has since become the hallmark of APNs across the world (Gabrielsson et al., 2020; Wesemann, 2019; Wesemann & Handrup, 2021). In South Africa, ten nurses first received basic training in mental health nursing in 1904 (Minde, 1977). In 1965, the SANC introduced the category of psychiatric nurse that was a three-year training programme (Minde, 1977). Students completed courses in biology and natural sciences, psychology, social sciences and recreational therapy (Minde, 1977). The first master's and doctoral programme in advanced psychiatric nursing was established in 1976 (Minde, 1977). The advanced psychiatric nurses who completed their master's programme in the 70s were reputed to be well skilled in therapeutic practices such as counselling (Minde, 1977).

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2.3 Peplau's approach to counselling

Peplau (1962) used the words counselling and psychotherapy interchangeably. She argued that despite resistance from other mental health disciplines and psychiatric institutions to the notion of a nurse conducting psychotherapy, it remains the core of advanced psychiatric nursing (Peplau, 1986). This view is still upheld by the National Organisation of Nurse Practitioner Faculties (NONPF) in the USA (McCoy, 2018). Peplau considered counselling as an interpersonal process between the nurse and the patient and warned that it must never be seen or used by the psychiatric nurse as mere psychological tricks or techniques obtained from a textbook (Peplau, 1962). For Peplau, the first rule in counselling was that the psychiatric nurse realise that he/she is the main instrument of therapy (Peplau, 1986). Peplau's Interpersonal Relations theory (IPR), developed in the 1950s, became the theoretical framework of choice for nurse counselling. This framework emphasises the use of communication skills such as empathy, sympathy and listening, which became the basis of the nurse-patient interpersonal relationship, fundamental to counselling. Throughout her career, she voiced concern that there was a growing focus on biomedical approaches to care and not counselling (Peplau, 1995).

2.4 Current advanced psychiatric nursing education and training in counselling

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APN training globally is in a constant state of change. Changes that have occurred have sometimes been positive (Delaney, 2017) but other changes have negatively impacted the profession (Lakeman & Molloy, 2018). In 2017, Vanderhoef and Delaney (2017) conducted a survey of 118 postgraduate APN programme directors in tertiary institutions. They found that 45 of these programmes offered psychotherapy theory as a separate module, whereas the others integrated psychotherapy into the coursework (Vanderhoef & Delaney, 2017). Also reported was that 53 programmes required students to complete at least 200 hours of psychotherapy practice (Vanderhoef & Delaney, 2017). This is in contrast to an earlier study, which reported that the majority of APN training programmes in the US focused primarily on physical assessment, neurobiology and psychopharmacology and not enough psychotherapy (Bjorklund, 2003). Wheeler and Delaney (2008) also expressed concern that although students were exposed to individual therapies such as Cognitive Behavioural Therapy, Gestalt and Narrative therapy in their training, the limited number of hours allocated to these

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psychotherapeutic interventions prevented graduates from acquiring meaningful counselling knowledge and skills. Although some problems still persist at present in some US APN programmes (Wesemann & Handrup, 2021), these issues are minor as counselling has recently begun to feature more prominently again in US APN academic programmes (Vanderhoef & Delaney, 2017).

In the United Kingdom (UK), negative changes in the training of mental health nurses have been reported, ascribed to policies based on political ideological austerity (Hemingway, 2016). Hemmingway (2016) argued that the curriculum of nursing educational programmes emphasised physical health, which would ultimately result in mental health nurses being ill-prepared and not ready for clinical practice.

Mental health nurse training in Sweden has also been challenged by the Swedish government's recommendation that advanced specialist nurse training follow a predominantly biomedical approach, to help address the shortage of doctors in the country (Gabrielsson et al., 2020). Despite reported discriminating policies (Lakeman, 2021), mental health nurses in Australia remain extensively trained in conducting psychotherapy for people with minor and major mental illness (Hurley et al., 2020a, 2020b).

Literature pertaining to the training of APNs in Africa is outdated and scarce, and not informative for the current study. Terakye and Olaf (2007) and Adejumo and Ehlers (2001) have described the curricula of APN training programmes in Turkey, Nigeria and Botswana.

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2.5 Specialist/advanced psychiatric nursing training programmes in the Western Cape

Three higher education institutions (HEIs) in the Western Cape currently offer postgraduate/post-basic programmes in advanced psychiatric nursing. One NEI in the Western Cape that offers a Diploma in Advanced Psychiatric Nursing includes counselling as an integral component of the one year programme (Van Wijk, 2019). In two universities in the Western Cape, the coursework in Advanced Psychiatric Nursing includes modules on child, adolescence and adult mental health and mental illness. Counselling techniques are taught in practical sessions (Startuniversity, 2022; UWC, 2019).

The SANC directives on education standards prescribe that course outcomes meet the needs of a population (SANC, 2020). Theoretical and practical learning must be based on

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competencies that are rooted in evidence-based research (SANC, 2020). Berry et al. (2022), Kline et al. (2019) and Linardon et al. (2020) have all conducted studies demonstrating the efficacy of counselling. The inclusion of counselling into the curriculum of APN programmes in the Western Cape therefore adheres to SANC programme standards.

2.6 Counselling practices of advanced psychiatric nurses

Studies on the counselling practices of APNS have been reported from mainly higher income countries. In a US survey conducted by Delaney et al. (2019), 65% of the APNs reported that they conduct a variety of counselling services in their work place, of which CBT was most used. Counselling approaches also used by APNs were crisis therapy, group psychotherapy, couple therapy, family therapy and child psychotherapy (Delaney et al., 2019). APNs in the US have a wider scope of practice than in other countries and have prescribing powers for psychiatric medication in 22 states. In the Czech Republic, APNs are only permitted to offer supportive counselling (Ward, 2012), and in the UK, APNs offer mainly behavioural psychotherapy (Ward, 2012). Iranian psychiatric nurses have an extremely limited scope of practice and very little counselling experience, and may not even provide psychoeducation to patients (Ramezani et al., 2017). In contrast, Irish psychiatric nurses have a wide scope of practice, which includes counselling approaches such as Goal Setting Therapy, CBT, Motivational Interviewing, Anxiety Management and limited Dialectical Behavioural Therapy (DBT) (Cusack et al., 2016). In Japan, psychiatric nurses conduct CBT with hospitalised patients with schizophrenia (Tanoue et al., 2018).

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There is very limited information about lower-middle income countries (LMICs) such as South Africa; and no studies conducted on the counselling practices of advanced psychiatric nurses who trained in South Africa, working in state psychiatric hospitals have been published.

2.7 The value of advanced psychiatric nurses' counselling skills in the treatment of mental disorders

There is growing worldwide concern over the increasing number of people affected by mental illness and the estimated cost of sixteen trillion US dollars required by 2030 to address the need (Wesemann, 2019). For this reason, leading scholars in psychiatric nursing

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across the globe argue that APNs are competent and efficient enough to address this need (Delaney, 2017; Hurley et al., 2020a, 2020b; Wesemann, 2019). To address the burden of mental disorders in the Western Cape (Jacobs & Coetzee, 2018), and with the shortage of psychologists (Bantjes et al., 2016), South African APNs, trained in counselling, can effectively be utilised to provide specialised counselling services to people suffering from mental disorders.

2.8 Conclusion

In this literature review, the researcher discussed the development of advanced psychiatric nursing. The importance of Peplau's approach to counselling was looked at in order to determine if current APN training, internationally and locally, still adheres to these principles. The value of APNs' counselling skills in the treatment of mental disorders was also briefly reviewed. The next chapter will describe the research methodology used for this study.

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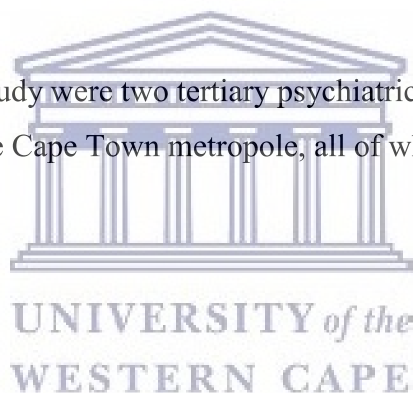
Chapter 3
Research Methodology

3.1 Research design and approach

This study utilised a qualitative descriptive approach (Doyle et al., 2020) to explore and describe the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape. A qualitative research approach was best suited to this study as qualitative research seeks to describe and understand a phenomenon (Nassaji, 2020). Research participants were able to describe their counselling experiences in their own words, and provide the researcher with clear descriptions and in-depth knowledge.

3.2 Research setting

The research settings for this study were two tertiary psychiatric hospitals and two primary health care level facilities in the Cape Town metropole, all of which have APNs on their personnel.



3.3 Study population

The population was SANC registered advanced psychiatric nurses who had completed the R212 programme at accredited South African higher education institutions (HEIs), employed at the state psychiatric facilities mentioned above. APNs in South Africa graduate with one of two options, both of which lead to registration with the SANC – a Master's degree in Psychiatric Nursing or a Postgraduate Diploma in Advanced Psychiatric Nursing Science (SANC, 2018).

3.4 Sampling

A non-probability sampling method was used for this study where the researcher purposefully selected APNs (Saunders et al., 2018). The two tertiary hospitals selected were diverse in settings and patient population. A combination of convenience and snowball sampling was

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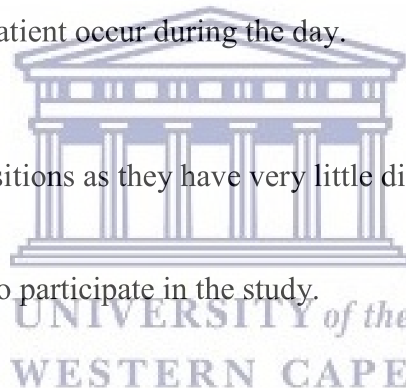
used. One participant at each facility who met the study criteria was purposively invited to participate. If they agreed to participate, they were then asked to inform other APNs about the study, and invite them to contact the researcher for more information; in alignment with the snowball sampling method (Parker et al., 2019). In determining the number of participants sufficient in qualitative studies, qualitative researchers are guided by the criterion of information redundancy (Vasileiou et al., 2018).

3.4.1 Inclusion criteria

- APNs working in the selected state tertiary and primary health care facilities
- APNs who possess an additional qualification in Advanced Psychiatric Nursing from a SANC accredited HEI in South Africa
- APNs who had at least one-year of post-qualification clinical work experience, to ensure that participants were able to reflect on their counselling experiences in the workplace
- APNs who were working day shift, as the majority of counselling interactions between the APN and patient occur during the day.

3.4.2 Exclusion criteria

- APNs in managerial positions as they have very little direct contact with mental health care users
- APNs who elected not to participate in the study.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3.5 Gaining access

Ethical clearance was obtained from the University of the Western Cape's Humanities and Social Science Research Ethics Committee (HSSREC) (Appendix C Ref: HS20/21). Permission to conduct the study was obtained from the Western Cape Department of Health (WCDOH), via the National Health Research Database (NHRD) (Appendix D, F & G Ref: WC 202103 007). The researcher also applied to the City of Cape Town to gain access to community health clinics, which was approved (Appendix E Ref: 28251). Once approval was obtained, the researcher contacted the Nursing Directors of the facilities via email to request permission to have access to APNs (Appendix H). These participants then contacted other APN colleagues at their facilities or provided contact numbers for these colleagues. Those

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who agreed to participate were asked to indicate a time and venue convenient to them for the interview.

3.6 Development of the interview guide

The interview guide was developed on the basis of allowing participants to first answer a general question, followed by core questions (sub-questions) and planned follow-up questions (DeJonckheere & Vaughn, 2019). The primary question ('Can you tell me about your counselling experiences as an advanced psychiatric nurse at this facility?') provided the participants with an opportunity to begin speaking broadly of their counselling experiences (DeJonckheere & Vaughn, 2019). Core questions (sub-questions) were developed to answer the research question and to explore the topic comprehensively (DeJonckheere & Vaughn, 2019; Kross & Giust, 2019). For example, sub-question one ('Can you please describe to me what types of counselling are offered to patients at this facility? I am referring to interventions such as individual therapy, group therapy and counselling, among others?') was based on research objective two. Sub-question two ('Can you tell me about the type of counselling/therapeutic interventions you were trained in during your APN programme?'), was based on research objective one, and question three on objective three. These questions provided the researcher with descriptions of APN training, counselling opportunities in their workplace and challenges related to counselling. Follow-up questions were used spontaneously when more detail of aspects related to core questions was required (DeJonckheere & Vaughn, 2019). For example, if a participant broadly described their APN training, specific questions were then asked to provide detailed information about aspects related to their training, such as lecturer teaching strategies and theoretical and clinical learning. This enabled the researcher to gather rich information, which provided deeper insight and understanding of their experiences.

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3.7 Pilot interview

An pilot interview was conducted with an APN at a tertiary facility to check the questions in the interview guide and determine the required length of the interview. The interview lasted 30 minutes. Afterwards, the researcher rephrased some guiding questions and sub-questions, but the substance of the questions did not change. The pilot also confirmed that 30 minutes

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was ample time to obtain enough information. The data from the pilot interview was used in this study.

3.8 Data collection

The researcher conducted semi-structured interviews, using an interview guide, as described in 3.6 (DeJonckheere & Vaughn, 2019; Simister, 2017), as this allowed the researcher to fully engage with the participants (Appendix B). The interviews were conducted in English (language of communication at facilities) (Angus, 2019) during APN lunch breaks or weekends so as not to interfere with patient care. The interviews were audio-recorded with the permission of the participants. The researcher ensured that the recording devices were fully charged and in working order prior to the commencement of each interview. Data collected from the pilot interview was included in this study. Ten APNs were interviewed, at which point data saturation was reached: eight APNs from two tertiary psychiatric hospitals in the southern Cape Town and two APNs from two Community Health Centres (CHCs). Seven participants were interviewed face to face at their places of work, with all Covid-19 protocols adhered to. Three participants preferred telephonic interviews to minimise any disruption at their work place or home. Interviews lasted approximately 30 minutes each.

3.9 Data management

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The interviews were transcribed verbatim by the researcher and stored electronically. Interviews were coded to protect participants' identity. Recordings of interviews were stored on a password-protected computer and university Google Drive folder, to which only the researcher and supervisor had access. All electronic and hardcopy documentation such as written consent was stored in a locked cupboard at the researcher's residence (Brink et al., 2012). The research data will also be stored on the university's Research Data Management system after this study is published to ensure that it is managed correctly, secure and accessible (UWC, 2021). All data will be destroyed after five years.

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3.10 Data analysis

Content analysis was used to analyse the transcripts (Erlingsson & Brysiewicz, 2017). Content analysis relies on the intuition, reflection and bracketing of the researcher; the researcher will read each interview transcript multiple times. Vaismoradi et al. (2013) further distinguish content analysis from other qualitative approaches such as thematic analysis. This approach allows the researcher to systematically code huge amounts of textual data to determine tendencies and motives in participants' words, the frequency of these words and how they link with each other (Vaismoradi et al., 2016; Vaismoradi et al., 2013). Content analysis and determining the meaning units (main points of what participants said) create clarity of themes (Erlingsson & Brysiewicz, 2017). The meaning units were condensed (Erlingsson & Brysiewicz, 2017) and each condensed meaning unit was given a code. Codes were categorised and finally grouped into themes (Erlingsson & Brysiewicz, 2017).

As an advanced psychiatric nurse, the researcher had to bracket personal biases that may have influenced the interpretation of participant descriptions. To ensure rigor, the researcher minimised abstraction and utilised an inductive approach where the codes were directly derived from the text (Vaismoradi et al., 2013). To ensure the researcher analysed data systematically, the researcher followed the steps of Vaismoradi et al. (2016):

Initial Step

The researcher repeatedly listened to each interview in order to gain a sense of what participants were saying, relating it to the research question. Each interview was then transcribed verbatim and units that were meaningful were underlined (Vaismoradi et al., 2016). Codes were generated through abstraction. Conceptual codes, the process of minimising large amounts of information into smaller sections, while still conveying the participant's original meaning, were generated (Vaismoradi et al., 2016). Caution was maintained not to over-analyse extracted units as this would have resulted in the codes being too abstract, too general and a deviation of what participants were describing (Lindgren et al., 2020). An exemplar of this process to demonstrate the rigor is presented in Appendix H. The researcher made reflective notes throughout this process to also maintain an audit trail of trustworthiness (Vaismoradi et al., 2016).

Construction Step

Fully immersed, the researcher analysed transcripts and classified codes, making use of typification or categories, which generally group all relevant or similar codes under one

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description. Similar or closely related codes were colour coded. Comparison of codes enabled determination of repeated patterns. When a repeated pattern was determined, a relevant theme was identified, as it is generally understood that the increase of the frequency of a category of code in transcript texts suggests a legitimate theme (Vaismoradi et al., 2016). The theme was then labelled, employing the researcher's understanding of codes, using simple phrases in order for the information to be clearly transferred to the reader (Vaismoradi et al., 2016).

Rectification Step

During this stage the researcher purposefully engaged in immersing and withdrawing from data analysis at regular intervals. This 'distancing' is recommended as a means of enabling the researcher to look critically at generated findings and is a continuous process of going back and forth to ensure the themes are trustworthy (Vaismoradi et al., 2016). This technique allowed the researcher to rectify incorrect single codes, adjust categorised codes and develop clearer and appropriate theme labels.

Stabilisation Step

The description of themes and sub-themes was a very important aspect. The tendency in most qualitative studies is just to present themes and sub-themes without providing a clear description of how they relate to each other (Vaismoradi et al., 2016). Detailed descriptions of themes and how these may link with sub-themes are offered.

Finalisation Step

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Developing a 'story line' in a coherent, interesting narrative is important in qualitative research. Themes are presented in the following chapter in a logical, creative manner.

3.11 Ethical considerations

The researcher adhered to the principles of beneficence, informed consent, safeguarding privacy of research participants and confidentiality (justice), and non-maleficence as outlined in the Helsinki Declaration (Shrestha & Dunn, 2020; WMA, 2013), which also aligns with the University's ethical guidelines (UWC, 2015). Participation in the study was voluntary and all information was kept confidential. Written consent was obtained from all participants (Appendix A). The anonymity of participants was maintained during the recording of interviews and they were referred to as Participant 1–10. The facilities in which they worked have also not been disclosed. Transcripts also contained no personal information of the

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research participants and were labelled, e.g. P1- Coded Transcript. Information about the study was emailed to the participants prior to each interview for their perusal, whereafter written consent was obtained (Moriña, 2021). The researcher also emphasised, before and at the beginning of each recorded interview, that participants should not be pressured to participate and if they felt at any point (even after the interview) the need to withdraw from the study, they could, and that none of their data would then be used in the final thesis. All hard documents, e.g. consent forms, were safely stored in a locked cabinet. All electronic documents were kept on a password-protected computer and the university Google Drive Folder to which only the researcher and supervisor had access. Non-maleficence was achieved by conducting the interviews at a time when the APN was not required to engage in patient care. Arrangements were made for participants who may have required support from issues surfacing during the interview to be referred to appropriate services for employee assistance (ICAS services) (ICAS, 2021). This was, however, not found to be necessary.

3.12 Ensuring scientific rigor (Trustworthiness)

The principles of trustworthiness in a qualitative study refer to the researcher ensuring credibility, transferability, dependability and confirmability of the study (Schurink et al., et al., 2021). For a qualitative study to be credible, the findings must be a true representation of the phenomenon that was investigated (Nassaji, 2020). To achieve trustworthiness, the researcher ensured that coding was not too abstract and was a true reflection of the participants' words and meanings (Lindgren et al., 2020), thus ensuring credibility (Appendix K). Five selected participants were asked to read the transcripts of their own interviews, to determine if they agreed with the truthfulness of the transcription (Johnson et al., 2020). The researcher received no objections from participants.

Findings in qualitative studies are not generalisable, however, efforts were made to ensure that the findings of the study were transferable (Nassaji, 2020). These efforts included selecting more than one research setting where APNs were employed. The sample size of ten was the point where data saturation was achieved, which is commonly agreed to indicate rigor in the data collection process (Johnson et al., 2020).

Confirmability, which focuses on whether other researchers are able to confirm the findings and conclusions reached in a study (Nassaji, 2020), was enabled by sharing interview guides, all recorded interviews, transcripts, coded transcripts, and documentation of the process of

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theme development with the research supervisor who is an experienced qualitative researcher. Exemplar of a transcribed interview (Appendix M), reflection notes (Appendix K) and summary of all participants' coded transcripts (Appendix L) are included in as an audit trail (Johnson et al., 2020).

Dependability, which focuses on having other researchers reaching the same conclusion as the author of the study (Nassaji, 2020) was enabled by the researcher by including relevant documentation, e.g. interview guide and exemplars of coding/theme development, in the appendices (Appendices K & L). To ensure further dependability, the researcher's supervisor, who is an experienced qualitative researcher, examined the codes, themes and sub-themes. The researcher, as an APN and educator, needed to be reflexive in his stance towards the data in order to minimise possible bias (Johnson et al., 2020). This was achieved by continual critique and guidance from the supervisor throughout this research project. Where bias was apparent, the researcher was advised to follow a different approach in order to be more objective. This guidance was accepted which significantly reduced possible biases.

3.13 Conclusion

This chapter provided a description of the research methodology used in this study. The next chapter will present the findings of this study.

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Chapter 4
Presentation of Findings

4.1 Introduction

In this chapter, the themes and categories generated through the data analysis are presented. Ten participants were interviewed. Extracted quotes from participants are presented as substantiation of the themes and subthemes. Clarifying phrases in brackets […] where the APNs used psychiatric jargon are included for context.

The demographics characteristics of the participants are presented in Table 1. To protect personal information of participants and links to facilities, participants are coded as P1–P10 and facilities similarly coded as tertiary (T1/T2) and primary level (CHC1/CHC2).

Table 1: Participant Demographics

Participant	Health facility	Gender	Unit type	NEI	Qualification
P1	Tertiary 1	Male	Acute Ward	College	Diploma in Advanced Psychiatric Nursing
P2	Tertiary 1	Female	Acute/ Medium Ward	College	Diploma in Advanced Psychiatric Nursing
P3	CHC 1	Female	CHC	College	Diploma in Advanced Psychiatric Nursing
P4	Tertiary 2	Male	Semi-acute	College	Diploma in Advanced Psychiatric Nursing
P5	Tertiary 2	Female	Acute/ Medium Ward	University	Diploma in Advanced Psychiatric Nursing
P6	Tertiary 1	Female	Semi-Acute	University	Master's Degree in Advanced Psychiatric Nursing
P7	Tertiary 1	Male	Acute Ward	College	Diploma in Advanced Psychiatric Nursing
P8	Tertiary 1	Female	Acute/ Medium Ward	College	Diploma in Advanced Psychiatric Nursing
P9	Tertiary 1	Male	Acute ward	College	Diploma in Advanced Psychiatric Nursing
P10	CHC 2	Female	CHC	College	Diploma in Advanced Psychiatric Nursing

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The most common counselling experiences of participants as identified from their descriptions are Marital, Family & Motivational interviewing, Bereavement, Supportive Interviewing, Group Therapy, Containment Therapy & CBT (Table 2).

Table 2: Participants' Counselling Experiences

Participant	Counselling experience
P1	Motivational & Supportive Interviewing, Group Therapy, CBT
P2	Motivational & Supportive Interviewing
P3	Group Therapy, Motivational & Supportive Interviewing, Couple Therapy
P4	None
P5	Marital, Family, Motivational Interviewing, Bereavement, CBT (occasionally)
P6	Sub-minimal
P7	Motivational & Supportive Interviewing, Family Therapy
P8	Group Therapy, Motivational & Supportive Interviewing
P9	Group Therapy
P10	Containment Counselling, Motivational Interviewing

Most of the participants provided some counselling activities to patients with mental disorders in their respective work settings; however, these experiences are varied and affected by many factors.

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4.2 Themes

Four themes emerged from the rich descriptions of APN participants regarding their counselling experiences: Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders; Institutional Barriers Affecting APN Counselling Experiences; Positive Experience of APN Training; Positive Counselling Experiences. The themes and subthemes are outlined in Table 3.

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Table 3: Themes and Sub-themes

Theme	Sub-themes
1. Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders	• Constraints affecting counselling role • Unrecognised APN counselling skills by MDT and relinquished APN counselling role • Underutilised counselling skills due to administrative duties
2. Institutional Barriers Affecting APN Counselling Experiences	• Settings with minimal counselling opportunities (acute psychosis, pragmatism and biomedical approach to care) • Workspace • Staff shortages
3. Positive Experiences of APN Training Programme	• Comprehensive specialist counselling exposure during APN training programme • Balanced theory, practice and assessment
4. Positive Counselling Experiences	• APN enabled patient recovery

4.2.1 Theme 1: Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders

Counselling interactions with patients for most participants was limited, as explained by this participant, *"I normally just do a brief counselling and if needed, containment counselling"*, (P10, female, CHC2). Participants found it difficult to find sufficient time due to shift work, short patient stays, *"…You just started to work with a client, tomorrow I am off, the next day the client is gone. So where is my time where I actually initiated this relationship with my client, where I can actually terminate the whole uh therapy session with my client."* (P2, female, T1). Despite these constraints, participants attempted to follow up their patients, *"…but I at least try to take a group and follow them up over a two-week period to do that with them... during this time it was extremely challenging to do your groups and stuff like that."* (P1, male, T1).

The range of counselling interactions with patients was limited and more general than specialised; *"I do a bit of counselling also in my assessment with the patient*" (P3, female, CHC1). Only two participants (P1, male, T1; P5, female T2) conducted CBT as part of their patient care. Motivational interviewing was however, more frequently used in counselling.

Participants described several factors, that contributed to their limited opportunities to use their counselling expertise.

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4.2.1.1 Constraints affecting counselling role

Participants frequently mentioned not having enough time to do counselling. *"Yah, like a said in the beginning, it's… it's just frustrating that…. we don't have the time"* (P2, female, T1). This led to some frustration in not being able to do what they were trained to do, as explained by this participant:

"*It does really take your time… we don't really have enough time to at least sit and do the things you were trained in, so the hours in the day is not enough to all those things. I have one patient, you would say maybe twenty minutes you can speak to that patient for the day, like really that is not enough time, to reach our clients and to do counselling with all the clients in the ward, because you have so many other…"* (P5, female, T2).

This participant felt confident to offer a range of counselling techniques but was constrained by lack of time: *"…I think I am very well confident in my ability to be able to do it, but like I said, the circumstances and the time frame is just doesn't allow stuff like that…"* (P8, female, T1).

P10 used what time was available to do brief counselling: *"… I would say it is very limited, and I believe it is because we are challenged with time. I normally just do a brief counselling and if needed, containment counselling, and then I would refer to the counsellor… I don't really do much counselling because of the time…"* (P10, female, CHC2).

Participants used different patient contact times to offer counselling and to engage with their patients:

> *"I do a bit of counselling also in my assessment with the patient… like mostly individual counselling…. In the past, I didn't book the patient for counselling…. So, during the assessment time, you also do a bit of counselling with the couple. However, time – you don't have time for it… time is against us to do that…. So, the little that I am doing with the counselling I do, I try to do it…"* (P3, female, CHC1).

4.2.1.2 Lack of recognition of APN counselling skills and role

There was a general lack of awareness of the specialist training and skills possessed by the APNs, which meant they were overlooked and ineffectively utilised, "*When he* [psychologist] *comes to the ward, he gets the files and he doesn't discuss it with us, most probably because*

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he doesn't know that we have the experience…" (P7, male, T1). The lack of recognition of the participants' counselling skills led to frustration:

> "*This is just how I feel personally about my role as an advanced psychiatric nurse. I don't always feel, or I don't feel that the role of the advanced psychiatric practice nurse is actually being… being …how do you say it now… People don't take it seriously, also, like it's not being put out there. Like, for instance, if I can make an example: Where you sit in a ward round and doctors refer the client to the psychologist, whereas here I am sitting. Isn't it easier to just ask* me*? I mean we as advanced psychiatric nurses, we work with the client everyday so we see them every day* so, *instead of like referring the client to me, the doctor will refer the psychologist that only comes from maybe her office that is in another ward.* (P2, female, T1).

For this participant, the lack of recognition of her counselling skills training resulted in extremely limited counselling opportunities, *"My counselling experiences at this facility are quite limited because we are not allowed to, most of the time, to do individual sessions with the clients. Most of our clients have either been booked by the other MDT members"* (P4, male, T2). The non-recognition of APNs created noticeable frustration and anger from some APNs towards psychologists, as some felt that their qualifications were not recognised, as explained by this participant. "*So, I would like to be more involved in counselling… advanced practitioners at this facility does not get recognised at the moment as advanced practitioners… we are just referred to as the senior nurse by the other MDT members although I correct them and tell them that I am not the senior nurse, I'm a specialist on my own."* (P4, male, T2).

A participant compared the amount of time that APNs spent with patients with that spent by psychologists, "*…the fact that we are closer… involved with the patient. They come and see the patient maybe once. We see our patients more on a daily basis and, doing interviews",* (P6, female, T1). While acknowledging the psychologist role, P2 felt undermined by team members: "*…The role of the advanced psychiatric nurse, I feel that it is – I don't know if this is the right word to use but – is undermined."* (P2, female, T1) This view was shared by P6 as explained. "*I would say a little bit undermined. If that is the correct word. Moreover, that we are not given the right opportunity – or our rightful opportunity to do so.* (P6, female,T1).

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There was also the sense that some members of the multidisciplinary team (MDT) felt that the APNs used "bullying" approaches in counselling and in doing so, victimised their patients. *"During feedback sessions, your input is not valued at times because they feel that you are either, uhm, victimising the client if you identify certain things, because when they had the interview with the client and then they never experienced what you are telling them.*" (P4, male, T2).

Despite the challenges experienced, one APN received formal counselling referrals from the MDT and felt valued, "…*The registrars referred them to me – maybe even for motivational interviewing, because obviously having seen how I do it…"* (P1, male, T1). This was not the experience of other participants who felt that only their nursing and custodial care was noticed, *"…your input is very valuable for the pure fact that you are there 24/7, but most of the time with the patient…"* (P7, male, T1).

Knowledge of psychopharmacology and the ability to accurately diagnose psychiatric illnesses is valued by the MDT. This participant felt that her knowledge, especially with respect to medication management, was appreciated:

> "*In the Acute system, they value my input a lot because, you know, of my years of experience. I can make valuable contributions towards treatment, you know, even medication recommendations. If you see that there's like mood components and stuff like that, what the doctors might miss because they only see the patients for a brief amount of time... they actually value your input as an Advanced Psychiatric Nurse. You know, when they want to prescribe medication, they would always ask what you think..."* (P8, female, T1).

Some APNs may lack confidence in their counselling abilities and training: "*Yes, I think that is the case because they [psychologists] are probably more trained in that area, so they feel more comfortable referring."* (P6, female, T1). Ambivalence was also observed in this participant when asked if the MDT would allow them to counsel if APNs advocated for it, *"I wouldn't know if they will be open because this is the way they have been doing it for years now…. They probably will, doctors are not… if we maybe put it on the table."* (P6, female, T1).

To meet the demand for counselling, some participants referred patients to psychologists instead of addressing it themselves, and thereby relinquishing their counselling role: *"Patients*

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that we screen during our history taking, if we see there is a need for counselling then we would normally refer the patient to our psychologist." (P5, female, T2). APNs are not expected to initiate counselling and patients are routinely referred: *"Basically, our patients mostly get referred to the psychologists… doctors will then refer them to the counsellors, so we don't do the actual counselling with our patients"* (P6, female, T1). Counselling therefore mainly remains the responsibility of psychologists. One participant explained:

> "*I appreciate it very much… although we could do with more… two psychologists and two counsellors; as we used to have two counsellors… we just have one counsellor on a Thursday because there's a long waiting list and some clients don't even get to see the psychologist."* (P10, female, CHC2).

The relinquished counselling role of APNs suggests that their experience of being underutilised, despite their counselling training and skills.

4.2.1.3: Underutilised counselling skills due to administrative duties

One of the challenges experienced by the participants was not being able to effectively use and develop their counselling skills due to their many administrative tasks, *"I'm sitting with all this, and I am not actually able to apply it… we have so much admin work to do. The admin work is such a huge load on you, and it really takes a lot of time at the end of day."* (P2, female, T1). This created feelings of frustration as it reduced the time APNs could spend with patients: "*It actually feels a bit frustrating to me personally as an APN…. But what I am saying is that it takes you away from your client. That is how I personally feel*. (P2, female, T1).

There are many routine and repetitive administrative tasks that limit time with the patients, as described by this participant: *"Then it is medication and after medication there is transfers… there are re-boards* [renewal of prescription charts] *and there is all these things, follow-up with the doctor in terms of the medication, how long and blah blah…* (P7, male, T1). This brought about feelings of anger that their counselling skills and APN training are being wasted, *"I feel disgusted, I feel, 'why did I go study Advanced Psychiatric nursing?' if I cannot use my skill…. You can't use these skills because you do not get the opportunity to use them."* (P7, male, T1). A participant also described the time-consuming nature of documenting medication, *"Before the end of day, end of shift, I make sure all medication is entered. That it's accounted for because most of our medications are schedule 5 drugs."* (P4,

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male T2). This participant commented, "*We have 3 sessions of medication. It's 08h00, 12h00 and 17h00. Then, if you look into that, it will take an hour, and then again, you have to go to your admin work. That's a lot... it has to be recorded."* (P9, male, T1). Supervision of junior staff is a further constraint, "*Because I have got a staff nurse who deals with it [giving medication], but overall supervision falls back to me."* (P4, male, T2).

The legal requirements when arranging to have a seriously ill patient admitted to a tertiary facility are also time consuming, as described by this participant, "*It takes forever for those forms to be scanned through because you know those are legal documents – you can't just send the patient. So, you wait for their approval. It can take two hours for me."* (P3, female, CHC1). Transferring and discharging patients is an important but time-consuming responsibility of APNS, *"It is a lot of administration…. It takes a lot of time for us. I made an estimation of the numbers, which are constantly coming to us, which is almost five per day. Then, in that context, in the 11 hours we are here, it takes almost 5 hours."* (P9, male, T1). This left the participants with very limited time to squeeze in patients to counsel. "*…if there is a chance, a moment to do the counselling."* (P6, female, T1).

Documentation is an important component of the APN's job description. This includes diagnostic assessments and problem cases that are reported to the MDT. *"Admin is plus-minus 70 to 80 percent... because as the specialist nurse you are supposed to report on all the problem cases in the unit. You do your MSE* [Mental Status Examination] *like I said. You start your MSE at seven in the morning until seven when you go home. So, before you go home, you write your report…"* (P4, male, T2). Fear of criticism and backlash from other nurses limited this participant's counselling interactions: *"The other staff might say that you are lazy… because you are only going to do counselling."* (P7, male, T1).

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4.2.2 Theme 2: Institutional Barriers Affecting APN Counselling Experiences

4.2.2.1 Settings with minimal counselling opportunities

The acute care settings, where the emphasis was on biomedical approaches to treatment and management, were not conducive to counselling, as explained by this participant, *"It's not possible for us to do the CBT*" (P2, female, T1). Another participant also explained their inability to conduct CBT in his work setting, *"We didn't get our chance to do CBT – I tried to do that when I came back from advanced."* (P1, male, T1). Most of the participants worked in acute male or female admission wards. APNs are often placed for long periods in acute

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wards as this participant described, "*For 8 years I have worked in the Acute admissions ward and that [counselling] is like impossible…"* (P8, female, T1).

The severity of patients' psychiatric symptoms limited the participants' opportunities to do counselling. Patients were often too psychotic or aggressive to be able to engage in meaningful counselling, as this participant explained:

> *"They are not really on that level yet that you have those in-depth conversations with them, not that in depth but the counselling, you know. They must be able to reflect and so forth, some of them are very concrete, and some of them are still somehow psychotic with the usual symptoms…. They are so psychotic and so aggressive that you can't really interact with them on that level in that state."* (P8, female, T1).

This was confirmed by another participant, "*…So, patients that come here are usually psychotic patients. So, it is difficult to counsel them."* (P7, male, T1). Psychologists may also perceive psychotic patients too difficult to counsel, as one participant pointed out, "*We hardly see a psychologist in the department"* (P9, male, T1).

APNs selected only a few patients for these therapeutic activities, to ensure that they could meaningfully engage, *"Then it's only when it's quiet and then you have to have a number because you can't take the whole group"* (P9, male, T1). Patient inclusion into therapeutic activities is dependent on the level of psychosis exhibited by the patient. *"Then you obviously start with your CBT with them, but remember that they are also still psychotic, so we take it day by day… not all the patients get those services, it's only the ones that you see and that you clerk and that you feel the need to do it with."* (P5, female, T2).

To meet the demand for beds, facilities adopted certain approaches to address this need, which interfered with APNs counselling opportunities. Most participants described that the psychiatric facilities they worked in followed a pragmatic approach, as explained by this APN, "*In a department like this department, I find myself in... an admission ward, and the movement when the other clients come in, we must move the others out. The others will be referred to the other institutions.* (P9, male, T1).

This approach resulted in high and fast patient turnover which limited opportunities for long-term counselling interventions with patients, *"Like I said, this is an acute ward – almost 99% of our patients are crisis discharged. That means… we do have pressure and that limits us a lot, you know, what counselling concerns it limits us a lot."* (P8, female, T1). Participants

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were unable to do follow up counselling as patients are transferred from the acute wards to predischarge settings as soon as they are stable enough, due to the pressure on beds.

> *"One of the other factors about good counselling is the fact that you have to do follow-up, and for us in the wards, it's difficult to actually do that follow-ups and see actually the progress. You cannot use these skills because you do not get the opportunity to use it. If there is an opportunity, you cannot follow up to see the progress with the patient, because the patient is there for two weeks and then he is gone."* (P7, male, T1).

4.2.2.2 Workspace factors

Institutional and workplace factors, particularly in the community health centres (CHCs) also limited the participants' ability to counsel patients in a therapeutic environment. Space was a major constraint, *"We don't have space. The clinics don't have space… I think 95 percent of the clinics don't have the space for the counselling."* (P3, female, CHC1). The CHC settings were not conducive to counselling, as appropriate private counselling rooms were not available, "*…Even now, the counselling is happening in a room that is not actually conducive for counselling."* (P3, female, CHC1). Noise from the patients' waiting area was another problem, as this participant explained, *"They would be banging and making a noise outside despite you setting limits."* (P10, female, CHC2). Participants frequently have to request assistance from security guards, *"Then you have to ask the security if you can just control the clients outside the door, I'm busy seeing clients. This happens every day…. So, ja… there is no privacy... the consultation rooms… It is not very therapeutic."* (P10, female, CHC2).

Other challenges noted by the participants included interruptions from other staff who needed an item from the room being utilised for the counselling session, "*There's a lot of distractions also when you are busy with a client because you are using somebody else's room and that person is coming in to fetch whatever he needs to fetch. So, there is a lot of interruption."* (P3, female, CHC1). Lack of privacy for patients was another concern, *"I would say one of the challenges is also privacy – because there is no real privacy, the Mental Health patients would just come barging through the door while you're busy with a client."* (P10, female, CHC1).

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4.2.2.3 Staff shortages

Staff shortages significantly restricted the participants' counselling opportunities, *"Here's so many, how do you say… things that prohibit me from actually doing that. 'Cause, I mean simple things – well not simple things like staff shortages…"* (P2, female, T1). Despite several efforts to plan counselling interventions with patients, for this participant it was difficult:

> *"The challenges can be – the thing is this especially – staff shortage. That is one of the major things in the settings because you can try so much, you know, to do your things or you've got a guide, 'I really want to try this now. I want to do this at least two times a week – or want to do it every day'. But sometimes it's extremely difficult…"* (P1, male, T1).

Overcrowded wards increased the challenges for the participants, "*The maximum was 28 [patients] but now the maximum went up to 45.*" (P9, male, T1). This reduced their ability to cope in wards, as described, "*Then when it comes to staffing, we are short of staff in such a way… we are four… if we are fully staffed. Out of the 45 [patients], then we manage to try our level best… it's too much for you."* (P9, male, T1). Meaningful counselling interactions were almost impossible, *"How many are you going to counsel as an individual on a daily basis?"* (P9, male, T1).

In the CHCs, APNs are expected to meet a daily patient contact quota and will be questioned if they do not meet this, as this participant explained, *"If you see two patients a day, they will definitely query, because how you do see two patients a day? They expect you to see at least 10–15."* (P10, female, CHC2). This makes counselling patients in the true sense difficult because there are simply not enough staff, as explained by another participant, *"… because we are short of staff, so cannot actually do more of these things."* (P7, male, T1). Despite the need, staffing has not been increased. P3 explained, *"I am the only psychiatric nurse practitioner here because we are an eight-hours' facility. In a month, it is something between three and four hundred [patients]. Which is a lot. Because for one mental health sister, it is actually 250. Above that, you actually need another help, yes."* (P3, female, CHC1).

Having added responsibilities because of limited staff also left some participants feeling overburdened, as explained by this participant, *"So, we don't really have a lot of advanced specialists currently in the ward – I'm the only advanced specialist in the ward… you are the shift leader, there are lots of other responsibilities that you need to fulfil."* (P5, female, T2).

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4.2.3 Theme 3: Positive Experiences of APN Training Programmes

For most participants, the APN training programme was a very positive experience. It promoted self-development and the skills and confidence to initiate counselling rather than refer patients to another member of the MDT, *"Before advanced you said, 'No, I'm going to refer the social worker', 'I'm going to refer you to this person'. With these skills now, you can also start doing it..."* (P1, male, T1). This participant described her experience of the APN training, *"When I came back, the knowledge was so much broader, the skills that you are taught is so much more, but now you know that you have so much more to give…"* (P5, female, T2).

4.2.3.1 Comprehensive specialist counselling exposure during APN training programme

Both college- and university-based APN programmes provided participants with good exposure to multiple counselling approaches, as explained by this participant:

> *"We did Individual Therapy, your Family Therapy, CBT, DBT…. Uhm, and then we had… Gestalt therapy. We had Group Therapies that we – there was even the Psychosocial Rehabilitation, Motivational Interviewing. And then also [had] play therapy – things like that we were also trained in during that year."* (P1, male, T1).

The varied counselling approaches and techniques to which they were exposed were valued by the participants, *"But it was all the therapies, the group [and] individual therapy, cognitive behaviour therapy. All those therapies were included within our course work."* (P6, female, T1). A participant who attended a university-based programme reflected on the importance of counselling:

> *"We learned about the other stuff like CBT, I think they focus more on, you know, almost like the type of motivational interview, you know, the one-on-one counselling – where the client must come to their own conclusion, you know, the reflection and that kinds of stuff. They focus more on that type of counselling."* (P8, female, T1).

Some participants also described that the APN programme focused on counselling therapies that would enable mental health patients to cope better in their personal lives, as explained by this participant, *"We also had to do… Life Skills groups…Assertiveness …what else is*

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there… uhm, Communications, which is also important especially for our clients. Yes, so we were exposed to Anger Management, Stress Management… that was also part of our curriculum." (P2, female, T1). Another participant confirmed this, *"We did lots of counselling… Bereavement, uhm, post-traumatic stress. Ja, containment, especially at the police office…. Ja, it is basically the same type of counselling."* (P10, female, CHC2). Family therapies were also included, *"We had Family Therapy, Couple counselling, but that was the bulk of the interviews that we did."* (P7, male, T1).

Participants also described how their theory aligned with their practicum and assessments.

4.2.3.2 Balanced theory, practical and assessment

Most participants described that their APN training programme placed equal focus on theory and practice. When one participant was asked to explain how lecturers presented the course content, the reply was, *"By demonstrating it and by explaining the academic side of it."* (P10, female, CHC2). Another participant confirmed this. *"The lecturers gave us an opportunity whereby they demonstrated to us, they also allowed us to do it – practice with them, practice with each other – in an environment whereby you learn."* (P1, male, T1). Only one participant mentioned that her APN programme was too academic when asked to describe the programme, *"Mainly theoretically, ya."* (P6, female, T1).

Some participants described that the educators used a Case-Based method to facilitate clinical learning. *"At first, in class, they will create a scenario and maybe use one of us to be the client."* (P7, male, T1), while some indicated that learning of skills also occurred through peer learning, as one participant described, *"Faults could be identified, and you could ask and say what did you pick up, what you found, which you missed out – to what can we basically work on."* (P1, male, T1).

Participants were required to practice these clinical skills during their clinical placements at the psychiatric facilities with mental health patients, as this participant described:

> *"The facilities were nice, especially the therapeutic wards, and I was at Valkenberg Hospital in Ward 9. They had sessions with the patients, and we would participate, because of our knowledge. We were taught how to ask questions..."* (P7, male, T1).

Some participants also reported that lecturers formally assessed them on CBT, as explained by this participant, *"…in our advanced course, we did a lot of counselling and I think we had ten sessions of CBT that we needed to pass."* (P3, female, CHC1). However, this was not a

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requirement for the participant who attended a university-based APN programme, as explained, "*It was not required of us to be able to do it for the evaluation purposes, but we did have to practice it…*" (P8, female, T1).

Participants who attended a college-based APN programme also reported that lecturers formally assessed them to conduct trauma counselling, as explained by this participant, "*For six months it was trauma counselling… we had to follow up with a client for six months and do all the trauma counselling and skills that we were taught to do."* (P7, male, T1).

Participants also provided positive feedback when they had the opportunity to actually engage in counselling with patients.

4.2.4 Theme 4: Positive Counselling Experiences

When the opportunity to counsel patients arose, even if only over weekends, participants felt affirmed and valued, as this participant explained. *"...Sometimes you feel like, on a weekend, when we do interviews with clients, and it's actually so nice just to sit and chat with your client."* (P2, female, T1). This allowed them to build therapeutic relationships with patients, *"…You know, build that relationship and getting the client to open up to you. I mean, that is one of the few opportunities you get" (*P2, female, T1). Therapeutic engagement was also an enjoyable experience for this participant, *"What I enjoy the most is when you sit with the patient…"* (P3, female, CHC1). Engagement with patients engendered feelings of fulfilment, *"...You see them thriving, that is what gives me so much fulfilment, knowing that I also had a hand in this… that has given you much joy and great fulfilment by doing that."* (P5, female, T2).

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Some participants also felt a sense of achievement, *"…The most fulfilling achievement I can say from my side, because just to see that you've made a difference in somebody else's life in that regard … because you can engage with them on a different level."* (P8, female, T1).

4.2.4.1 APN engagement facilitated patient recovery

Participants described that even though their counselling interactions with patients were brief, they made a difference and facilitated recovery, *"…You definitely see that brief intervention did make a difference"* (P10, female, CHC2). Counselling was seen as a therapeutic tool that could reduce the patient dependency on the mental health services, *"A lot of patients that*

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come to us, especially those that just need that containment for that brief episode of emotional outburst, and they don't come for follow up. And you know you had spent a lot of time with this client, but then the situation is resolved, and they don't come back… or they would come and still follow up at Mental Health." (P10, female, CHC2).

Despite challenges in the workplace, participants made efforts to ensure that as many patients as possible were offered therapeutic engagement opportunities, *"I try to still do the groups during this time [Covid-19], there was good results."* (P3, female, CHC1). This was really appreciated by some patients, "*Like people came back and you know they would say: 'If it was not for me or if it was not for that session or for that group, they don't know how they supposed to make it'."* (P3, female, CHC1).

Participants were able to assist patients with social problems, as described by this participant, *"I assisted him [patient]… sitting and talking and doing certain counselling things with him, which actually helped him to get a job, get a place to stay also – some of the contacts that I have, you know, over the years with people with houses and homes and stuff like that."* (P1, male, T1). The participant was able to achieve this through the use of APN skills. *"It was with your skills and stuff that you actually assisted those people…"* (P1, male, T1).

When opportunities are available, participants used their specialised APN skills and knowledge effectively to promote recovery, *"I worked with this client where I actually also had to do individual sessions with this client, and I had to follow up on her, uhm, with this client and all that. And in the end of my interventions, everything turned out that she actually became a new person."* (P2, female, T1).

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4.3 Conclusion

The findings revealed that the counselling interactions of the APNs with patients with mental disorders were brief and limited. The participants in this study faced several constraints, such as lack of time, or lack of recognition of their training and counselling skills by the multidisciplinary team. Participants tended to relinquish their counselling roles in favour of other team members, such as psychologists, which limited their experience in counselling. The burden of administrative responsibilities limited their ability to use their wide range of counselling skills. The work settings of the APNs offered limited counselling opportunities due to the acute nature of patient illness, a focus on medical management of illness, inadequate counselling spaces and staff shortages.

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Chapter 5
Discussion

5.1 Introduction

In this chapter, the findings of the study are discussed with reference to relevant literature. The study aimed to explore the counselling experiences of advanced psychiatric nurses, who trained at HEIs in South Africa and were working in state psychiatric facilities in the Western Cape. Four themes were generated through the data analysis and are discussed in relation to findings from other studies in existing literature. Literature reviews in qualitative studies may be conducted after data analysis is completed, to reduce the possibility of biases and preconceived ideas influencing theme development (Vaismoradi et al., 2016), but for this study an initial literature review was conducted, and findings have been discussed in the light of relevant literature.

5.2 Theme 1: Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders

Most participants described that their counselling experiences with patients with mental disorders were brief. Glantz et al. (2019) reported similar findings in a study with psychiatric nurses in Sweden, finding that nurses spent most of their working time on ward activities and very limited time engaging therapeutically with patients with mental disorders. Limited therapeutic engagement with patients was also reported in an earlier study by Sharac et al. (2010), who found that psychiatric nurses spend only 4–20 percent of their working time engaging in therapeutic activities with patients.

Eight of the ten APN participants reported some counselling experiences with psychiatric patients, which included Supportive Interviewing, Group Therapy, Couple Therapy, Marital Therapy, Bereavement Therapy, Family Therapy and Containment Therapy. Only two participants had some clinical experience in Cognitive Behavioural Therapy (CBT), although all had been trained in it. CBT is a well-established therapeutic intervention (Nakao et al., 2021) for non-psychotic mental disorders, and may be effectively utilised by nurses (Delaney et al., 2019). CBT is practised by Advanced Mental Health/Psychiatric nurses in the US

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(Delaney et al, 2019), and by Mental Health Nurse Psychotherapists (MHNP) in Australia (the equivalent of APNs) with persons with eating disorders and in outreach programmes for teenagers with complex mental health disorders such as Borderline Personality Disorder (Hurley et al., 2020a, 2020b). In Ireland, psychiatric nurses engage in a number of therapeutic interventions, including Goal Setting Therapy, CBT, Motivational Interviewing, Anxiety Management and DBT (Cusack et al., 2016). Motivational Interviewing, an exit level outcome of the advanced psychiatric nursing programme (Van Wijk, 2019), was the most reported counselling intervention utilised by the participants in the current study.

Counselling by nurses in high income countries, such as the US and Australia, appears to be more integrated into the mental health system. Iranian psychiatric nurses, however, reported an extremely limited scope of practice with severe restrictions, which does not even allow them to do psychoeducation (Ramezani et al., 2017). Wong et al. (2021) reported that most psychiatric nurses in Hong Kong refrain from conducting CBT after their training. Despite their limited range of counselling experiences, study participants did not report any official institutional barrier or prohibition regarding nurse counselling. The limited experience and opportunity may require further investigation, as these may be related to lack of awareness or inappropriate utilisation of APNS within the public health system.

A number of constraints impacting counselling opportunities were identified by the study participants. Limited time was a particular constraint as routine ward tasks occupied a large component of their working day. Time to counsel is critical to effective engagement with patients and clients. Peplau (1960a, 1960b) argued that the process of assisting a patient to make sense of his life [counselling] is not a brief activity but a daily long labouring process that requires much time. Psychiatric patients with profound psychiatric illnesses felt neglected and described a delay in their recovery when nurses did not have time to engage with them therapeutically (Glantz et al., 2019; Ljungberg et al., 2016). A qualitative UK study reported that the psychiatric nurses in their study described frustration over not having enough time to engage therapeutically with patients (Terry, 2020). Similar findings were reported in Norway (Jansen et al., 2020). In contrast, Delaney et al. (2019) reported that 80 percent of US APNs reported feeling satisfied with the amount of time they were able to spend with patients.

An unexpected finding was that counselling for the study participants in community settings was difficult due to time limitations. This finding is in contrast to that of Hurley et al. (2020)

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who found that an Australian mental health nurse psychotherapist was able to perform more counselling in a community than in a hospital setting (Hurley et al., 2020b).

Peplau (1986) asserted that the core role of psychiatric nursing specialists is that of counsellor, which is echoed by current authors (Glantz et al., 2019; Terry, 2020; Wesemann, 2019). Terry (2020) argued that psychiatric nurses must declare their core function explicitly and be assertive in order for MDT members and nursing managers to understand their core therapeutic role. This also raises the question of whether APNs in this study are aware of their significant counselling role. None of the participants alluded to this. APNs should exercise their core role as counsellors, and take the initiative to advocate for time to conduct psychotherapeutic activities with patients (Terry, 2020).

Most of the APNs in this study reported that their counselling skills were not recognised within the MDT, which made them feel undermined, resulting in many relinquishing their counselling role. In psychiatry, the practice of different health workers working together in a multidisciplinary team has been the norm since the 70s (Haines et al., 2018). The participants of this study all work in different wards and psychiatric facilities and operate within a multidisciplinary team, which typically consists (in a psychiatric setting) of Psychiatrists, Medical Officers, Psychologists, Social Workers and Occupational Therapists (Jacobs & Mkhize, 2021). A recent study conducted by McCarrick, Irving and Lakeman (2022) found that some Irish psychiatric nurses working in acute psychiatric wards also experienced feeling undervalued by the MDT and that this 'subordinate' role within the MDT often prevented them from providing care that was more therapeutic. Efforts to build therapeutic relationships with patients through psychotherapeutic means was often considered irrelevant by the MDT, which diminished their role and autonomy within the team (McCarrick et al., 2022). However, in light of the study conducted by Terry (2020), the non-recognition of the counselling skills of APNs could be because of MDT members being not sure about the actual counselling role and abilities of the APNs. Gabrielsson et al. (2020) share this view in their discussion paper regarding the confusion as to the exact role of APNs in Sweden's health care system. Hurley et al. (2020b) confirm this and stated that APNs' counselling abilities are often invisible in MDT teams. This could be as a result of the ambiguous roles nurses often display (Terry, 2020). They may act as biomedical experts through knowledge of psychopharmacology and medication administration and also as coordinators of the MDT team. This may leave the MDT and APNs themselves confused as to their actual role (Terry, 2020). In addition, nurses often find themselves in the 'awful middle', being jacks-of-all-

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trades, mastering nothing, thereby perpetuating their own role confusion in the MDT through this ambiguity (Terry, 2020).

It was evident in the study participants' responses that they felt that their counselling role was unrecognised. There may be a number of reasons for this, including a lack of awareness of the APNs' training in counselling, the lack of definition of the role of the APN in a psychiatric setting, and non-articulation by APNs of what they can contribute to the MDT – counselling skills that can actually improve patient treatment. This often leads to unnecessary frustration and role confusion in nurses and the MDT (Terry, 2020). Mukaihata et al. (2019) asserted that psychiatric nurses cannot be passive players, expecting others to implement change in their work place; instead they should actively use their skills to promote the positive change they desire. Gabrielsson et al. (2020) urged APNs to rise up and become active participants in changing their interactions with patients to reflect person-centred practice.

Resistance from psychologists and other MDT members also contributed to the lack of counselling opportunities and experience for APNs. Factors such as poor communication may also be responsible for the non-recognition of APN skills within the MDT. In particular, the belief described by one study that the MDT felt that patients are being 'victimised' by APNs is of concern. Although the participant did not elaborate on the exact details of how this 'victimisation' occurred, the manner in which some APNs communicate with patients when eliciting information may be perceived as 'bullying' by the MDT. In the 2021 qualitative study conducted in KwaZulu Natal, South Africa, Jacobs and Mkhize (2021) reported that MDT members often found the communication styles of APNs with patients too harsh and rude. This highlights the importance of effective communication among team members and the understanding of each other's roles.

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Another possible reason APNs experienced resistance from psychologists is the lack of understanding by APNs of the psychologists' role. There was a perception that psychologists visited infrequently and spent very limited time with their patients. This may cause misunderstanding and miscommunication between APNs and psychologists (Haines et al., 2018).

Hurley argues that the non-recognition of APNs' counselling skills in the MDT may be the very title of 'nurse' (Hurley et al., 2020a). The perceived stereotype of what a nurse is, and what they actually can do, could explain why psychologists received referrals for counselling

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from the MDT and not from APNs, despite their extensive training in psychotherapeutic skills.

The referral by some participants of patients requiring counselling to psychologists, instead of addressing the need themselves, suggests that these APNs relinquished their own counselling role. Rice et al. (2019) argued that APNs must actively participate in the advancement of their own profession based on their extensive knowledge of the effectiveness of different treatments and the limitations of these treatments. As participants in this study have not asserted themselves enough in this regard, they are perpetuating the notion that psychologists are the only health professionals that can address the high demand for counselling at psychiatric facilities (Hurley et al., 2020a). This is the antithesis of Peplau's stance, as she argued that the core function of psychiatric nursing specialists (APNs) is that of counsellor (Peplau, 1986). Furthermore, no health profession can claim sole ownership of counselling/psychotherapy (Wesemann, 2019). Counselling may have originated outside of the nursing profession, but it is already deeply integrated into modern psychiatric nursing (Gabrielsson et al., 2020). APNs therefore cannot relinquish their counselling role to any MDT member, irrespective of the challenges they experience in the work place. This is evidenced by some Canadian APNs, who still maintained their counselling role despite work challenges (Jackson, 2019). Despite Australian APNs experiencing severe difficulties and hostility in the workplace, some still highly prioritised counselling with patients despite them or their efforts not being valued (Hurley et al., 2020a, 2020b).

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The many administrative responsibilities affected opportunities for counselling. This is a commonly reported experience among psychiatric nurses. In a study by Glantz et al. (2019), nurses reported spending as much as 17.5 percent of their time at work conducting tasks related to the administration of medication (Glantz et al., 2019), and complained that this prevented them from engaging therapeutically with patients (Glantz et al., 2019). Repetitive administrative tasks created severe frustration and anger in some participants, as they were unable to utilise the skills and training they have. Hurley et al. (2020) reported similar responses of APNs in Australia where one participant described being reduced to a "pill pusher" and "custodial carer" (Hurley et al., 2020b).

Additionally, the negative attitudes of other nurses towards counselling may also prevent some APNs from doing more counselling. One APN in this study described fearing negative responses from other nurses if he did more counselling and less administration. Similarly, Hurley et al. (2020b) pointed out that APNs in Australia reported negative attitudes of other

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nurses towards counselling, which deterred them from doing more counselling and less administration work.

Ironically, the new Mental Health Care Act 2002 (Act no. 17 of 2002) was premised on World Health Organization (WHO) principles that strongly focused on "patient-centred" psychiatric care (Kaliski & Szabo, 2018). The mere fact that administrative tasks take precedence over patient counselling is contradictory to this objective. This observation was also made by Glantz et al. (2019), who stated that the precedence given to administrative tasks in in-patient psychiatric settings in Sweden, in comparison to reduced nurse-patient psychotherapeutic engagement, cast doubts as to whether patient-centred care is really the focus in patient care.

This is worrisome, as APNs require frequent therapeutic engagements with patients in order to improve and maintain their counselling skills. One APN reflected in an overseas study that APN's become "de-skilled" when they do not engage therapeutically with patients (Hurley et al., 2020b). Consequently, only having brief and limited counselling activities because of time constraints stemming from administration duties, unrecognised counselling skills or relinquished counselling role, will reduce the likelihood of APNs developing therapeutic relationships with patients, essential for counselling (Glantz et al., 2019) and prevent APNs from refining and improving their counselling skills.

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5.2 Theme 2: Institutional Barriers Affecting APN Counselling Experiences

The allocation of APNs in wards with psychotic patients, pragmatism and a favoured bio-medicalised treatment approach in psychiatric care may all have impacted the counselling opportunities of APNs in this study. Participants in this study described experiences of ward settings that were not conducive to counselling. In the acute wards, patients are either too ill (psychotic) or patient turnover is too rapid for them to do any meaningful counselling. Staff shortages also prevented them from engaging therapeutically with patients. There is a paucity of literature describing institutional barriers affecting the counselling experiences of APNs (Taylor et al., 2022).

Therapeutic settings are generally better suited for counselling than acute wards (Hurley et al., 2020b). The current study felt that counselling should be reserved for less psychotic patients. This view is not uncommon, and the usefulness of standardising counselling to psychotic patients in acute wards is questioned (Paterson et al., 2018). In contrast, some

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researchers advocate that all patients with mental disorders receive counselling, irrespective of their level of psychosis (Kendall et al., 2016). Some scholars, however, caution against this, arguing that more harm can in fact be done if counselling is applied on patients who are too psychotic, as it may cause the psychotic symptoms to worsen (Hasson-Ohayon et al., 2017). APNs should therefore be cognisant of these views.

Participants also described high turnover rates of patients in acute wards as another factor preventing them from doing more counselling. They described initiating counselling, only to find the patient transferred to another ward or discharged when they resumed shift. This is mainly due to places needed for newly admitted, severely ill patients. Similar findings were reported by Jansen et al. (2020), who stated that the institutional demand of faster patient discharges in acute psychiatric settings prevented psychiatric nurses from meeting the therapeutic needs of patients. In Australia, Hurley et al. (2020) also reported that mental health nurses felt pressured to discharge patients without counselling being provided (Hurley et al., 2020b). Wyder, et al. (2017) cites Johansson, Skarsater and Danielson (2013), who reported psychiatric nurses not able to complete therapeutic care plans they developed, as a result of premature discharges of patients (Wyder et al., 2017).

In the CHCs, the APNs experienced a very high turnover of patients and reported that the services are 'stats driven', with each APN required to treat between 300 and 400 patients a month. This is indicative of pragmatism which rates the effectiveness of services in high patient turnover rates, quick assessments and fast treatments (Hummelvoll & Severinsson, 2008). This ultimately produces stress and internal conflict in nurses between what is required of them professionally and what they humanly expect of themselves (Hummelvoll & Severinsson, 2008).

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Hasty discharges of patients in acute wards can also be attributed to the dominating biomedical model in psychiatric services (Hummelvoll & Severinsson, 2008). Studies have shown that this approach has resulted in frustration in psychiatric nurses and standardised medicalised treatment for all patients with mental disorders (Hummelvoll & Severinsson, 2008). Some researchers also observed that biomedicalism allows for very little therapeutic nursing (Santangelo et al., 2018), as the material brain is the centre in biomedical treatments and not the patient's emotions (Brown et al., 2022). Consequently, there is no real use for counselling when the psychiatric problem is physical in origin, as proponents of biomedicalism place mental disorders in the same category as physical illness (Brown et al.,

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2022). This has had a devastating effect on the therapeutic roles of psychiatric nurses and has been noticed and reported on, even by non-nursing scholars (LeFrançois et al., 2016).

The APNs working at CHCs reported that counselling spaces were not conducive to counselling. The consultation rooms were small, noisy and not private – common problems at most CHCs. Hunter, et al. (2017) cited an audit by the Office of Health Standards Compliance, which revealed that a large portion of the 3477 national primary health care facilities in South Africa still lacked congenial spaces for patients (Hunter et al., 2017). This is troublesome as it is widely understood that a therapeutic physical environment is fundamental to positive patient outcomes (Belsiyal et al., 2022). Signage is an important aspect of promotion of therapeutic environments; however, this was not noted by participants in this study. The use of simple, visible signs in corridors and on doors may reduce the incidence of noise and disruptions (Ergun et al., 2017).

Staff shortages in wards negatively impacted participants' counselling opportunities. APNs in most US states did not complain of experiencing any staff shortages (Delaney, 2017). The number of psychiatric nurses in the US was predicted to increase by 2020 with an additional 2000 new psychiatric nurses, due to a 63 percent increase in intake of students in 2017 at training facilities (Delaney, 2017; Kaas, 2020). International literature does indicate that a shortage of qualified, competent psychiatric nursing staff exists in most countries. This is evidenced by studies from China, Greece, Australia and Iran, which reported shortages of psychiatric nurses in hospitals – this reduced the quality of patient care (Cranage & Foster, 2022; Huang et al., 2020; Konstantinou et al., 2018; Ramezani et al., 2017) and was responsible for low morale and frustration among psychiatric nurses (Cranage & Foster, 2022). In South Africa, Maila et al. (2020) made brief reference to APNs being affected by staff shortages and how this leads to burnout. This field therefore requires more exploration by future researchers.

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5.3. Theme 3: Positive Experiences of APN Training Programmes

The South African Nursing Council requires the curricula of all academic programmes offered at Nursing Education Institutions (NEIs) to adhere to national and international standards of education, including the professional and regulatory requirements for practice (SANC, 2020). APN programmes must therefore be internationally comparable.

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Most participants in this study had obtained their qualification through a Diploma in Advanced Psychiatric Nursing Science obtained at a Nursing College in the Western Cape. Two participants had university qualifications (a Postgraduate Diploma and a Master's Degree in Advanced Psychiatric Nursing, respectively). Most recalled positive experiences of their APN training and described the counselling content in their programme, the teaching strategies lecturers used, work-integrated learning and assessment methods, and felt prepared for practice on completion of the programme. One participant (with a university master's degree) was dissatisfied with her APN programme. Kaas (2020), who cites Adams and Black (2016), reported that graduates from some postgraduate programmes in the US felt ill-prepared for practice after graduation (Kaas, 2020). Experiences of APN programmes vary. APN students in two mid-western universities in the US had positive training experiences (Wesemann & Handrup, 2021). In another study, some APN graduates reported disappointment in their training, mainly due to the lack of counselling training in their APN programme (Wesemann, 2019). No South African studies exist of this nature. The closest was a master's qualitative study by King (2020), not relevant to this study, which explored the experiences of APN graduates who participated in service learning in their training, which further highlights the need for more research studies on the training experiences of APNs in South Africa.

Participants described that their APN academic programme focused strongly on counselling and included specialist therapies such as Cognitive Behavioural Therapy and Motivational Interviewing. Hurley et al., (2020) found that Australian APNs reported being well-trained in various counselling techniques (Hurley et al., 2020a, 2020b). Delaney (2017) stated that most US APNs received education and extensive training in a variety of counselling styles (Delaney, 2017), and counselling was incorporated in coursework of 118 APN programmes (Vanderhoef & Delaney, 2017).

In South Africa, NEIs are mandated by the SANC to ensure that theoretical and practical learning are based on competencies that are rooted in evidence-based research (SANC, 2020). The inclusion of counselling in APN programmes is therefore justified as there is extensive evidence detailing the efficacy of counselling therapies (Barkowski et al., 2020; Berry et al., 2022; Kline et al., 2018; Linardon et al., 2019). The training institutions of APNs in this study therefore adhere to SANC training directives.

The majority of positive descriptions from participants in this study provided some indication that SANC educational standards directives are mostly well adhered to at some NEIs. Most

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participants described a balance between theory and practicum in their APN programme, explaining that they received theoretical lectures and clinical demonstrations from lecturers. One participant who obtained her APN qualification from a university described her academic programme as too theoretical.

CBT was also a formal assessment for participants who were enrolled in the nursing college programme. Not all participants reported conducting a formal CBT assessment examination in their APN programme. The SANC training standards emphasise that course outcomes meet the needs of a population (SANC, 2020). With mental illness on the increase globally (Cook et al., 2017; Gabrielsson et al., 2020), NEIs must ensure that APNs are formally prepared and assessed in the best way possible to address this need. CBT is an excellent evidence-based therapy that educators should emphasise though formal assessments. This may also help reduce the burden of mental illness (Cook et al., 2017; Ergun et al., 2017) in the Western Cape.

5.4. Theme 4: Positive Counselling Experiences

Despite the challenges experienced by most participants to conduct counselling, participants in this study felt feelings of joy and fulfilment when they engaged in counselling. For them, the reward was seeing patients recover through counselling or social interventions they implemented. The participants therefore still valued the emotional 'caring' side of their therapeutic nursing interventions. An exploratory mixed-method study in Ireland, reported that a large portion of psychiatric nurses still felt that it is important that they not lose the "caring" aspect in psychiatric nursing (Cusack et al., 2016). This is significant, as Gabrielsson et al. (2020) pointed out that reducing the importance of emotions in nursing care would lead psychiatric nurses to completely disengage and abandon person-centred nursing. In the current nursing climate, technical approaches, pragmatism and medical treatments are favoured. Dalhberg et al. (2016) commented that some scholars blame the over-emphasis of "evidence-based nursing" and the "nursing process" prevalent in nursing today for the devaluation of emotion in nursing. Nursing's caring knowledge base is considered by many outside of the profession as non-scientific (Dahlberg et al., 2016). To appear more scientific, many nursing scholars ditched emotional nursing care and refocused their attention and emphasis on "evidence-based" practices, in an effort to raise the scientific status of the profession (Dahlberg et al., 2016). Consequently, caring devolved into curing (Dahlberg et

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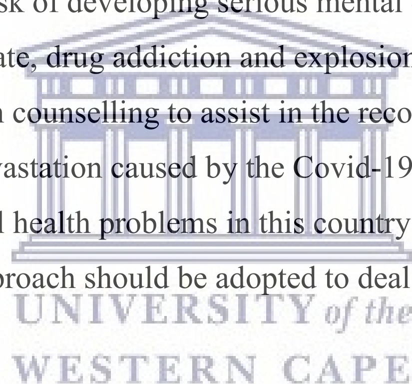
al., 2016), resulting in therapy-based interventions being sidelined. Participants in this study, in line with Peplau, considered counselling a rewarding experience, despite the pressures of a challenging and biomedical approach to care in their working environments.

Many participants, despite limited counselling opportunities, lack of time and administration responsibilities, were still able to positively impact some patients' lives. In the brief moments they had for counselling, participants were able to effectively utilise their specialised knowledge and skills, which led to some patients recovery. This supports Wesemann's argument that even brief, limited counselling interactions with patients are beneficial (Wesemann, 2019). APNs reported how grateful some patients were when their counselling efforts or interventions improved overall the patients' mental well-being, facilitated re-acceptance back into families, or made it possible to find work or housing. Tanoue et al. (2018) found that a group of Japanese psychiatric nurses successfully alleviated depression in patients through CBT. In the UK, a team of psychiatric nurses was also able to effectively enable recovery in patients suffering from post-partum depression and anxiety (Dennis et al., 2020). As more people are at risk of developing serious mental disorders in South Africa because of the increased HIV rate, drug addiction and explosion of violence (Mokitimi et al., 2018), APNs are well trained in counselling to assist in the recovery of those affected, if they are utilised effectively. The devastation caused by the Covid-19 pandemic, which will most likely further exacerbate mental health problems in this country (Posel et al., 2021), requires that an "all-hands-on-deck" approach should be adopted to deal with this impending disaster.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5.5 Conclusion

In this chapter, the four main themes were discussed, and compared and contrasted to international and local studies. In the concluding chapter, the study limitations and recommendations are presented.

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Chapter 6

Study Limitations, Recommendations and Conclusion

6.1 Introduction

In this chapter, a summary of the findings, limitations of the study and recommendations are presented.

6.2 Summary of Themes

6.2.1 Theme 1: Brief and Limited Range of Counselling Experiences with Patients with Mental Disorders

Although participants in this study had some counselling experiences, these experiences were brief and limited, which is similar to what most overseas researchers reported. Despite receiving training to do specialist counselling such as Cognitive Behavioural Therapy (CBT) in their training programmes, not all had clinical experience in CBT, which is worrisome as most overseas APNs are also well trained in CBT and their skills are then utilised to treat patients with a variety of psychiatric disorders. Most participants, however, did have some experience in Motivational Interviewing and were permitted to conduct these types of specialist psychotherapies without any institutional prohibitions. This is noted as some psychiatric nurses abroad do experience severe institutional and governmental restrictions. Most participants also described a lack of time to do meaningful psychotherapeutic engagements with the patients, which brought about feelings of frustration. Other factors that severely impacted their counselling experiences were daily administrative duties, which consumed most of their working time, resulting in underutilisation of their counselling skills. Some participants also felt unrecognised within the MDT, while others reported being valued in the MDT, mostly for custodial care, work experience and knowledge of psychopharmacology but not for their counselling skills. Most participants lacked assertiveness, were not advocating for their speciality and had inadvertently relinquished their counselling role.

A paucity of literature exists of the limited counselling experiences and opportunities of APNs, which require further investigation, as these may be related to lack of awareness, or inappropriate utilisation of APNs within the public health system.

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6.2.2 Theme 2: Institutional Barriers Affecting APN Counselling Experiences

Many participants explained that the patients in acute wards are not suitable for counselling, which limited their counselling opportunities. Some participants, including the two CHC APNs, also described the high turnover rates of patients, which derailed counselling attempts already started with patients. It would seem that in order to deal with the huge demand for mental health services, hospital managers rely on pragmatism and biomedical treatments to solve this problem. Although practical, this limited the counselling experiences of most participants in this study as wards were understaffed despite high patient numbers, which kept APNs away from therapeutic engagements with patients. CHC participants also explained that their workspaces were not conducive to counselling.

6.2.3 Theme 3: Positive Experiences of APN Training Programmes

Most of the participants were satisfied with the structure of APN programme and that their training gave them new knowledge and skills. This was comparable to some studies conducted in the US where most graduates of APN programmes also felt well prepared. Many APNs in this study reported that they received comprehensive exposure to psychotherapies in their APN training programme, which compared well to overseas APN programmes. Most of the APN programmes met the training standards of the SANC as it exposed students to evidence based therapies that can assist a large part of the population affected by mental disorders. Some participants also reported balanced theory and practicum, and that teaching strategies used by educators were diverse. Many participants were also formally evaluated by educators on CBT, except for one.

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6.2.4 Theme 4: Positive Counselling Experiences

Most APNs described positive feelings such as "joy" and "fulfilment" when they had the opportunity to counsel patients, which indicate that they still valued therapeutic engagement with patients despite facing challenges and frustration.

Despite the limited and brief counselling experiences with patients, most participants in this study described that they were able to enable recovery in patients. They explained that patients praised them for intervening when they needed it most. Some APNs also proved to

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be very effective and resourceful in administering psychosocial rehabilitation to patients. This corresponds with overseas literature that reported on the effectiveness using psychiatric nurses to enable recovery in patients with mental disorders.

6.3 Study limitations

The impact of the Covid-19 pandemic delayed the data collection and one of the community facilities was therefore excluded. There were more participants from one tertiary facility. Data saturation was achieved however, in the sample of participants from two tertiary and two community facilities. The sample was not as diverse as originally planned, as most of the participants had an advanced diploma and not a Master's degree qualification. This may have impacted the counselling experiences reported.

6.4 Recommendations

The following recommendations emanating from the study findings are offered, with respect to education, practice, policy and research are offered:

6.4.1 Nursing Education

- Educators provide clarity to APN students regarding the role of psychologists and how their methods of assessment may differ from nurses, in order to understand them more and facilitate better team work within the MDT.
- Educators in APN programmes lay strong emphasis on the APN core counselling role to avoid confusion among graduates regarding their counselling role in the ward and within the MDT.
- NEIs develop quality assurance strategies that will ensure educators provide lessons to students that balances theory and practicum.
- NEIs develop short refresher courses for APNs who may require assistance relearning counselling skills as a result of prolonged underutilisation, and training in assertiveness in order to effectively communicate their significant counselling role to team members.

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6.4.2 Psychiatric Nursing Practice

- Nursing managers should be made aware of APNs' knowledge, skills and training in specialised counselling, and facilitate the effective utilisation of their skills in appropriate clinical settings.
- Nursing managers assign Case Manager Roles to APNs (to augment existing hospital Assertive Care Teams) where possible, as they are trained in providing Psychosocial Rehabilitation.
- Operational Managers should play a large role in promoting the APN qualifications in counselling to the MDT and hospital managers, as they are mostly APNs themselves and have more authority to advocate for APNs.

6.4.3 Nursing Policy

- SANC periodically audits NEIs offering post graduate diplomas in mental health to determine if evidence-based psychotherapies, such as CBT or DBT, were formative or summative in Exit Level Outcomes, in order to meet the counselling needs of populations who do not have access to these services.

6.4.4 Research

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- More qualitative and quantitative research studies on the institutional barriers affecting the counselling experiences of APNs in public hospitals in South Africa, and how this may relate to the underutilisation of their counselling skills.
- A national survey of the best clinical placement for APNs to determine where their counselling skills are utilised effectively.
- More qualitative and quantitative research studies on the training experiences of APNs who trained at NEIs in South Africa

6.5 Conclusion

This study explored the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape. Six chapters in this dissertation provided background of the topic, a literature review, a

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description of research methodology, presentation of findings, and a discussion of the findings and recommendations. The researcher hopes the reader found the findings of this study helpful and that it will generate discussion that will eventually improve the counselling experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

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Appendices

APPENDIX A: Consent Letter & Interview Guide

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South

Africa Tel: 021 9591723

E-mail: pmayers@uwc.ac.za

CONSENT FORM

Title of Research Project: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve, and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

Participant's name……………………….

Participant's signature……………………………….

Date………………………

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APPENDIX B. Interview Guide

Topic: An Exploration of the counselling work experiences of advanced psychiatric nurses (R212) who trained at a higher education institution in South Africa, working in state psychiatric facilities, in the Western Cape.

Interview Guide Preamble

I am Adam Petersen, a Master's in Nursing Education student **(3692896)** at the University of the Western Cape. I am conducting a research study on the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

You are invited to participate in this study. Participation is entirely voluntary and your rights in the study will be respected and protected.

Interview Guide Primary Interview Question

Can you tell me about your counselling experiences as an advanced psychiatric nurse at this psychiatric facility?

Sub-questions

1. Please can you describe to me what types of counselling are offered to patients at this facility? I am referring to interventions such as individual therapy, group therapy and counselling, among others. (Objective 2)
2. Can you briefly tell me about the type of counselling/therapeutic interventions you were trained in during your APN programme? (Objective 1)
3. In your current work setting, can you describe what opportunities you have to counsel patients? (Objective 3) 2)
4. Can you tell what you enjoy about counselling patients in your workplace? (Objective 2)
5. Can you tell me about any challenges have you experienced related to conducting counselling at the psychiatric facility you work? (Objective 3)
6. Can you describe a counselling interaction with a patient in which you felt that you had contributed to his/her road to recovery? (Objective 2)

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APPENDIX C: UWC Ethics Permission

UNIVERSITY *of the* WESTERN CAPE

Department of Institutional Advancement
University of the Western Cape
Robert Sobukwe Road
Bellville 7535
Republic of South Africa

26 October 2020

Mr AJ Petersen
School of Nursing
Faculty of Community and Health Sciences

Ethics Reference Number: HS20/8/21

Project Title: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

Approval Period: 26 October 2020 – 26 October 2023

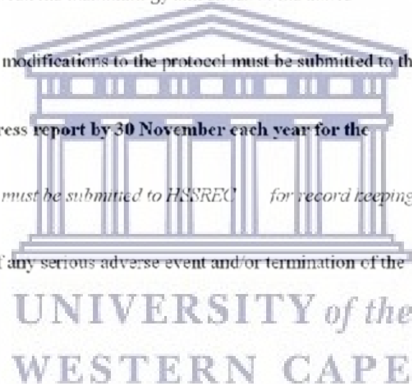
I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report by 30 November each year for the duration of the project.

The permission to conduct the study must be submitted to HSSREC for record keeping purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.



UNIVERSITY *of the*
WESTERN CAPE

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

NHREC Registration Number: HSSREC-130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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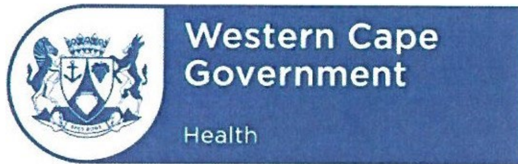
APPENDIX D: WCDOH Permission (Tertiary Hospital 1)



STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za tel: +27 21 483 0866: fax: +27 21 483 6058 5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC 202103 007

ENQUIRIES: Dr Sabela Petros

Private Bag X 17

Bellville

7535

Republic of South Africa

For attention: Mr Adam Petersen

Re: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

UNIVERSITY of the
WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

[redacted] Hospital [redacted] [redacted]

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of

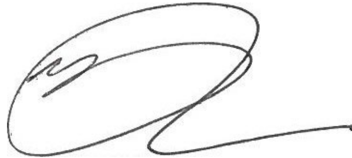
https://etd.uwc.ac.za/

completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (Annexure 8) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely



DR M
MOODLEY

DIRECTOR: HEALTH INTELLIGENCE

DATE: 19/05/2021

CC

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APPENDIX E: City of Cape Town Permission Letter (CHC 1)

CITY HEALTH

Dr Natacha Berkowitz

Epidemiologist: City Health

T: 021 400 6864 F: 021 421 4894

E: Natacha.Berkowitz@capetown.gov.za

Ref: 28251 2021-06-21

RE: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

Dear Mr Adam Petersen

Your research request has been approved as per your protocol. Please refer to the subsequent pages for the approval of any facilities or focus areas requested. Especially with regards to APN interviews. Approval comments on any proposed impact on City Health resources are also provided.

Eastern & Khayelitsha:

Contact Person: Prof Vera Scott (Area East Manager)

Tel/Cell: 021 360 1258/082 308 8059

Email:

Vera.scott@capetown.gov.za Northern & Western:

Contact Person: Dr Andile Zimba (Area North Manager)

Tel/Cell: 021 980 1230/084 627

2425 Email:

Andile.Zimba@capetown.gov.za

Tygerberg & Klipfontein:

Contact Person: Mr Ruberto Isaaks (Area Central Manager)

Tel/Cell: 021 444 0893/078 565

7607 Email:

UNIVERSITY of the WESTERN CAPE

https://etd.uwc.ac.za/

Ruberto.Isaaks@capetown.gov.za Mitchells Plain

& Southern:

Contact Person: Mrs Soraya Elloker (Area South Manager)

Tel/Cell: 021 400 3983/084 222 1478

Email: Soraya.Elloker@capetown.gov.za

Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to the clinic and its patients must be arranged with the relevant Manager such that normal activities are not disrupted.
3. A copy of the final report must be uploaded to https://web1.capetown.gov.za/web1/mars/ProjectClosure/UploadReport/0/9417, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (9417). Please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises
6. If this research gives rise to a publication, please submit a draft before publication for City Health comment and include a disclaimer in the publication that "the research findings and recommendations do not represent an official view of the City of Cape Town "

Thank you for your co-operation and please contact me if you require any further information or assistance.

Kind Regards
Dr Natacha Berkowitz Epidemiologist: City Health

https://etd.uwc.ac.za/

Facilities

Area	Subdistrict	Facilities		
Area East	Eastern	Facility name	Interaction start date	Interaction end date
			2021-07-05	2021-07-30
Area South	Mitchells Plain	Facility name	Interaction start date	Interaction end date
			2021-07-05	2021-07-30
Area Central	Tygerberg	Facility name	Interaction start date	Interaction end date
			2021-07-05	2021-07-30
Area North	Western	Facility name	Interaction start date	Interaction end date
			2021-07-05	2021-07-30

Please note

- If a requested facility does not appear in the list above, its interaction request has been rejected and the reason for the rejection can be viewed in the link below
- Approval comments for facilities may exist. These comments can be viewed in the link below.

https://web1.capetown.gov.za/web1/mars/ProjectFacility/Read/0/9417

Impacted resources

Impacted resource	Decision	Comment
Communications	Approved	You have received approval access these facilities. You may need to apply to Provincial health to interview the APNs as they are employed by Provincial Health.

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https://etd.uwc.ac.za/

APPENDIX F: WCDOH Permission Letter (CHC 2)

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za tel: +27 21 483 0866: fax: +27 21 483 6058 5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001 www.capegateway.gov.za)

REFERENCE: WC 202103 007
ENQUIRIES: Dr Sabela Petros

Private Bag X 17

Bellville

7535

Republic of South Africa

For attention: Mr Adam Petersen

Re: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

UNIVERSITY of the WESTERN CAPE

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

CDC		021 350 0801
CDC		0215344361

Kindly ensure that the following are adhered to:

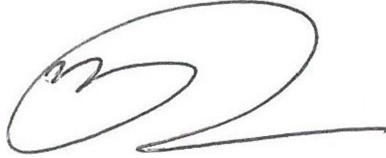
1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

https://etd.uwc.ac.za/

3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (Annexure 8) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely



DR M
MOODLEY

DIRECTOR: HEALTH
INTELLIGENCE DATE:
a 2 / c c 12 02/ cc

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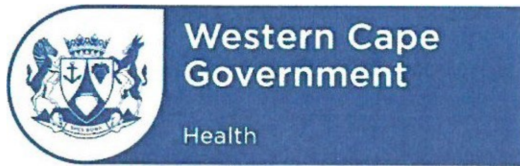
APPENDIX G: WCDOH Permission Letter (Tertiary 2)



STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za tel: +27 21 483 0866: fax: +27 21 483 6058
5th Floor, Norton Rose House,, 8 Riebeek Street,
Cape Town, 8001 www.capegateway.gov.za)

REFERENCE: WC 202103 007

ENQUIRIES: Dr Sabela Petros

Private Bag X 17

Bellville

7535

Republic of South Africa

For attention: Mr Adam Petersen

UNIVERSITY of the
WESTERN CAPE

Re: An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

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https://etd.uwc.ac.za/

2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (HealthResearch@westerncape.gov.za).
3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (Annexure 8) to the provincial Research Co-ordinator (HealthResearch@westerncape.gov.za).
4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLE
DIRECTOR: HEA

DATE:

CC

https://etd.uwc.ac.za/

APPENDIX H: WCDOH Research Request Form for Managers

Research Request Form

Please make this form easy to read and concise (max 1.5 pages).

Facility where you will conduct research: ███ CHC, ███ CHC, ███ CHC, ███ Psychiatric Hospital, ███ Psychiatric Hospital

Research Title: **An exploration of the counselling work experiences of South African trained Advanced Psychiatric Nurses (R212) working in state psychiatric facilities in the Western Cape.**

Researcher Name and contact number: Mr A J Petersen (Cell. ███) Prof P. Mayers (Cell. ███)

NHRD Number: WC_202103_007

Have you obtained full ethics approval (Yes/No)– Yes

Summary of Research (please make this section easy to read - maximum 250 words)

In South Africa the teaching directives of the South African Nursing Council requires advanced psychiatric nursing students to conduct multiple individual therapy, group therapy, milieu therapy, crisis therapy, case management and family therapy sessions with psychiatric patients. It is also an essential job requirement of Advanced Psychiatric Nurses (APNs) in the Western Cape. The counselling skills of APNs are much needed in the Western Cape, because of the high incidence of mental disorders in this province, which cannot be met by the small percentage of psychologists in state psychiatric facilities. The aim of this study is to explore the counselling experiences of advanced psychiatric nurses, who have trained at HEIs in South Africa, working in state psychiatric facilities in the Western Cape.

The objectives of this study will explore the training and skills of APN's and what opportunities they have in the workplace to utilise their counselling skills. A qualitative research approach, through an exploratory descriptive design, will be used. Through the non-probability sampling method, data will be conveniently collected from participants, working at two major tertiary psychiatric hospitals (███ and ███) and three primary health care facilities (███i, ███ and ███ Community Health Clinic), located in the Western Cape. Through the permission obtained from the

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Western Cape Department of Health (WCDOH)to conduct the study, the researcher will contact the Nursing directors of the selected psychiatric health facilities, to request permission to explain the research study. The researcher will also request to have a brief meeting with APNs in the facilities in order to introduce the study and hand out information and the researcher's contact details. APNs who are interested can then contact the researcher, who will the contact the APN to explain the study further. If they agree to participate, a time for the interview can be set up. The data collected will analysed using content analysis to develop themes.

Ethical principles will be strictly adhered to in this study as data will only be collected once ethical clearance and permission have been obtained from relevant organisational entities.

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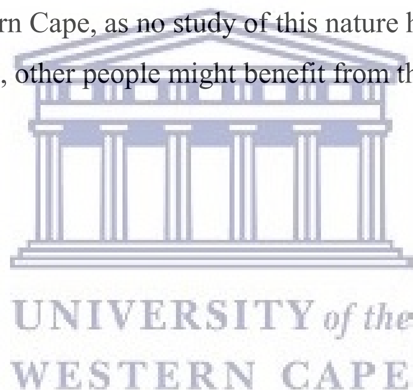
1. *Benefits of the study:*

The results from this research study may help the investigator learn more about the counselling experiences of APNs in the Western Cape, as no study of this nature has ever been conducted in South Africa. We hope that, in the future, other people might benefit from this study through



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APPENDIX I: DOH Advanced Psychiatric Nursing Job Information Summary (Tertiary)

JOB INFORMATION SUMMARY:

PROFESSIONAL NURSE: SPECIALIZED MENTAL HEALTH NURSE

Name and Surname	
Job title of post	Professional nurse: Specialized Mental Health Nurse
Minimum qualification required	SANC R425 qualification (diploma or degree) or equivalent qualification that allows registration with SANC as a professional nurse. Current registration with SANC. A post-basic qualification, with a duration of at least 1 year, accredited with SANC in the speciality of Mental Health. Grade1: A minimum of 4 years appropriate/recognisable experience in nursing after registration as a Professional nurse with SANC in General Nursing. Grade 2: A minimum of 14 years appropriate/ recognisable experience in nursing after registration as Professional nurse with SANC in General Nursing. →NB! At least 10 years of the period referred to above must be appropriate/recognisable experience in the Mental Health speciality after obtaining the 1-year post-basic qualification in Mental Health.
Motivation for minimum qualification required	Grade 1: Provide comprehensive nursing treatment and care to patients in a specialized Mental Health unit in a cost effective, efficient, and equitable manner. Perform administrative tasks. Manage human resources and if necessary, act as a shift leader. Grade 2: Provide more complex and advanced comprehensive nursing treatment and care to patients in a speciality Mental Health unit in a cost effective, efficient, and equitable manner. Perform administrative tasks. Manage human resources and if necessary, act as a shift leader.
Current qualification of incumbent	
Job title of incumbent	Professional nurse Specialized Mental Health: Grade 1 (PN-B1) or 2 (PN-B2)
CORE	Nursing and Support Personnel
Salary level	*PN-B1 or PN-B2*

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Date of appointment/ promotion into post	
Date of promotion into current rank	
Institution	
Component	Nursing department
Reports to	Operational Manager Nursing
Organogram	Operational Manager Nursing ↑ Professional nurse: Speciality in Psychiatry ↓ Enrolled nurse

B. JOB PURPOSE: Professional nurse: Specialized Mental Health Nurse

Describe in short, the purpose of the job. No more than two sentences. The description of the purpose should include such key words as *who, where, why, what, and how*
Grade 1: Provide comprehensive nursing treatment and care to patients in a specialized Mental Health unit in a cost effective, efficient, and equitable manner. Perform administrative tasks. Manage human resources and if necessary, act as a shift leader.
Grade 2: Provide more complex and advanced comprehensive nursing treatment and care to patients in a specialized Mental Health unit in a cost effective, efficient, and equitable manner. Perform administrative tasks. Manage human resources and if necessary, act as a shift leader.

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POST DIMENSIONS

Personnel expenses	*Applicable to salary level 9 and higher. Minimum rand value in R10 000, R100 000 or R1 000 000*
Budget	
Equipment	
Buildings	
Livestock	
Clients	

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D DESCRIPTION OF JOB: (Key Performance Areas (KPA's)) Registered Professional nurse: Specialized Mental Health Nurse: Grade 1 and 2

KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
The final product or main objective to of a job achieved against one or more outputs without which results cannot be achieved	Describe the sub results in order to achieve the KRA. Limit the outputs to as few as possible	Describe the activities in order to achieve the output	Indicate the weight of each output. All outputs together should not weigh more than a total of 100%	Describe legislation, protocols, policy, directives, minimum requirements, set parameters and rules that govern or define the output. Describe the criteria according to which the output must conform	Describe how you would prove that the output has been achieved. What would exist because it has been achieved. The evidence must be tangible PERFORMANCE MEASUREMENTS	Describe the knowledge, skills and behaviour necessary in order to achieve the output
Clinical Service delivery by providing continuous health care and comprehensive nursing care within a safe environment. **30%**	Effective clinical practice, nursing care and safety.	-Observe, interpret and report patients' vital signs, behaviour and disorder profile -Act as a case manager -Identify gaps in nursing care -Gathers accurate and relevant data. Analyse and interpret data. Assess, compile and implement individual nursing care and action plans according to patient's needs. Discuss suggestions or ideas with other team members. Making a nursing diagnosis that includes a psychodynamic formulation. Prepare for and manage special procedures and tests with the input of the team.	**30 %**	- Scope of Practice - Mental Health Care Act No 17 of 2002 and amendments - Human rights - Batho Pele - Ethical Codes - R425, R880, R882 - Nursing Act No 33 of 2005 and amendments - Procedure Manual Clinical No 1, 2, 4, 5, 6, 8, 9,10, 11, 12, 13, 15, 16, 30, 32,33, 40 - Procedure Manual Administrative No 4, 16, 18, 21, 26, 27, 42 - Doctor's prescriptions - Internal Policy Manual No 6, 23, 30 - Research methodology - Univ. research policy - Act No 101 of 1965 as amended - Procedure Clinical Manual No 17, 18, 19, 23, 24 - Procedure Manual Administration No 23 - Provide 100% factually correct information		**Knowledge:** Knowledge and understanding of nursing care processes, nursing procedures, nursing statutes, and other relevant legal and ethical practices such as: Nursing Act, Health Act, Occupational Health and Safety Act, Patient Rights Charter, Batho-pele principles, Public Service Regulations, Labour Relations Act, Disciplinary Code and Procedure, Grievance Procedure, Incident reports **Skills:** Good Communication skills Report writing skills Facilitation skills Co-ordination skills Liaison skills Networking skills Problem solving skills Information Management Knowledge Management Planning &

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KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
		-Management / Administration of patient's medication. -Initiate and implement psycho-social rehabilitation (PSR)and group activities - Advanced interventions / therapy/ sessions must be done with the input of the team: - Family therapy - Individual therapy -Gestalt therapy -Narrative therapy -Counselling -Crisis intervention etc.				Organising Computer Literacy **Personal:** Responsiveness Pro-activeness Professionalism Accuracy Flexibility Initiative Cooperation Team player Supportive Assertive Plan and organise own work and that of ward / colleagues
		-Manage key control, alarm system, lock doors and gates, damaged equipment, sharp objects and detergents. - Search of patients -Respond immediately and appropriately to emergency situations - Implement evacuation plan and drills -Maintain an appropriate therapeutic environment		- Occupational Health and Safety Act No 85 of 1993 - Procedure Manual Clinical No 32-38 - Internal Policy Manual No 18, 20, 21, 23, 40, 41, 42, 51		

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KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
2. Manage administrative duties according to quality assurance strategies **30 %**	Maintain accurate completed patient, staff and other appropriate documentation	Communicates clear, consistent and accurate information verbally, in writing and electronically. Manage and complete: - admissions documents, discharge, transfers, absconds, IOP seclusion. -Adverse incidents: Management and reporting - Keep statistics - Audit of patient records -Evaluation of nursing care and the scientific method of care --Undertake regular review of own practice. Do audits and peer review Management and completion of: - MHCA documents, and other appropriate patient related note-keeping	**30%**	- Mental Health Care Act No 17 of 2002 - Human rights - Batho Pele - Procedure manual Administrative No 18, 21, 27, 42 - Internal Policy Manual No 30 - Dr's prescriptions - *Provincial Directives -*Internal Policy - SPMS Circulars H 122, 18, 52, 74, 132, 60 - Quarterly reports - Utilise all types of leave responsibly - Procedure Manual Administration No 5 - Treasure Regulations - Handle all hospital property with respect and in a cost-effective manner		
3.1 Corporate Governance: Management of human resources **30%**	3.1 Participation in appropriate personal /professional development activities: Self, students, other categories of staff	- Use supportive strategies such as: precepting, orientation, mentoring, supervising and monitoring of students and new staff -Upkeep of own professional development and maintenance of competence -Participate in unilateral and team teaching / learning - Attend in-service training and courses - Implement Remedial shortcomings	*30%*	- Micro-orientation - SANC and Training Facilities prescriptions and guidelines for students SPMS Circulars H 122, 18, 52, 74, 132, 60 - Quarterly reports - Utilise all types of leave responsibly - Procedure Manual Administration Professionalism		

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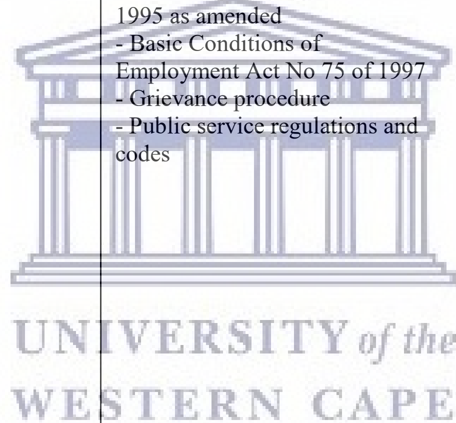
KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
	Professional interaction with members of Public, all staff and departments at all times.	- Duty register, absenteeism and daily control - Allocate tasks - Control execution of tasks - Provide evidence, interview and write SPMS/PERMIS and quarterly reports Staff morale boosting activities Participate in SSS and Barret surveys - Treat persons of diverse intellectual, cultural, racial or religious differences, in a professional manner. -Consult with or refers to appropriate others when encountering situations beyond your competence -Acts in an advocacy role to protect the health care user and human rights -Challenge healthcare practices that could compromise the health care user's privacy, safety, dignity and care - Manage labour relations issues, conflict and disciplinary procedures. Recognises and acts upon laws relating to the professional role and professional code of conduct		- Labour Relations Act No 66 of 1995 as amended - Basic Conditions of Employment Act No 75 of 1997 - Grievance procedure - Public service regulations and codes		



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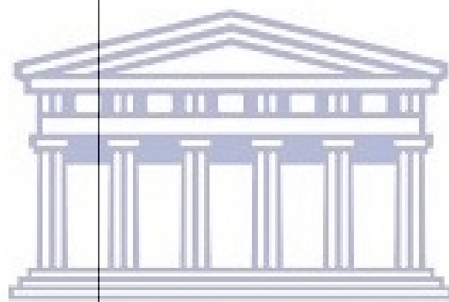
KRA	OUTPUT	ACTIVITIES	WEIGHT OF OUTPUT	STANDARD	EVIDENCE	COMPETENCY
		- Implement research projects or assist colleagues with research project Maintain effective communication and good interpersonal relationships with key role players: - Demonstrate effective communication with patients, clinicians and supervisors - Interact with multi professional team, traditional healers, supervisors, support services, family and friends of patients to ensure good nursing care - Work effectively, co-operatively immaculately with persons of diverse intellectual, cultural, racial or religious differences				
3.2 Financial resources	3.2 Management of donations, assets, consumables and non-consumables as delegated	- Manage clothing, valuable articles and private funds - See to the availability and appropriate utilisation of consumable stock and assets. - Manage stock shortages -See to security control measures / norm -Asset counts	**10%**	Treasury regulations PFMA		As above



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REQUIREMENTS OF THE JOB:

The inherent requirement of the job is derived from the essential functions of the job. The incumbent must be able to perform these essential functions. For example, the 24-hour service provided in a hospital environment will require that the individual work shifts in order to meet operational requirements. The inherent requirement of the job is therefore that the incumbent is able to work shifts. Similar examples relate to working hours, standby, willingness to travel and a driver's licence. *Other examples of inherent requirements could relate to the physical attributes of the incumbent. These can be linked to section 6(2) of the EEA, 1998, which states that the employer may fairly discriminate against the incumbent if such a physical attribute is regarded as an inherent requirement of the job. These include race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV/Aids status, conscience, belief, political opinion, culture, language and birth.*
Incumbent must be prepared to work shifts and maintain positive interpersonal skills with all categories of staff in the execution of his/her functions. *Incumbent undertakes not to refuse a reasonable instruction and to function within the scope of his/her practice.*

F. MEDICAL TESTING

In cases where specific health or physical attributes are essential for the performance of the job, the Minister of Labour must be approached for the necessary exemption. If exemption is obtained, such requirements should clearly be stated in the job description and advertised as such. *Health requirements should relate to the inherent requirement of the job. No pre-employment testing (health questionnaire, medical testing, medical reports, etc.) should be undertaken should the inherent requirement of the job not require health/physical attributes.*

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G. CAREER PATHING: Registered Professional nurse: Specialized Psychiatry (Operational Manager)

Describe the necessary knowledge, skills and behaviour in order to progress with regard to career pathing (career advancement). This may be horizontal (lateral transfer) or vertical movement (promotion). This should include in service training as well as formal education. *Promotion to the next higher post is subject to availability of a post, satisfactory work performance as well as conforming to the applicable recruitment and selection procedures.*

H. AGREEMENT

Agreement	This job description has been consulted and agreed to between the relevant parties.	
Employee	*Signature*	*Date*
Direct supervisor/manager	*Signature*	*Date*
Higher level supervisor	*Signature*	*Date*

Updated: May 2012 Revised: Dec 2014 Revised 2022

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APPENDIX J: DOH Advanced Psychiatric Nurse Job Information Summary (Community)

JOB INFORMATION SUMMARY:

REGISTERED PROFESSIONAL NURSE: Community Mental Health

Name and Surname	
Job title of post	*Registered Professional nurse:* *Specialized Mental Health Professional Nurse Grade 1 (Mental Health), as per the OSD Collective Agreement*
Minimum qualification required	*SANC R425 qualification (diploma or degree) or equivalent qualification that allows registration with SANC as a professional nurse* *Current registration with SANC* *A post-basic qualification, with a duration of at least 1 year, accredited with SANC in the speciality of Mental Health* *Grade1: A minimum of 4 years appropriate/recognisable experience in nursing after registration as a Prof. nurse with SANC in General Nursing* *Grade 2: A minimum of 14 years appropriate/ recognisable experience in nursing after registration as Professional. Nurse with SANC in General Nursing.* *At least 10 years of the period referred to above must be appropriate/recognisable experience in the Mental Health speciality after obtaining the 1-year post-basic qualification in Mental Health*
Motivation for minimum qualification required	*Grade 1: Provide comprehensive nursing treatment and care to patients with severe and chronic mental illness in a specialized community-based mental health unit in a cost effective, efficient and equitable manner. Perform mental health-related administrative tasks and manage mental health-related human resources including providing consultation and assist with supervision to other members of Community Health team* *Grade 2: Provide more complex and advanced comprehensive nursing treatment and care to patients in a speciality mental health unit in a cost effective, efficient, and equitable manner. Perform MH-related administrative tasks, assist with managing MH-related human resources and if necessary, act as a shift leader*
Current qualification of incumbent	
Job title of incumbent	*Professional Nurse Grade 1 / 2 (Specialty: Mental Health)*
CORE	*Nursing and Support Personnel*

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Salary level	*PN-B1 or PN-B2*
Salary level of incumbent	
Date of appointment/promotion into post	
Date of promotion into current rank	
Institution	
Component	*Nursing department*
Reports to	*Operational Manager Nursing*
Organogram	*Operational Manager Nursing* ↑ *Professional nurse: Speciality in Mental Health* ↓ *Staff Nurse (Job Title as per structure)*

B. JOB PURPOSE*: Professional Nurse Grade 1/2: Mental Health*

Describe in short, the purpose of the job. No more than two sentences. The description of the purpose should include such key words as who, where, why, what and how
Grade 1: Provide comprehensive nursing treatment and care to patients with severe and chronic mental illness in a specialized mental health unit in a community setting in a cost effective, efficient, and equitable manner. Perform MH-related administrative tasks and related HR tasks and provide consultation and assist with supervision to other members of the Community Health team
Grade 2: Provide more complex and advanced comprehensive nursing treatment and care to patients in a specialized mental health unit in a cost effective, efficient, and equitable manner. Perform administrative and HR tasks including providing consultation and assist with supervision and if necessary, act as a shift leader

POST DIMENSION

Personnel expenses	*Applicable to salary level 9 and higher. Minimum rand value in R10 000, R100 000 or R1 000 000*
Budget	
Equipment	
Buildings	
Livestock	
Clients	

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KEY PERFORMANCE AREAS (KPA'S)	PERFORMANCE OUTPUTS	ACTIVITIES	GENERIC ASSESSMENT FACTORS (GAF'S	PERFORMANCE STANDARDS/MEASURES	EVIDENCE OF MEASURABLE ACTIVITIES	COMPETENCY
The final product or main objective of a job achieved against one or more outputs without which results cannot be achieved	Describe the sub results in order to achieve the KRA. Limit the outputs to as few as possible	Describe the activities in order to achieve the output	Identified generic assessment factors	Describe legislation, protocols, policy, directives, minimum requirements, set parameters and rules that govern or define the output. Describe the criteria according to which the output must conform	Describe how you would prove that the output has been achieved. What would exist because it has been achieved? The evidence must be tangible	Describe the knowledge, skill and behaviour necessary in order to achieve the output
KRA 1 Clinical services for severe chronic mental illness (30%)	Provision of optimal, holistic specialized client care with set standards and within a professional/legal framework	1. Provide effective management and follow-up for clients with severe and chronic mental illness 2. Ensure appropriate and efficient referral across the service platform (liaising with CBS, L2 and L3 services) 3. Over-see and assist MH specialist/registrar/intern psychology ambulatory clinics at facility. 5. Supervise and monitor the assessment, transfer, and devolvement of stable MH patients to the general chronic care platform. 6. Refer to and assist to develop psycho-social interventions for severe chronic mental illness at the clinic. 7. Liaise with and assist CBS	Technical skills Teamwork Quality of Care	Millennium Development Goals Healthcare 2030 Ekurhuleni Declaration of MH (April 2012) Nursing Council Code of Conduct. Batho Pele principles. Provincial Quality of Care Policy Internal/hospital/ departmental policies/controls/guidelines/SOPs including adherence to indicators Evidence based protocols. Continuing Medical Development (CPD) principles. Patients' Charter. Mental Health Care Act 2002	Markers: • Total patients seen daily • Audits to show waiting times • Attendance after discharge • Overall hospital morbidity improves • Positive Reports from other colleagues • External referrals audit • Implement PACK protocols • MHRB feedback • Feedback from registrars	• As per JD • Knowledge of MHCA 2002 • Policy on referrals and Continuation of Care Plan • Good patient care practice

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KRA 2 Clinical advice and support for CNPs/MOs managing Non-severe Chronic Mental Illnesses (CMDs) (30%)	Provide specialist mental health advice and supervision for colleagues managing CMD patients at community setting. Effective management of human resources and assist with supervisory functions	1. Support effective development, implementation and management of PACK MH programme at primary care facility. 2. Effective diagnostic and treatment advise to medical officers, medical interns and CNPs managing CMDs. 3. Effective clinical supervision of other multidisciplinary team members, e.g., lay counsellors, CCWs. 4. Appropriate in-service training activities. 5. Assesses and refers complex or treatment resistant CMDs 6. Assists to develop appropriate psycho-social therapies for CMDs at clinic level	Interpersonal relationships Technical skills Teamwork Quality of work	Millennium Development Goals Healthcare 2030 Ekurhuleni Declaration of MH (April 2012) Nursing Council Code of Conduct. Batho Pele principles. Provincial Quality of Care Policy Internal/hospital/ departmental policies/controls/guidelines/SOPs including adherence to indicators Evidence based protocols. Continuing Medical Development (CPD) principles. Patients' Charter. Mental Health Care Act 2002	Markers: • Total patients seen daily • Audits to show waiting times • Attendance after discharge • Overall hospital morbidity improves • Positive Reports from other colleagues • External referrals audit • Implement lab protocols • MHRB feedback • Feedback from registrars	Knowledge of clinical aspects Good interpersonal skills Has attended own professional supervision
KRA 3 Corporate Governance (20%)	Participate in training, research, mortality and morbidity meetings, clinical governance meetings.	1. Formal teaching/course administration/curriculum, e.g., PACK as required by WC department/facility. 2. Appropriate personal and professional development 3. Participate in service development activities	Technical skills Management of Human Resources Financial management	As dictated by academic standards for a primary health care establishment and Relevant Human Resources policy Assists with or initiate's research Attends SCWGs, MnMs, seminars, facility-based teaching, academic events	Feedback from supervisors Leave planning and completed registers	• Knowledge of corporate governance structures

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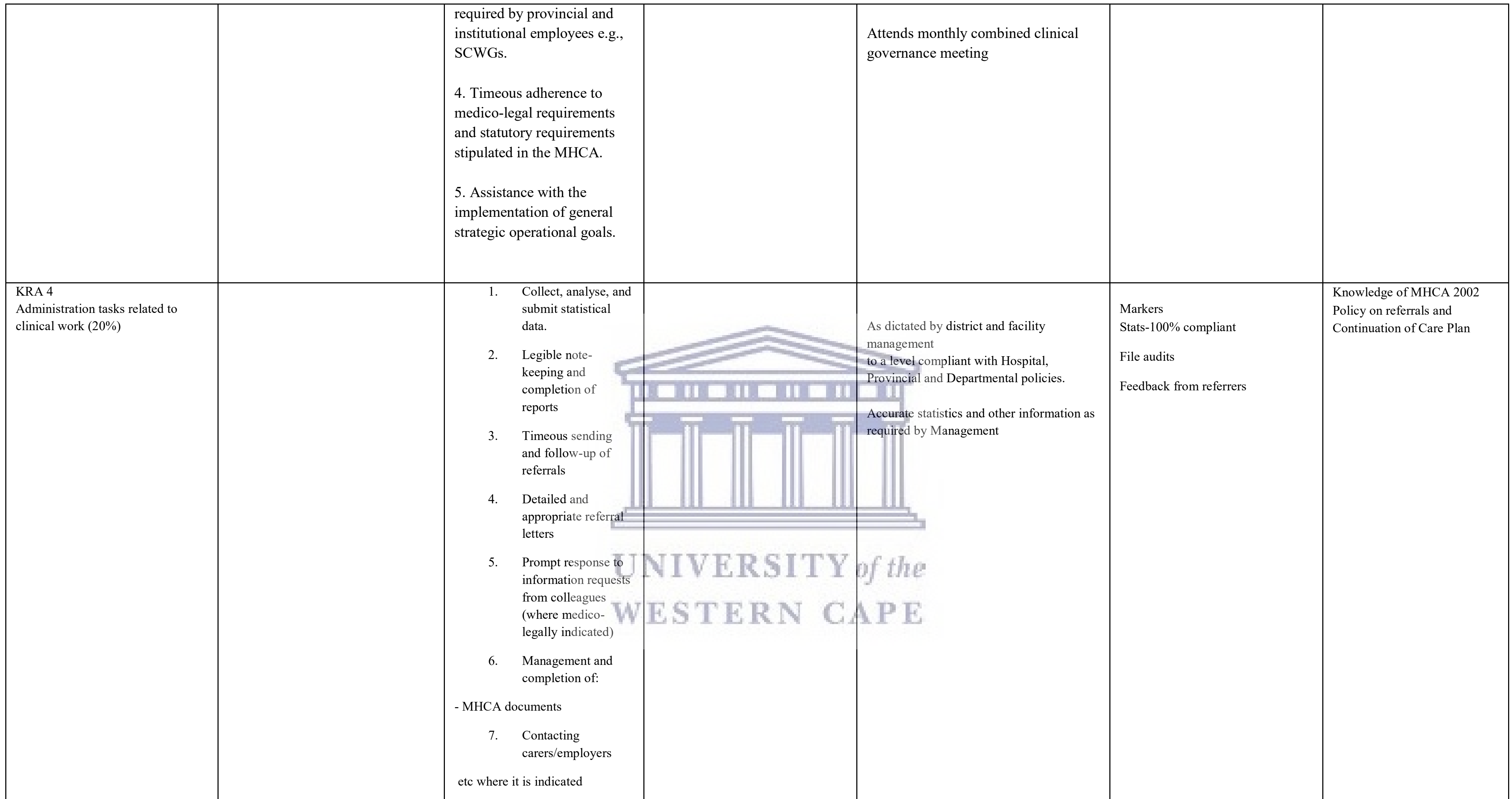

		required by provincial and institutional employees e.g., SCWGs. 4. Timeous adherence to medico-legal requirements and statutory requirements stipulated in the MHCA. 5. Assistance with the implementation of general strategic operational goals.		Attends monthly combined clinical governance meeting		
KRA 4 Administration tasks related to clinical work (20%)		1. Collect, analyse, and submit statistical data. 2. Legible note-keeping and completion of reports 3. Timeous sending and follow-up of referrals 4. Detailed and appropriate referral letters 5. Prompt response to information requests from colleagues (where medico-legally indicated) 6. Management and completion of: - MHCA documents 7. Contacting carers/employers etc where it is indicated		As dictated by district and facility management to a level compliant with Hospital, Provincial and Departmental policies. Accurate statistics and other information as required by Management	Markers Stats-100% compliant File audits Feedback from referrers	Knowledge of MHCA 2002 Policy on referrals and Continuation of Care Plan

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DEVELOPMENT PLAN

Key Skills required (Indicate what knowledge, skills and competencies are required by the employee in order to successfully achieve the desired result/outputs)15 GAF's to be used to identify development areas)	**Training/development programme identified** (Identify internal and external occupational development programs which would aid in the attainment of the required skills)	**Target date** (Indicates a commitment date for the development programme)	**Resources** (Allocate resources, especially for external service providers to the development programme)	**Desired outcome for** (Career Management is where the employee's personal goals and the department's goals meet)	
				Employee	Department

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APPENDIX K: Exemplar Coding & Code Abstraction-

Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
Research Interview Participant 3 Me: I'm at [redacted] clinic. I'm speaking to participant 3 on the 11th of the 3rd eleven minutes past 10. Participant 3 thank you for participating in my study. As I have explained to you earlier on that everything that we discuss here- it's only me and my researcher that will have access to the electronic file- I mean my supervisor- that will have access to the electronic files and if you feel at any point- even after this interview- that you do not want the data that we have collected to be used in the study, you can withdraw at any time. Is that ok? P3: Okay					Codes were extracted through an inductive & deductive process (hybrid approach). Inductive as not a lot of literature exist on the topic in South Africa- didn't want abstraction of codes to be too rigid. Deductive not to deviate too much from research question		
Me: Right, once again thank you for participating in this study. As I explained to you also my study basically it just wants to gather information about the counselling experiences of advanced psychiatric nurses	Community Health centre based on statistics	Stats-based	Workload	So it's really a lot. It is strictly based on stats. So it's based on stats"			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
who trained in South Africa. So that would be psychiatric nurses who work in the community setting and also in the tertiary setting. So I will just be asking you couple of questions. If you are unclear- we can just stop or if you need a minute to recollect your thoughts, that will be all in order. Ok. Uhm so the big question now is can you tell me of your counselling experiences as an advanced psychiatric nurse at this psychiatric facility? P3: Okay in the 1st place uhm…this is a community health centre. So it is really a lot. It is strictly based on stats. So it's based on stats so in this facility we make use of psychology.	Psychologist also performing counselling	Psychologist does most counselling	Counselling Experience Limited psychologists	'So it's really a lot. It is strictly based on stats. So it's based on stats" "We make use of psychology."			
Me: So when you say psychology do you mean, are you referring to another discipline like the psychologists? P3: Yes. I refer to a psychologist who's coming in every week on a Wednesday, four hours which we also discovered- I discovered that it is really not enough because we've got more on the waiting list.	Services offered by psychologists are not enough for amount of patients Does a bit of individual therapy in assessment	Limited psychologists Minimal Individual therapy	Counselling Experiences Counselling Experiences	Yes. I refer to a psychologist" "I discovered that it is really not enough because we've got more on the waiting list."			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
We managed now to get in an intern psychologist on a Friday. He's here for 8 hours, but she sees mostly 6, 5-7 patients on a Friday Counselling yes, when I assess a patient, I do a bit of counselling also in my assessment with the patient. Like mostly individual counselling. In the past- I don't book the patient for counselling but I- especially when it comes to couples and stuff I will ask the person husband or wife to bring in the partner. So during the assessment time, you also do a bit of counselling with the couple.	Lack of specific focus on counselling Able to perform couple therapy Some counselling occurs as part of assessment of patient	Lack of Focus on counselling Couple therapy Counselling weaved in	Counselling Experience	"We managed now to get in an intern psychologist on a Friday" He's here for 8 hours, but she sees mostly 6, 5-7 patients on a Frida , I do a bit of counselling also in my assessment with the patient			
But *time*- you don't have time to it.	Lack of time to do extensive counselling	Time CONSTRAINTS	Counselling Experiences	But *time*- you don't have time to			
As we in our advanced course, we did a lot of counselling and I think we had ten sessions of CBT that we needed to pass- we did a lot of different types of counselling- *but*…we can't really do the counselling here. As I said in the beginning it's stats based-	Exposed to many specialised counselling techniques in training	Comprehensive psychotherapy training Applying training	APN Training Training	As we in our advanced course, we did a lot of counselling As we in our advanced course, we did a lot of counselling and I think			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
	Cannot completely apply skills and knowledge of training because of time constraints			we had ten sessions of CBT that we needed to pass- we did a lot of different types of counselling- - *but*…we can't really do the counselling here . As I said in the beginning it's stats based			
time is against us to do that. So the little that I am doing with the counselling I do, I try to do it… Me: …Mm… especially with also our ADHD. We don't have the time but you know, I would *love* to do counselling with the mummies- you know parenting skills and stuff – but as I said there's no time. I try to do groups with	Challenge of time to conduct counselling in workplace Challenge of time to perform counselling on ADHD children and parenting skills	Time constraints Time constraints	Time Time	time is against us to do that So the little that I am doing with the counselling I do, I try to do especially with also our ADHD. We don't have the time but you know			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
the mommies, I try to get parents in- you start with ten, you end up with one, you know, because the time- we are an eight hours' facility				I would *love* to do counselling with the mummies – but as I said there's no time we are an eight hours' facility			
. It's either they have to go to fetch the child from school or they must take the child to school and they are working also. And you end up sitting with the grandparent that is not really the carer of the child. Yah…	Parents are not available for counselling	Unavailable patients	COUNSELLING EXPERIENCE	And you end up sitting with the grandparent that is not really the carer of the child.			
Me: Okay… you mentioned something about when you did the advanced psychiatric course. With regards to CBT- were you exposed in your training to any other therapies that you were taught? P3: Except the CBT? Yes, we did individual counselling, we did couple therapy. What was the…coping skills, all that stuff. Yes, we did a lot of counselling	Exposure to abundant counselling techniques in training Training was based on counselling	Comprehensive psychotherapy training Training focus	APN Training APN Training	Except the CBT? Yes, we did individual counselling, we did couple therapy. What was the…coping skills, all that stuff. Yes, we did a lot of counselling. I think our course was based more on counselling			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
think our course was based more on counselling than what I am doing now (giggles) here in the clinic.				I think our course was based more on counselling			
Me: Okay thank you. And I can see also that you mentioned a lot about time. Would you say that you have opportunities here at your work place to do counselling? P3: Yes, you know currently- I'm going to speak a lot of my experiences that I am having… Me: …yes I want to hear of your experiences P3: We've got a lot of patients with the same diagnosis. You know we've got a lot of GAD patients, Anxiety Disorders. I started also that group of getting them all in one place and from that I discovered ok this one needs an individual session. This one I need to assess to start on medication and that…but there's a turnaround with this Covid and after Covid that you can't really do the things that you used to do. So that also phased a little bit out for the past one year- with this Covid period and there is	Experience conducting group therapy in workplace to help counsel more patients Challenges to conduct past counselling activities with increase in anxiety patient numbers as a result of Covid pandemic	Conducting group therapy increased anxiety cases	Counselling Experience Workload	We've got a lot of patients with the same diagnosis. You know we've got a lot of GAD patients, Anxiety Disorders, I started also that group of getting them all in one place and from that I discovered ok this one needs an individual session So that also phased a little bit out for the past one year- with this Covid period and there is really a need because a lot of			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
really a need because a lot of people is suffering from anxiety now.				people is suffering from anxiety now			
Me: Okay thank you I understand what you are saying that there is so little time- the moments and the periods that you do get to engage with patients and do a little bit of counselling. Can you tell me about you enjoy most about counselling patients in your workplace? What I enjoy the most is when you sit with the patient and you follow your patient up for his third session and there is improvement. There's a bigger understanding about what is happening with him or her and you know some of them don't even start on medication after the counselling, you know. As soon as they understand what is happening with them, then they said "no sister I'm not gonna worry with medication. Yah. The changes of the people, the understanding into what is happening with them. Yah.	Enjoyment improvement due to counselling Improvement in patient understanding and coping with symptoms after counselling	Enjoys counselling Improvement	Counselling experience Counselling efficacy	What I enjoy the most is when you sit with the patient and you follow your patient up for his third session and there is improvement There's a bigger understanding about what is happening with him or her and you know some of them don't even start on medication after the counselling, you know The changes of the people, the understanding into what is happening with them. Yah			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
Me: You know you've mentioned a lot about time…are there any factors you know that you have experienced that have- like challenges with regards to counselling- other than time? P3: You know one of the things is spaces also. We don't have a space- the clinics don't have spa…I think 95% of the clinics don't have the space for the counselling. Because even now the counselling is happening in a room that is not conducive actually for counselling. You understand rooms- there's a lot of distractions also when you are busy with a client because you are using somebody else's room and that person is coming in to fetch whatever he need to fetch. So there is a lot of interruption.	Workplace space in clinics is not conducive for counselling practices with patients Rooms in clinics not conducive for counselling due to interruptions and distractions	Confined space Interruptions	Counselling Experience	You know one of the things is spaces also. We don't have a space- the clinics don't have spa So there is a lot of interruption.	- ai I think we're all stuck with this whole Covid- I wouldn't love that		
Me: Mm. Okay. And I think I also wanted to ask you…you know…if there has been any counselling interaction with a patient in which you felt like you contributed to the patient's recovery? Any you know, any examples from what you have experienced where you really felt or at least saw that you had a major role in the recovery of the patient.	Personal difficulties due to Covid pandemic impacted on ability to perform counselling	personal anxiety professional behaviour Counselling groups	APN Role Counselling Efficacy	Then because I try to put the groups still during this time and there was good results- But what was so good about this thing that they could never pick			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
P3: Impact like? Me: Yes, yes. Yah P3: I think during this- ai I think we're all stuck with this whole Covid- I wouldn't love that. But during this time we all experienced difficulties. Like you as the counsellor is experiencing the same anxiety that the client was experiencing. But what was so good about this thing that they could never pick up the anxiety from my side while I was busy with them because I try to put the groups still during this time and there was good results- like people come back and you know they could speak about if it was not for me or if it was not for that session or for that group, they don't know how they supposed to make it.	Maintained separation of personal anxiety from patient Groups conducted improved patient's ability to cope			up the anxiety from my side while I was busy with them like people come back and you know they could speak about if it was not for me or if it was not for that session or for that group, they don't know how they supposed to make it			
Me: Do you think there's a lot of support for you here as somebody that you know. Can you maybe tell also how many patients you see in a week or even a month? I think the support (pause) I can't really say there is support. Because currently I've been seeing – we've got 4 CNP's 2 Dr's and all of them just whatever they are experience, are sent to the mental health sister. So also that-	No support from managers irrespective of staff shortages and high patient numbers	Poor support	Support	Like you as the counsellor is experiencing the same anxiety that the client was experiencing.			

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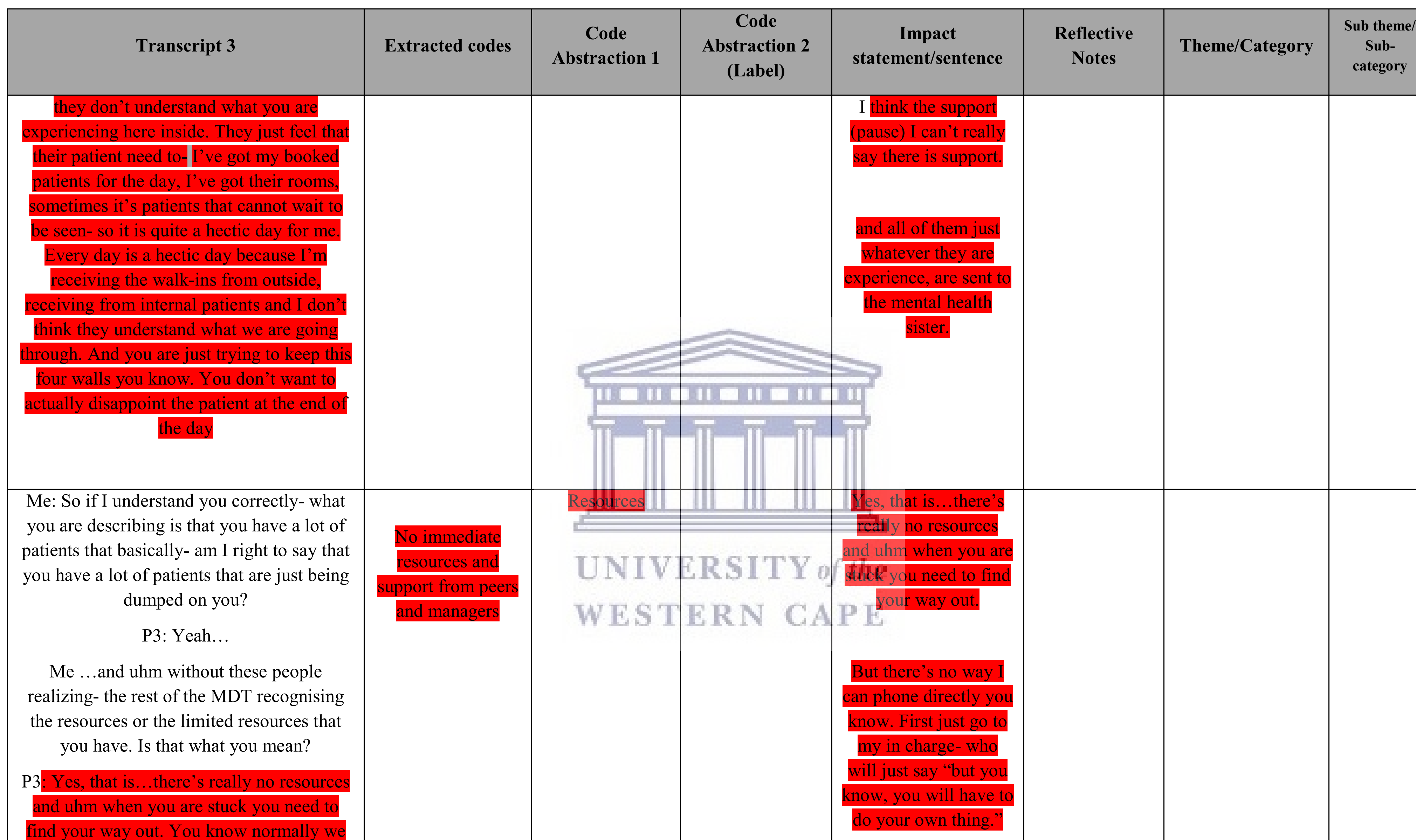

Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
they don't understand what you are experiencing here inside. They just feel that their patient need to- I've got my booked patients for the day, I've got their rooms, sometimes it's patients that cannot wait to be seen- so it is quite a hectic day for me. Every day is a hectic day because I'm receiving the walk-ins from outside, receiving from internal patients and I don't think they understand what we are going through. And you are just trying to keep this four walls you know. You don't want to actually disappoint the patient at the end of the day				I think the support (pause) I can't really say there is support. and all of them just whatever they are experience, are sent to the mental health sister.			
Me: So if I understand you correctly- what you are describing is that you have a lot of patients that basically- am I right to say that you have a lot of patients that are just being dumped on you? P3: Yeah… Me …and uhm without these people realizing- the rest of the MDT recognising the resources or the limited resources that you have. Is that what you mean? P3: Yes, that is…there's really no resources and uhm when you are stuck you need to find your way out. You know normally we	No immediate resources and support from peers and managers	Resources		Yes, that is…there's really no resources and uhm when you are stuck you need to find your way out. But there's no way I can phone directly you know. First just go to my in charge- who will just say "but you know, you will have to do your own thing."			

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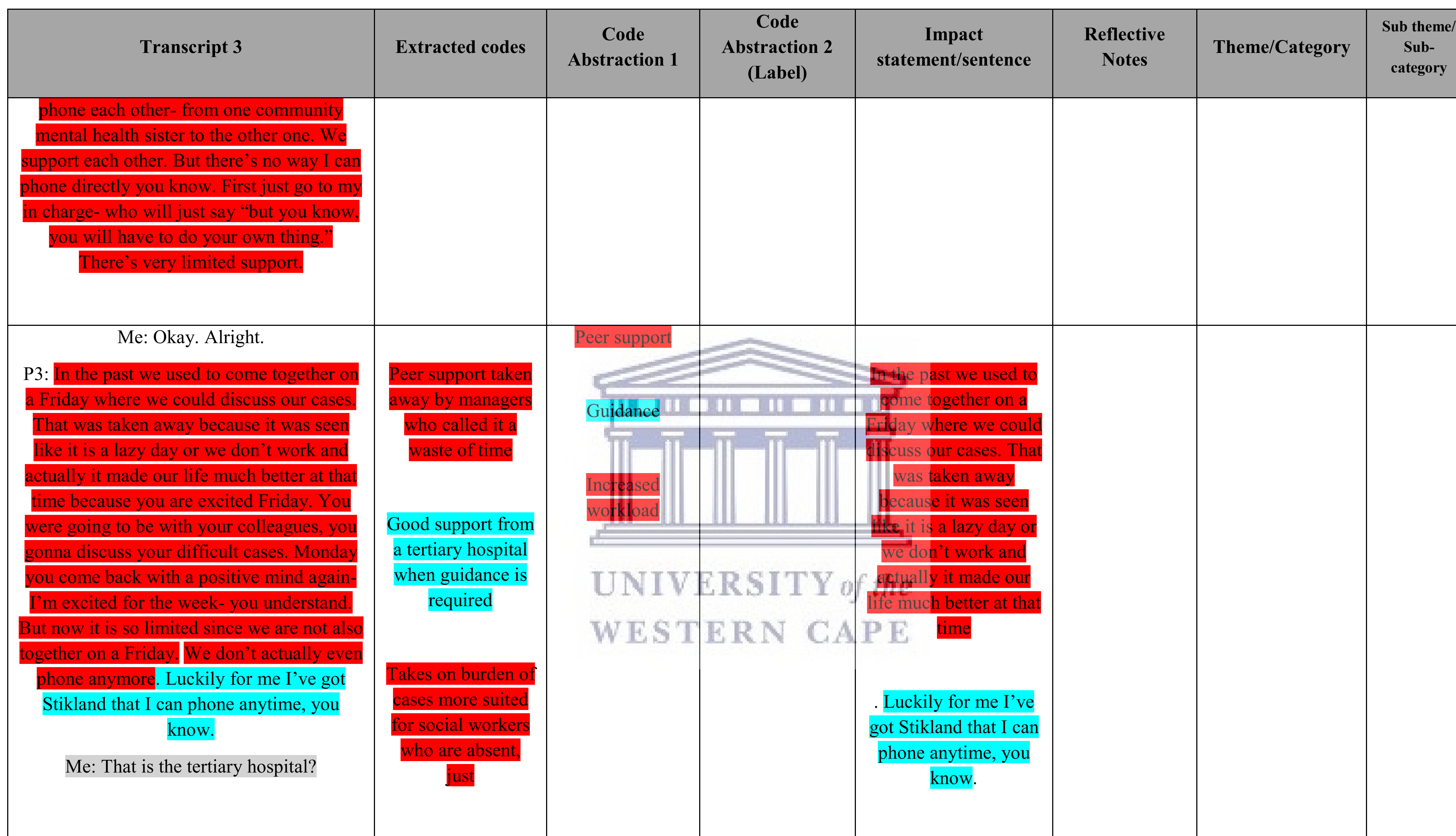

Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
phone each other- from one community mental health sister to the other one. We support each other. But there's no way I can phone directly you know. First just go to my in charge- who will just say "but you know, you will have to do your own thing." There's very limited support.							
Me: Okay. Alright. P3: In the past we used to come together on a Friday where we could discuss our cases. That was taken away because it was seen like it is a lazy day or we don't work and actually it made our life much better at that time because you are excited Friday. You were going to be with your colleagues, you gonna discuss your difficult cases. Monday you come back with a positive mind again- I'm excited for the week- you understand. But now it is so limited since we are not also together on a Friday. We don't actually even phone anymore. Luckily for me I've got Stikland that I can phone anytime, you know. Me: That is the tertiary hospital?	Peer support taken away by managers who called it a waste of time Good support from a tertiary hospital when guidance is required Takes on burden of cases more suited for social workers who are absent, just	Peer support Guidance Increased workload		In the past we used to come together on a Friday where we could discuss our cases. That was taken away because it was seen like it is a lazy day or we don't work and actually it made our life much better at that time . Luckily for me I've got Stikland that I can phone anytime, you know.			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
P3 The tertiary hospital yes. I've got a very open channel to them. They're very helpful in that. But otherwise you are ma stuck, you phone, you sit with a patient that you need to get into a safe home. You end up sitting here with a patient until- social worker don't- you know I don't know where they are? But they are somewhere. So a lot of stuff that- in fact you do the social worker's job or you do the police job- you do everybody's job. Me: Okay P3: Yah				I've got a very open channel to them. They're very helpful in that But now it is so limited since we are not also together on a Friday social worker don't- you know I don't know where they are? But they are somewhere. in fact you do the social worker's job or you do the police job- you do everybody's job			
Me: And with regards to all these activities that you and responsibilities that are placed on you, do you think that it has an impact on your ability to do counselling with patients?	Admission process of aggressive patients to	Administration	Workload				

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
You know in a normal sense- all the varieties that you were exposed to in your training? You've described that it is very time consuming… P3: …it's very time consuming. Because let me make an example. If I come on duty and the police is waiting with a patient for me. And that is an admission to a tertiary hospital. It can two hours for me. Because the patient has to be assessed by me as the mental health sister/ practitioner. It has to be seen by a medical officer then the forms need to be completed- sometimes the family member can't even read or write. You understand. Then you had to phone Stikland and discuss the patient with Stikland. And it takes forever for those forms to be scanned through because you know those are legal documents- you can't just send the patient. So you wait for their approval. And it can take up to 2hours. Patients are aggressive, the police say "Sorry, we've got a phone call now – we had to go and attend to their work." So that system is a lot of bit challenges. So two to two and a half hour from your day…	secondary or tertiary hospital is time consuming due to specific correctness of administration forms						
Me: …on one patient…							

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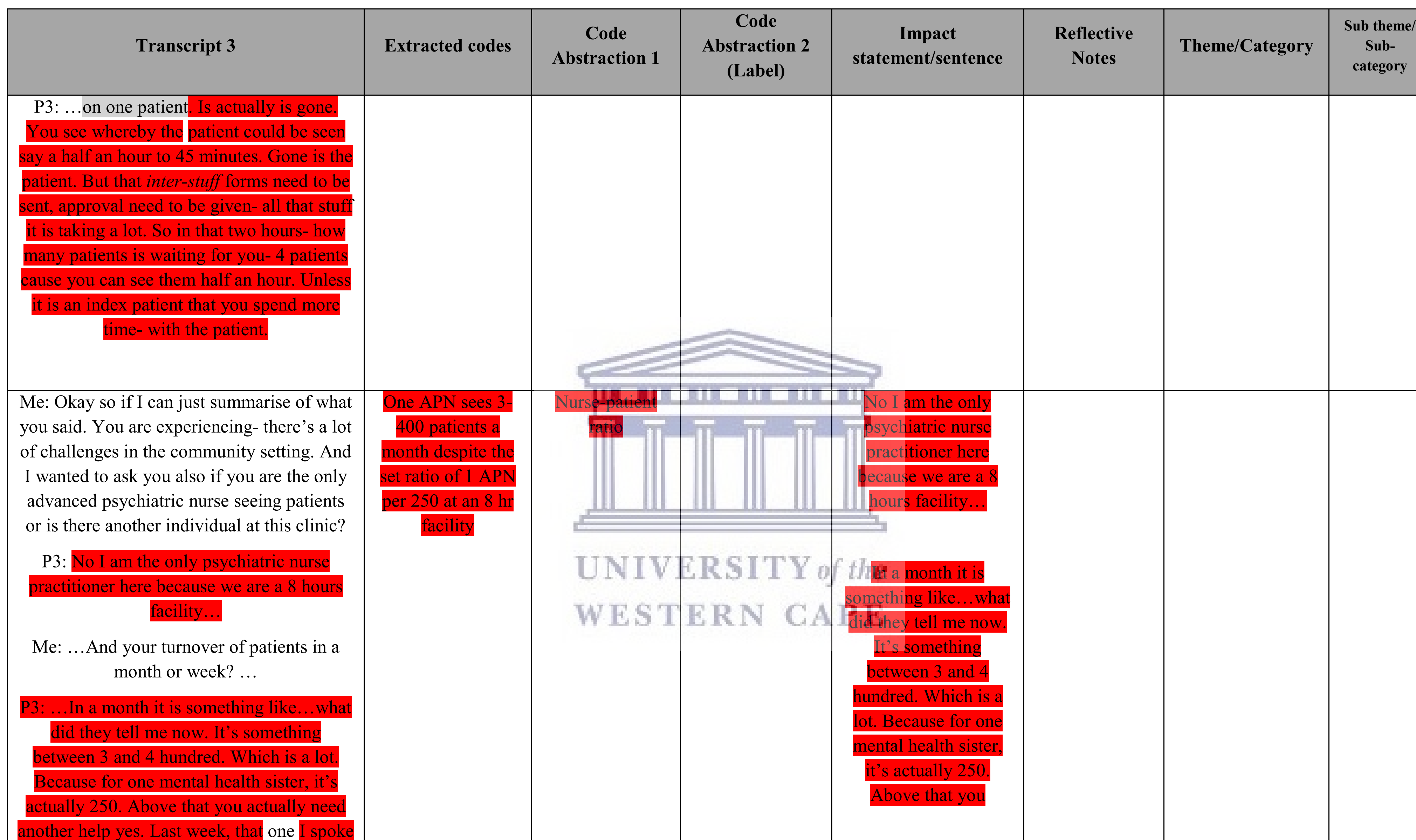

Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
P3: …on one patient. Is actually is gone. You see whereby the patient could be seen say a half an hour to 45 minutes. Gone is the patient. But that *inter-stuff* forms need to be sent, approval need to be given- all that stuff it is taking a lot. So in that two hours- how many patients is waiting for you- 4 patients cause you can see them half an hour. Unless it is an index patient that you spend more time- with the patient.							
Me: Okay so if I can just summarise of what you said. You are experiencing- there's a lot of challenges in the community setting. And I wanted to ask you also if you are the only advanced psychiatric nurse seeing patients or is there another individual at this clinic? P3: No I am the only psychiatric nurse practitioner here because we are a 8 hours facility… Me: …And your turnover of patients in a month or week? … P3: …In a month it is something like…what did they tell me now. It's something between 3 and 4 hundred. Which is a lot. Because for one mental health sister, it's actually 250. Above that you actually need another help yes. Last week, that one I spoke	One APN sees 3-400 patients a month despite the set ratio of 1 APN per 250 at an 8 hr facility	Nurse-patient ratio		No I am the only psychiatric nurse practitioner here because we are a 8 hours facility… In a month it is something like…what did they tell me now. It's something between 3 and 4 hundred. Which is a lot. Because for one mental health sister, it's actually 250. Above that you			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
about, even that even our CEO picked up that my stats is increasing. And they wanted to know how I manage…the patients. How do I get it right to see such a lot of patients within a month?				actually need another help yes even that even our CEO picked up that my stats is increasing. And they wanted to know how I manage…the patients. How do I get it right to see such a lot of patients within a month?			
Me: How do you get it right? P3: I think the stats also grow because of the groups. I can put more than 5 people in and our services of the psychologist of the psychology services and then after many moons we at least have again an intern doctor. So those extra resources helped a lot also. But my day I see something like 20 patients which is a lot. That's why I brought in the system on a Tuesday I will see the new patients. But I cannot really say- it's unpredictable. Today it's like this, tomorrow it's like that. Yah. As I say to you and then the inter-referrals also. We have a lot of influx of our IDU- infectious disease	Managing huge patient numbers through creation of group activities in conjunction with psychology and medical intern Increased HIV and TB patient's numbers as a result of the mental symptoms they suffer from	limited resources	Support	I can put more than 5 people in and our services of the psychologist of the psychology services and then after many moons we at least have again an intern doctor. But my day I see something like 20 patients which is a lot. That's why I brought in the system on a			

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Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
patients, like the HIV patients, Tb patients. So we've got a lot of them nowadays and they become very difficult with treatment. Me: Do they come to see you? P3: They come, yes…				Tuesday I will see the new patients We have a lot of influx of our IDU-infectious disease patients, like the HIV patients, Tb patients. So we've got a lot of them nowadays and they become very difficult with treatment.			
Me: for…? P3: …depression, it depends on very difficult- not difficult very challenging. You know the psychotic side and the IDU, the mental health. So those patients, when I see them the 1st time I book them for the registrar that is coming every second week to the facility.		Influx of IDU patients	Workload				
Me: So you have to correct me if I'm wrong here but, you seem to function almost very independently in the managing of your patients and the clinic and that must be difficult?	Works mostly independently on mental health related work issues	Work Independent	APN Role	I'm working kind of on my own- with my resources outside of the facility			

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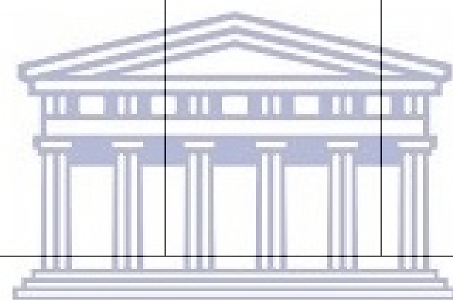
Transcript 3	Extracted codes	Code Abstraction 1	Code Abstraction 2 (Label)	Impact statement/sentence	Reflective Notes	Theme/Category	Sub theme/ Sub-category
P3: Yeah…. yes. I'm working kind of on my own- with my resources outside of the facility. Unless there is a medical condition I will pick up then I will refer that patient to the medical officer. But otherwise pure mental health- I'm on my own. Me: Okay. Participant three I think we have come to the end of our interview. Once again, thank you very much for participating in my study. I know that uhm- from our discussion here that there's a lot going on at your clinic and that's why I am so appreciative for taking the time for this interview. Thank you so much P3: A pleasure. Thank you hey.				But otherwise pure mental health- I'm on my own			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APPENDIX L: Exemplar Code Formulation/ Theme/ Sub-theme (Category)

Colour Code (C) Theme/ Sub-theme Transcript 2 Participant 2		
C: Admin Duties consume time CTG: Time	C: Frustrated CTG: Counselling experience	Eschewed contribution (this can be a theme instead- from APN feeling undermined)
C: Multimodal Counselling approach CTG: Counselling experience	C: Factors preventing counselling CTG: Heavy Workload	C: Limited Role CTG: APN role
C: Limited opportunities to counsel CTG: Counselling Experience	C: Supportive Interviews CTG: Counselling experience	C: Psycho rehabilitative interventions CTG: Counselling Efficacy
C: Suitable Wards for Counselling CTG: Counselling experience	C: Motivational interviewing CTG: Counselling Experience	C: Enjoys talking to patients CTG: Counselling experience
C: Trained in Multi-modal psychotherapies CTG: APN Training	C: Unused skills CTG: Counselling Experiences	C: Lack of time CTG: TIME
C: Balanced theory & practical CTG: APN Training	C: Eschewed Role by MDT/ Adversity CTG: APN Role	C: MDT eschews APN skills CTG: Adversity
C: Limited opportunity in ward CTG: Counselling Experience	C: Refers to psychologist CTG: Adversity	C: Impact of Admin duties CTG: Workload
C: More staff CTG: Staff shortages	C: Fulfilment CTG: Counselling experience	

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Colour Code & Category Transcript 1 Participant 1		
C: Transition in role of APN CTG: APN Role	C: Reward and Achievement CTG: Counselling Experience	C: Adversity from Psychologists CTG: Adversity
C: Multi-modal counselling approach CTG: Counselling Experience	C: Understanding Professional Role CTG: APN Development	C. Only Theoretical Gestalt exposure CTG: Training
C: Limited Experiential knowledge of CBT CTG: Counselling Experience	C: Counselling helps CTG: Counselling efficacy	
C: Trained in multimodal psychotherapies CTG: Training	C: Staff shortages CTG: Heavy Workload	C: Broad Teaching Strategies in Training CTG: Training
C: Challenges to CBT CTG: Counselling Experiences	C: Training 4th years' workload CTG: Heavy workload	C: Only theoretical Gestalt exposure CTG : Training
C: Teaching APN trainees CTG: APN Role	C: Psychosocial interventions CTG: Counselling efficacy	C: Good opportunities for counselling CTG: Counselling Experience
C: Counsels staff members CTG: Counselling Experience/ APN Role	C: MDT confidence in APN skills CTG: APN Role	

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Colour Code (C) Category (CTG) Transcript 2 Participant 2		
C: Admin Duties CTG: Time	C: Frustrated CTG: Counselling experience	
C: Multimodal Counselling approach CTG: Counselling experience	C: Factors preventing counselling CTG: Workload	C: Limited Role CTG: APN role
C: Limited opportunities CTG: Counselling Experience	C: Supportive Interviews CTG: Counselling experience	C: Psycho rehabilitative interventions CTG: Counselling Efficacy
C: CTG: Counselling experience	C: Motivational interviewing CTG: Counselling Experience	C: Enjoys talking to patients CTG: Counselling experience
C: Trained in Multi-modal psychotherapies CTG: APN Training	C: Unused skills CTG: Counselling Experiences	C: Lack of time CTG: TIME
C: Balanced theory & practical CTG: APN Training	C: Undermined Role by MDT/ Adversity CTG: APN Role	C: Undermine APN skills CTG: MDT
C: Limited opportunity in ward CTG: Counselling Experience	C: Refers to psychologist CTG: MDT	C: Impact of Admin duties CTG: Workload
C: More staff CTG: Staff shortages	C: Fulfilment CTG: Counselling experience	C: SIPD CTG: Ward

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Colour Coding Transcript 3 Participant 3		
C: Stats-based CTG: Workload	C: Improvement CTG: Counselling Efficacy	C: Peer Support CTG: Support
C: Psychologist does most counselling CTG: MDT	C: Confined space CTG: Workspace	C: Resources CTG: Support
C: focus on Counselling CTG: Counselling Experience	C: Personal anxiety CTG: Counselling experience	C: Guidance CTG: Support
C: Time Constraints CTG: Time	C: Maintained Professional CTG: APN Role	C: Administration CTG: Time
C: Comprehensive psychotherapy training CTG: APN Training	C: Poor support CTG: Support	C: Increased workload CTG: Workload
C: Personal Anxiety CTG: Counselling Experience	C: Resources CTG: Support	C: Work Independent CTG: APN Role
C: Unavailable patients CTG: Counselling Experiences	C: Professional behaviour CTG: APN role	C: Enjoys counselling CTG: Counselling experience
C: Conduct couple therapy CTG: Counselling experience	C: Applying training CTG: APN Training C: Interruptions CTG: Workspace	C: Unavailable patients CTG: Counselling Experience
C: Nurse patient ratio CTG: Workload	C: Improvement CTG: Counselling efficacy	C: Minimal Opportunities

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Colour Coded Category Transcript 4 Participant 4		
C: Prohibited to counsel CTG: Counselling Experiences/ MDT	C: Life Skills CTG: APN Training	C: Challenging Management CTG: APN Role
C: Deprived counselling CTG: Counselling Experience/ MDT	C: Psychosocial ward CTG: Counselling experience	C: Administration CTG: Time
C: Not Valued CTG: APN Role	Limited opportunity	C: Diagnostic activities CTG: Time
C: Willingness CTG: Counselling Experience	C: Practice Skills CTG: Counselling Experience	C: Check Medication CTG: APN Role
C: Unavailable Patients CTG: Counselling experience	C: Minimal experience CTG: Counselling Experience	C: Previous Routine CTG: APN Role
C: Psychologist CTG: MDT	C: Non-recognition CTG: APN Role	C: Challenging Management CTG: APN ROLE
C: Exclusion CTG: APN Role	C: Improved patients CTG: Efficacy of Counselling	C: Denied applying training CTG: Counselling Experience/ APN Training
C: Eschewed Title CTG: APN Role	C: No Experience CTG: Counselling experience	C: Patient mistrust CTG: Counselling experience
C: Poor recall CTG: APN Training		

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Colour Coded & Category Transcript 5 Participant 5		
C: Referral Psychology CTG: MDT	C: Shift Leader CTG:	C: Family Therapy Counselling Experience
C: Marital, Family, Motivational CTG: Counselling experience	C: fulfilment CTG: Counselling Experience/ Counselling Efficacy	C: CBT, Trauma, Bereavement CTG: Counselling experience
C: Female Admission CTG: Ward	C: Stigma/language barriers CTG: Counselling experience	C: Counsels Psychotic Patients CTG: Ward
C: Only APN CTG: Workload	C: Heavy Workload CTG: Workload	C: Applies Training CTG: APN Training
C: Specialised Psychotherapy CTG: APN Training	C: Soft Skills Confidence CTG: Counselling Experience	C: Screening APN Role
C: Feel valued CTG: MDT	C: Patient recovery CTG: Counselling efficacy	C: Confident Counselling CTG: Counselling Experience
C: Time Limitation CTG: Time	C: Psychotic Patients/ Rapport CTG: Ward	C: Gained knowledge, skills CTG: APN Training

Colour Coded/ Category Transcript 6 Participant 6		
C: Referred psychology CTG: MDT	C: Routine Medication round/ Admin CTG: APN Role	Good support
C: Multiple specialist therapies CTG: APN Training	C: MSEs CTG: APN Role	C: Limited recollection CTG: Counselling Experience
C: Limited scope CTG: Counselling experience	C: Pharmacy staff CTG: Support	C: No difference CTG: APN Training
C: Mainly theoretical CTG: APN Training	C: Possible Counselling role CTG: MDT	C: Not applying Skills CTG: APN Role/ Counselling Experiences
C: Psychologist more trained CTG: MDT	C: OPM Supportive CTG: Support	
C: Practice Skills CTG: Counselling Experiences	C: Access to patients CTG: APN Role	
C: Practice Skills CTG: Counselling Experiences		

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Coded & Categorised Transcript P 7		
C: Limited counselling CTG: Counselling Experience	C: Lack of Time CTG: Time	C: Acute Ward/ Psychotic CTG: Ward
C: Partial Motivational Interviewing CTG: Counselling Experience	C: Motivational Interviewing, Supportive Interviewing, Family Therapy, Couple Therapy CTG: APN Training	C: Staff Shortage CTG: Ward
C: SIPD Patients CTG: Ward	C: Demonstrations, work integrated Learning, Questioning Techniques CTG: APN Training	C: Unknown APN Skills CTG: MDT
C: Motivational Interviewing, Supportive Interviewing CTG: Counselling Experience	C: Trauma Counselling CTG: APN Training	C: Basic Nursing/ Medication round/ Admin CTG: APN Role
C: Strong points CTG: Counselling Experience	C: Valued CTG: MDT	C: Enjoy CTG: Counselling Experience
C: Recovery CTG: Counselling Efficacy	C: Psychologist CTG: MDT	C: Excluded CTG: MDT/ Psychology
C: Poor Leadership CTG: Support	C: Commitments CTG: APN Role	C: Administration CTG: APN role
C: Family Therapy CTG: Counselling Experience	C: Patient Progress CTG: Counselling efficacy	C: Lack of Time CTG: Time
C: Poor follow up CTG: Ward	C: Criticism CTG: APN	C: Transformed CTG: Training
C: Unused skills/ Disgusted CTG: Counselling Experience	C: Same type of work CTG: APN Role	

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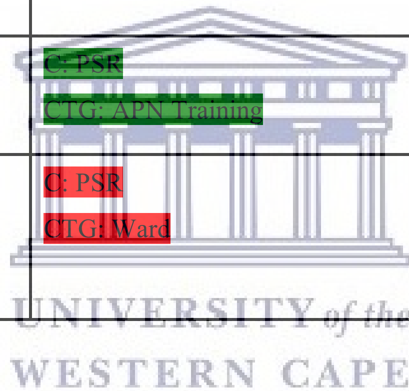
Coded & Categorised Transcript 8 P 8		
C: Psychologist MDT	C: Admin CTG: Workload	C: Lack of time CTG: Time
C: Psycho-education CTG: APN Role	C: Limited Opportunities C: Ward	C: Group Therapy CTG: Counselling Experience
C; CBT/ One-on-one Counselling CTG: APN Training	C: Psychologist CTG: MDT	C: Limited Opportunities CTG: Counselling Experience
C: Don't Remember CTG: APN Training	C: Supportive Interview CTG: Counselling Experience	C: Therapeutic Ward CTG: Wards
C: Motivational Interviewing CTG: APN Training	C: Observational Role CTG: MDT/ APN Role	C: Fulfilled CTG: Counselling Experience
C: Valued CTG: Valued	C: PSR CTG: APN Training	C: Motivational Interviewing CTG: Counselling Experience
C: APN vs RN CTG: APN Role	C: PSR CTG: Ward	C: Weakened Skills CTG: Ward/ Counselling Experience



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Colour Coded & Categories Transcript 10 Participant 10		
Non-nursing Counselling services/ Psychology	C: Containment Counselling CTG: Counselling Experience	C: Non-therapeutic CTG: Workspace
C: Limited Time/ Containment counselling CTG Time/Counselling experience	C: Specialised & Crisis Counselling CTG: APN Training	C: Brief interventions CTG: Counselling Efficacy
C: Counsellors & Psychologists CTG: MDT	C: Theoretical/ Practical sessions CTG: APN Training	C: CBT Skills/ Motivational Therapy
C: Non-intensive counselling/ Time constraints CTG: Counselling experience/ Time	C: Statistics CTG: Workload	C: Collaboration/ Waiting List CTG: MDT
C: Valued CTG: MDT/ APN Role	C: CTG: Support	

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APPENDIX M: Exemplar Transcript

Research Interview Participant 3

Interviewer: I'm at [redacted]. I'm speaking to participant 3 on the 11th of the 3rd eleven minutes past 10. Participant 3 thank you for participating in my study. As I have explained to you earlier on that everything that we discuss here- it's only me and my supervisor that will have access to the electronic file- I mean my supervisor- that will have access to the electronic files and if you feel at any point- even after this interview- that you do not want the data that we have collected to be used in the study, you can withdraw at any time. Is that ok?

P3: Okay

Interviewer: Right, once again thank you for participating in this study. As I explained to you also my study basically it just wants to gather information about the counselling experiences of advanced psychiatric nurses who trained in South Africa. So that would be psychiatric nurses who work in the community setting and also in the tertiary setting. So I will just be asking you couple of questions. If you are unclear- we can just stop or if you need a minute to recollect your thoughts, that will be all in order. Ok. Uhm so the big question now is can you tell me of your counselling experiences as an advanced psychiatric nurse at this psychiatric facility?

P3: Okay in the 1st place uhm…this is a community health centre. So it is really a lot. It is strictly based on stats. So it's based on stats so in this facility we make use of psychology.

Interviewer: So when you say psychology do you mean, are you referring to another discipline like the psychologists?

P3: Yes. I refer to a psychologist who's coming in every week on a Wednesday, four hours which we also discovered- I discovered that it is really not enough because we've got more on the waiting list. We managed now to get in an intern psychologist on a Friday. He's here for 8 hours, but she sees mostly 6, 5-7 patients on a Friday. Counselling yes, when I assess a patient, I do a bit of counselling also in my assessment with the patient. Like mostly individual counselling. In the past- I don't book the patient for counselling but I- especially when it comes to couples and stuff I will ask the person husband or wife to bring in the partner. So during the assessment time, you also do a bit of counselling with the couple. But *time*- you don't have time to it. As we in our advanced course, we did a lot of counselling and I think we had ten sessions of CBT that we needed to pass- we did a lot of different types of counselling- *but*…we can't really do the counselling here. As I said in the beginning it's stats based- time is against us to do that. So the little that I am doing with the counselling I do, I try to do it…

Interviewer: …Mm…

P3: …especially with also our ADHD. We don't have the time, but you know, I would *love* to do counselling with the mummies- you know parenting skills and stuff – but as I said there's no time. I try to do groups with the mommies, I try to get parents in- you start with ten, you end up with one, you know, because the time- we are an eight hours' facility. It's either they have to go to fetch the child from school or they must take the child to school, and they are working also. And you end up sitting with the grandparent that is not really the carer of the child. Yah…

Interviewer: Okay… you mentioned something about when you did the advanced psychiatric course. With regards to CBT- were you exposed in your training to any other therapies that you were taught?

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P3: Except the CBT? Yes, we did individual counselling, we did couple therapy. What was the…coping skills, all that stuff. Yes, we did a lot of counselling. I think our course was based more on counselling than what I am doing now (giggles) here in the clinic.

Interviewer: Okay thank you. And I can see also that you mentioned a lot about time. Would you say that you have opportunities here at your workplace to do counselling?

P3: Yes, you know currently- I'm going to speak a lot of my experiences that I am having…

Interviewer: …yes, I want to hear of your experiences

P3: We've got a lot of patients with the same diagnosis. You know we've got a lot of GAD patients, Anxiety Disorders. I started also that group of getting them all in one place and from that I discovered ok this one needs an individual session. This one I need to assess to start on medication and that…but there's a turnaround with this Covid and after Covid that you can't really do the things that you used to do. So that also phased a little bit out for the past one year- with this Covid period and there is really a need because a lot of people is suffering from anxiety now.

Interviewer: Okay thank you I understand what you are saying that there is so little time- the moments and the periods that you do get to engage with patients and do a little bit of counselling. Can you tell me about you enjoy most about counselling patients in your workplace?

P3: What I enjoy the most is when you sit with the patient, and you follow your patient up for his third session and there is improvement. There's a bigger understanding about what is happening with him or her and you know some of them don't even start on medication after the counselling, you know. As soon as they understand what is happening with them, then they said "no sister I'm not gonna worry with medication. Yah. The changes of the people, the understanding into what is happening with them. Yah.

Interviewer: You know you've mentioned a lot about time…are there any factors you know that you have experienced that have- like challenges with regards to counselling- other than time?

P3: You know one of the things is spaces also. We don't have a space- the clinics don't have spa…I think 95% of the clinics don't have the space for the counselling. Because even now the counselling is happening in a room that is not conducive actually for counselling. You understand rooms- there's a lot of distractions also when you are busy with a client because you are using somebody else's room and that person is coming in to fetch whatever he need to fetch. So there is a lot of interruption.

Interviewer: Mm. Okay. And I think I also wanted to ask you…you know…if there has been any counselling interaction with a patient in which you felt like you contributed to the patient's recovery? Any you know, any examples from what you have experienced where you really felt or at least saw that you had a major role in the recovery of the patient.

P3: Impact like?

Interviewer: Yes, yes. Yah

P3: I think during this- ai I think we're all stuck with this whole Covid- I wouldn't love that. But during this time we all experienced difficulties. Like you as the counsellor is experiencing the same anxiety that the client was experiencing. But what was so good about this thing that they could never pick up the anxiety from my side while I was busy with them because I try to put the groups still during this time and there was good results- like people come back and you know they could speak

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about if it was not for me or if it was not for that session or for that group, they don't know how they supposed to make it.

Interviewer: Do you think there's a lot of support for you here as somebody that you know. Can you maybe tell also how many patients you see in a week or even a month?

P3: I think the support (pause) I can't really say there is support. Because currently I've been seeing – we've got 4 CNP's 2 Dr's and all of them just whatever they are experience, are sent to the mental health sister. So also that- they don't understand what you are experiencing here inside. They just feel that their patient need to- I've got my booked patients for the day, I've got their rooms, sometimes it's patients that cannot wait to be seen- so it is quite a hectic day for me. Every day is a hectic day because I'm receiving the walking from outside, receiving from internal patients and I don't think they understand what we are going through. And you are just trying to keep this four walls you know. You don't want to actually disappoint the patient at the end of the day.

Interviewer: So if I understand you correctly- what you are describing is that you have a lot of patients that basically- am I right to say that you have a lot of patients that are just being dumped on you?

P3: Yeah…

Interviewer …and uhm without these people realizing- the rest of the MDT recognising the resources or the limited resources that you have. Is that what you mean?

P3: Yes, that is…there's really no resources and uhm when you are stuck you need to find your way out. You know normally we phone each other- from one community mental health sister to the other one. We support each other. But there's no way I can phone directly you know. First just go to my in charge- who will just say "but you know, you will have to do your own thing." There's very limited support.

Interviewer: Okay. Alright.

P3: In the past we used to come together on a Friday where we could discuss our cases. That was taken away because it was seen like it is a lazy day or we don't work and actually it made our life much better at that time because you are excited Friday. You were going to be with your colleagues, you gonna discuss your difficult cases. Monday you come back with a positive mind again- I'm excited for the week- you understand. But now it is so limited since we are not also together on a Friday. We don't actually even phone anymore. Luckily for me I've got Stikland that I can phone anytime, you know.

Interviewer: That is the tertiary hospital?

P3 The tertiary hospital yes. I've got a very open channel to them. They're very helpful in that. But otherwise you are ma stuck, you phone, you sit with a patient that you need to get into a safe home. You end up sitting here with a patient until- social worker don't- you know I don't know where they are? But they are somewhere. So a lot of stuff that- in fact you do the social worker's job or you do the police job- you do everybody's job.

Interviewer: Okay

P3: Yah

Interviewer: And with regards to all these activities that you and responsibilities that are placed on you, do you think that it has an impact on your ability to do counselling with patients? You know in a

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normal sense- all the varieties that you were exposed to in your training? You've described that it is very time consuming…

P3: …it's very time consuming. Because let me make an example. If I come on duty and the police is waiting with a patient for me. And that is an admission to a tertiary hospital. It can two hours for me. Because the patient has to be assessed by me as the mental health sister/ practitioner. It has to be seen by a medical officer then the forms need to be completed- sometimes the family member can't even read or write. You understand. Then you had to phone Stikland and discuss the patient with Stikland. And it takes forever for those forms to be scanned through because you know those are legal documents- you can't just send the patient. So you wait for their approval. And it can take up to 2hours. Patients are aggressive, the police say "Sorry we've got a phone call now –we had to go and attend to their work." So that system is a lot of bit challenges. So two to two and a half hour from your day…

Interviewer: …on one patient…

P3: …on one patient. Is actually is gone. You see whereby the patient could be seen say a half an hour to 45 minutes. Gone is the patient. But that *inter-stuff* forms need to be sent, approval need to be given- all that stuff it is taking a lot. So in that two hours- how many patients is waiting for you- 4 patients cause you can see them half an hour. Unless it is an index patient that you spend more time- with the patient.

Me: Okay so if I can just summarise of what you said. You are experiencing- there's a lot of challenges in the community setting. And I wanted to ask you also if you are the only advanced psychiatric nurse seeing patients or is there another individual at this clinic?

P3: No I am the only psychiatric nurse practitioner here because we are an 8 hours facility…

Interviewer: …And your turnover of patients in a month or week? …

P3: …In a month it is something like…what did they tell me now. It's something between 3 and 4 hundred. Which is a lot. Because for one mental health sister, it's actually 250. Above that you actually need another help yes. Last week, that one I spoke about, even that even our CEO picked up that my stats is increasing. And they wanted to know how I manage…the patients. How do I get it right to see such a lot of patients within a month?

Interviewer: How do you get it right?

P3: I think the stats also grow because of the groups. I can put more than 5 people in and our services of the psychologist of the psychology services and then after many moons we at least have again an intern doctor. So those extra resources helped a lot also. But my day I see something like 20 patients which is a lot. That's why I brought in the system on a Tuesday I will see the new patients. But I cannot really say- it's unpredictable. Today it's like this, tomorrow it's like that. Yah. As I say to you and then the inter-referrals also. We have a lot of influx of our IDU- infectious disease patients, like the HIV patients, Tb patients. So we've got a lot of them nowadays and they become very difficult with treatment.

Interviewer: Do they come to see you?

P3: They come, yes…

Interviewer: for…?

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P3: …depression, it depends on very difficult- not difficult very challenging. You know the psychotic side and the IDU, the mental health. So those patients, when I see them the 1st time, I book them for the registrar that is coming every second week to the facility.

Interviewer: So you have to correct me if I'm wrong here but, you seem to function almost very independently in the managing of your patients and the clinic and that must be difficult?

P3: Yeah…. yes. I'm working kind of on my own- with my resources outside of the facility. Unless there is a medical condition, I will pick up then I will refer that patient to the medical officer. But otherwise pure mental health- I'm on my own.

Interviewer: Okay. Participant three I think we have come to the end of our interview. Once again, thank you very much for participating in my study. I know that uhm- from our discussion here that there's a lot going on at your clinic and that's why I am so appreciative for taking the time for this interview. Thank you so much

P3: A pleasure. Thank you hey.

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