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UNIVERSITY OF KWAZULU- NATAL

**EXPLORING THE LIVED EXPERIENCES OF REINTEGRATION
INTO THE COMMUNITY OF MENTAL HEALTH CARE USERS IN
THE LIBODE DISTRICT**

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UNIVERSITY OF KWAZULU NATAL

**EXPLORING THE LIVED EXPERIENCES OF
REINTEGRATION INTO THE COMMUNITY OF MENTAL
HEALTH CARE USERS IN THE LIBODE DISTRICT.**

**Dissertation submitted to the School of Nursing
Faculty of Health Sciences**

UNIVERSITY OF KWAZULU-NATAL

**In partial fulfilment of the requirement for
COURSE WORK MASTER'S DEGREE IN NURSING
(MENTAL HEALTH)**

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NOVEMBER 2010

DECLARATION

I declare that this research project: exploring the lived experiences of reintegration into the community of mental health care users in the Libode district is my own work. It is being submitted for the course work master's degree in mental health nursing at the University of KwaZulu-Natal, Durban, South Africa. It has never before been submitted for any purpose. All sources of information that have been utilised or quoted have been acknowledged by a complete reference.

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ABSTRACT

Aim: The aim of this study was to explore the lived experiences of reintegration into the community of mental health care users in the Libode district.

Methodology: A phenomenological approach was used in this study to explore the lived experiences of reintegration into the community of mental health care users. It describes the feelings experienced by mental health care users concerning their reintegration into the community, and explores barriers to their reintegration into the community. The study was conducted in the Libode mental health clinic in the Libode district. A total of six participants volunteered to participate in the study. The interviews were audio-taped then transcribed. The data were manually analysed using Tesch's approach of phenomenological analysis.

Findings: The results of the study revealed that the participants were not living independent lives following their discharge from the mental health institution. The evidence suggests that the environment is not conducive to meeting the needs of mental health care users. They lack support from families and communities which impacted on them negatively, contributing to the high relapse and readmission rate. This study explores the barriers to their reintegration into the community such as the following: poor medication compliance, lack of vocational skills, unemployment, substance abuse, stigma and discrimination which were the main barriers to their reintegration into the community. The study consequently makes recommendations for practice and policy which can contribute to an improved quality of service delivery.

Table of contents	Page
Title page.....	i
Dedication.....	ii
Acknowledgements.....	iii
Abstract	iv
List of table of content.....	v
Annexure.....	.vi
List of tables.....	vii

Chapter one

1.1 Introduction and background of the study.....	1
1.2 Problem statement.....	2
1.3 Purpose of the study	3
1.4 Research objectives.....	3
1.5 Research questions.....	3
1.6 Significance of the study.....	3
1.7 Operational definitions.....	4

Chapter two

Literature review.....	6
2.1 Introduction.....	6
2.2 Deinstitutionalisation and reintegration into the community of mental health care users.....	7
2.3 Importance of psychosocial rehabilitation in the reintegration into the community of mental health care users.....	8
2.3.1 The club house model.....	10
2.4 The importance of primary health care in the reintegration into the community of mental health care users.....	10

2.5 The reintegration into the community of mental health users: global perspective.....	13
2.6 The reintegration into the community: SA perspective.....	14
2.7 Discharge planning.....	15

Chapter three

Methodology.....	17
3.1 Research design.....	17
3.2 Research setting	19
3.3 Population.....	19
3.4 Participants.....	20
3.4.1 Inclusion criteria.....	20
3.4.2 Exclusion criteria.....	20
3.5 Data collection procedure	20
3.6 Description of the participants.....	21
3.7 Interview process.....	24
3.8 Translation and transcription.....	24
3.9 Data analysis.....	25
3.10 Trustworthiness.....	26
3.11 Bracketing.....	27
3.12 Ethical consideration.....	28

Chapter four

4.1 Discussion of the findings.....	29
4.1.1 Conceptual framework.....	32
4.1.2 Living.....	33
4.1.3 Learning.....	34
4.1.4 Working.....	34
4.1.5 Socialising.....	34
4.2 Medication compliance.....	38
4.3 Burden of care.....	40

4.4 Individual functioning.....	41
4.5 Inadequate skills, training and education.....	41
4.6 Unemployment and vocational skills.....	42
4.7 Stigma and discrimination.....	42
4.8 Social relations.....	43
4.9 Impact of reintegration into the community.....	43
4.10 Community resources.....	44

Chapter five

5.1 Summary of the findings.....	45
5.2 Experiences of reintegration into the community.....	45
5.3 Barriers to their reintegration into the community.....	45
5.4 Limitations of the study.....	47
5.5 Recommendations.....	48
5.5.1 Recommendation for practice.....	48
5.5.2 Recommendations for education.....	50
5.5.3 Recommendation for policy	50
5.5.4 Recommendation for future research	50
5.6 Conclusion.....	50
References	52

Annexures

Annexure A: Information sheet	59
Annexure B: Voluntary consent form.....	60
Annexure C: Interview guide....	61
Annexure D: Ethical clearance approval.....	62
Annexure E: Permission to undertake research study.....	63
Annexure F: Permission to interview the participants.....	64
Annexure G: Interview with a participant	65

Tables

Table 1: Description of the participants.....	22
Table2: Description of themes, categories and codes.....	30

CHAPTER ONE

1.1 Introduction and background of the study

Reintegration into the community is important in the care of individuals following their discharge from a mental health institution. However, it appears that the reintegration of mental health care users is not always implemented properly. As a result, such people who have been discharged from psychiatric units usually relapse and are readmitted. This phenomenon is known as the revolving door syndrome which refers to a cyclical pattern of short term readmissions of mental health care users to the psychiatric units (WHO, 2001).

In South Africa, the relapses and readmissions of mental health care users are some of the challenges influencing the reintegration of mental health care users into their communities (WHO, 2003). This is supported by Mzimela (2001), who found that the Western Cape had fewer relapses and readmissions compared to the Eastern Cape where good support services for mental health care users are lacking. This fact may possibly suggest that the reintegration of mental health care users in the Libode district in the Eastern Cape is affected by a lack of support services.

Despite the fact that some areas in South Africa lack good support services for the reintegration of mental health care users (WHO, 2005), the Mental Health Care Act, No. 17 of 2002 (Government Gazette, 2002) provides for the care, treatment and rehabilitation of these people, hence the reintegration of mental health care services into primary health care and community-based care with the focus on psychosocial rehabilitation in the post-apartheid South Africa (WHO, 2001; 2003). According to WHO (2005) the management and treatment of mental health care users at primary health care level makes it possible for most people to have access to services and enjoy a quality life in the community.

Uys & Middleton (2009) asserted that the reintegration of mental health care services in primary health care services helps to decrease stigmatisation of mental health care users, prevents relapse, and facilitates deinstitutionalisation of chronic mental health care users. In South Africa, the reintegration of mental health care users is largely supported by legislation as alluded to earlier on. For instance, the Mental Health Care Act stipulates that mental health care users should have 72 hour admission in general settings, so that they are treated near their families and communities (Government Gazette, 2002).

However, it is evident that the reintegration of mental health care users is sometimes impeded by a lack of knowledge and skills on the part of health workers, and a lack of material resources (Sokhela, 1998; Mavundla, 1998). In addition to this, the literature suggests that the dominance of a biomedical model has a negative influence on the reintegration of mental health care users into the community (Solombela, 1990; Magadla, 1991). This may possibly be due to its lack of emphasis on the psychosocial rehabilitation of mental health care users.

Mental health care users require curative treatment and psychosocial rehabilitation if they are going to be reintegrated properly into the community after discharge from mental health institutions. Little is known about the experiences of mental health care users regarding their reintegration into the community after discharge in the Libode district; therefore, a qualitative study was conducted to explore the experiences of reintegration into the community of mental health care users in the Libode district.

1.2 Problem statement

In this study, mental health care providers are always grappling with the task of reintegrating mental health care users into the community following their discharge from hospital. This is evident, given the increased numbers of readmissions of mental health care users (Sokhela, 1998). This may mean that many mental health care users are poorly prepared for reintegration into the community. Uys (2009) asserted that the lack of rehabilitation services is one of the factors that affect the reintegration of mental health care users back into society. Notwithstanding the fact that mental health care users are

not always properly reintegrated in the community after discharge, little is known about their experience regarding their reintegration. A study was thus carried out to explore the lived experiences of reintegration into the community of mental health care users in the Libode district.

1.3 Purpose of the study

The purpose of the study was to explore the lived experiences of reintegration into the community of mental health care users in the Libode district.

1.4 Research objectives

1.5 The objectives of the study were:

- To explore the lived experiences of reintegration into the community of mental health care users attending a primary health care clinic in the Libode district.
- To explore factors that could assist with the reintegration into the community of mental health care users in the Libode district.
- To explore barriers to the reintegration into the community of mental health care users in the Libode district.

1.5 Research questions

What are the lived experiences of mental health care users who attend primary health care services concerning their reintegration into the community in the Libode district?

1.6 Significance of the study

Preparing mental health care users for reintegration into the community is an important aspect of mental health care. The Mental Health Care Act, No. 17 of 2002 states that, “Every mental health care user must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential to facilitate his/her integration into community life” (Government Gazette, 2002; p.34). However, little is known concerning the experiences of reintegration into the community

of mental health care users who attend primary health care services in the Libode district. The district is an under-developed rural area with a huge population of 45000 and is served by 14 primary health care service centres, and a mental health care unit that provides 72 hour assessments of mental health care users. This study was thus carried out to explore and describe the experiences of the reintegration into the community of mental health care users attending primary health care services.

The significance of this study was fourfold: firstly, in practice, the findings of this study might help in making recommendations about the care of mental health care users with regard to their reintegration into society. Secondly, the study's findings may influence policy about mental health care. Thirdly, educators might utilise the study's findings in implementing their curricula. Finally, the study's findings might serve as a baseline for future research.

1.7 Operational definitions

Mental Illness

“Mental illness” means a positive diagnosis of mental health related issues in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis (Government Gazette, 2002; p.10).

Mental health care user

A “mental health care user” refers to a person receiving care, treatment and rehabilitation services or using health services at a health establishment aimed at enhancing the mental health status of a user, State patients and mentally ill prisoners and, where the person concerned is below the age of 18 years or is incapable of taking decisions, and in certain circumstances may include: prospective users; the person's next of kin; a person authorised by any other law or court order to act on that person's behalf; an administrator appointed in terms of this Act and an executor of that deceased person's estate (Government Gazette, 2002; p10).

Reintegration

“Reintegration” means the return and acceptance of a disabled person as a participating member of the community. In this study it means the return of a mental health user to well-adjusted functioning in community life following disturbances due to mental illness (WHO, 2003).

Community

“Community” refers to a group of people living in the same locality under the same government, having common interest, viewed as forming a distinct segment of society, having similarity or identity in community of interests and sharing a common understanding who reveal themselves by using the same language, manners, customs and law which is their tradition (WHO, 2003).

Primary Health Care Service

“Primary health care service” refers to the provision of professional comprehensive health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems, and the overall management of an individual’s or family’s health care services. It entails first contact care of persons with undifferentiated illnesses; comprehensive care that is not disease or organic specific, care that is longitudinal in nature, and cares that includes the coordination of other health services (WHO, 2003).

Mental health care unit

“Mental health care unit” means a health establishment that provides care, treatment and rehabilitation services only for users with mental illness (Government Gazette, 2002; p 12).

CHAPTER TWO

Literature review

2.1 Introduction

In this study, the literature review was done to highlight the existing literature and identify gaps in previous research. In addition, the literature was used to provide a context for the research, and to deepen the perspective of the experiences of reintegration into the community of mental health care users. The researcher has, however approached the research without an explicit conceptual framework regarding the topic of the study due to the inductive nature of the research (Creswell, 2009). Related research studies, articles and journals were reviewed in order to establish other researchers' views on the experiences of the reintegration into the community of mental health care users.

The literature was sourced from various data bases such as Medline, Proquest, EBSCOhost and Google scholar. Included in the review were journal articles, research reports, books and theses published locally and internationally from 2000 to 2010. Books and theses were used as primary sources of information although they were old sources. The literature found which could provide information regarding the experiences of reintegration into the community of mental health care users proved to be insufficient. The review of the literature will be organised as follows:

- Deinstitutionalisation and reintegration into the community of mental health care users.
- Importance of psychosocial rehabilitation on reintegration into the community of mental health care users.
- Implementation of primary health care on community reintegration of mental health care users.
- Reintegration into the community: global perspective.
- Reintegration into the community: South African perspective.
- Discharge planning.

2.2 Deinstitutionalisation and reintegration into the community of mental health care users

According to Lamb and Bachrach (2001) deinstitutionalisation refers to a process of replacing long stay psychiatric hospitals with less isolated community mental health care services for those diagnosed with mental disorders. In support, the WHO (2001) stated that mental health care has progressed from institutionalisation to community care supplemented by hospital care for acute cases. Further to that, the goal of community care is to empower mentally ill people and integrate them into their community (Read, 2009).

However, Mzimela (2001) found that the implementation of the process has negative consequences, because developing countries like South Africa have challenges with deinstitutionalisation, such as a shortage of community support services and the socio-economic status of the community mental health resources. In addition, Fakhoury and Priebe (2007) noted that although deinstitutionalisation is recognised internationally, it is limited mainly to Western, industrialised countries. Similarly, in developing countries like Uganda, where institutionalised mental health care hardly exists because there is only one psychiatric hospital, there is very little scope for deinstitutionalisation (Kigozi, 2007). As such, for mental health care users to experience positive community reintegration, accessible, appropriate services should be developed in the community.

In support of this, Nasrallah (2008) found that due to insufficient mental health resources, mental health care users experience difficulties in their reintegration into the community because of the challenges encountered, such as the lack of residential facilities for placement of mental health care users, easy access to substances, including alcohol, unemployment, the stigma attached to mental health care users and a lack of skills. Similarly, Read (2009) stated that without sufficient mental health resources, there may be an increased risk of homelessness, not adhering to treatment instructions, or drug or alcohol addiction which is referred to as dual diagnosis. It is crucial to note that mental health care users need community support to maintain wellbeing. However, there needs to be a balance between independence and support. As such, the need to understand the

complexities involved in the process of deinstitutionalisation has highlighted the needs of mental health care users as individuals.

Uys (2009) states that institutional care does not encourage independent function, rather, community care, which includes rehabilitation for mental health care users to achieve the highest possible level of functioning, provides this support. Conversely, Gale and Lambert (2006) found that deinstitutionalised mental health care users who were cared for in rural mental health care communities were experiencing distressing mental symptoms, financial problems, unemployment, a lack of opportunities to participate in social activities and that these were the results of discrimination and stigmatisation.

Lamb and Bachrach (2001) found that community mental care is potentially more human and more therapeutic than hospital care, but this potential is realised only when certain preconditions have been met. These preconditions include: realising that deinstitutionalisation is a social process with secondary consequences, tailoring service planning to individual's needs, facilitating access to hospital care, ensuring cultural relevance of services, involving mentally ill persons in service planning, and maintaining flexibility of services and continuity of care in the community.

2.3 Importance of psychosocial rehabilitation in reintegration into the community of mental health care users

Psychosocial rehabilitation is the major health care movement currently influencing mental health care in most public health sectors worldwide, and represents a shift from the traditional model to the social functioning model (WHO, 2001; 2003). Psychosocial rehabilitation is defined by Rossler (2006) as a process that offers the opportunity for the individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning within the community. Rossler states further that the goal of psychosocial rehabilitation is to help people with disabilities to develop the emotional, social and intellectual skills needed to live, learn and work in the community, with the least amount of assistance from mental health care practitioners.

WHO (2003) states that preparation for reintegration into the community is essential for mental health care users, because it helps with for psychosocial rehabilitation. Therefore, psychosocial rehabilitation is one of the important aspects when providing primary health care. Naidoo (2004) found that mental health care users are prepared for reintegration into the community, but that there are challenges regarding the implementation of services in South Africa which need to be improved, such as the lack of focus on community-based services, the inequitable distribution of limited resources, the lack of development of an infrastructure and the issue of stigmatisation.

In support, Anthony, Cohen, Farkas and Gagne (2002) emphasised the comprehensiveness of psychiatric rehabilitation which aims to increase the optimum level of functioning of mental health users so that they can be successfully reintegrated into the community. They state further that an individual's outcomes are dependent upon the individual's personal aspects, the rehabilitation goal, symptom management, medication compliance and the prevention of further disability. In addition, Madianos (2006) found that service outcomes relate to the changes that may be brought about at community level due to a psychosocial rehabilitation programme. Such factors include awareness of mental disorders by the community, the improvement of residential facilities, vocational rehabilitation and community support services.

Psychosocial rehabilitation is essential in the reintegration into the community of mental health care users because it facilitates the rehabilitation process, which ultimately increases a disabled individual's ability to function independently within the community. However, the reintegration of mental health care users into the community is a social concern, so it is important that a psychosocial rehabilitation programme is implemented effectively to achieve the goal of the Mental Health Care Act, No. 17 of 2002 (Government Gazette, 2002).

In agreement, Barbato (2006) stated that psychosocial rehabilitation strategies are an important part of the treatment of mentally ill individuals. Conversely, Farkas (2006) argued that psychosocial rehabilitation strategies vary according to the user's needs and the focus on the community, which can be difficult, because the community is always a socio-political issue.

2.3.1 The club house model

Anthony et al. (2002) found that the Club House model is an intentional therapeutic community which was designed to accommodate individuals with psychiatric disabilities. They add that the goal of the Club House model was to enhance the quality of life of mentally ill individuals by offering vocational and socialisation skills. However, it is important to note that psychosocial rehabilitation cannot be forced on individuals with psychiatric disabilities; the person needs to experience a measure of dissatisfaction with the current situation. Madianos (2006) found that urban areas have more opportunities available with regards to resources than rural areas, providing greater potential for mental health care users to recover. According to Pepper (2005), recovery is defined as the taking back of a meaningful life, which means overcoming the functional disabilities of severe mental illness and achieving the best possible quality of life.

2.4 The importance of primary health care in the reintegration into the community of mental health care users

In South Africa, mental health care was fragmented during the apartheid era and was provided according to race (Mkize and Kometsi, 2005). The focus was institutionalisation, and a curative care approach which was, at times, violating the rights of mental health care users. In 1994 the democratic government came into power, the new political dispensation focus was directed at providing mental health care at primary health care level as well as providing psychosocial rehabilitation in community psychiatric care (WHO, 2003).

The introduction of primary health care in South Africa was in response to the Alma Ata Declaration (WHO, 2001). According to the Alma Ata Declaration, the integration of mental health care into primary health care in the South African government should take all necessary steps to improve mental health care at every organisational level, but especially at the community level because it is the first level of care. In addition, the integration of mental health care into primary health care will provide the following benefits: firstly, it will improve coverage of the population. It will reduce the cost of health care, and mental health care will be provided by the clinic staff. The service will be nearer to consumers, and will therefore be more accessible to and economical for them. Lastly, the rehabilitation of patients will be improved, since this system allows families to be involved in treatment.

WHO (2003) asserted that the primary health system was to take place at district level, so that users could access all their health care needs in an integrated health care system at the level closest to them (Mkize and Kometsi, 2005). In line with the primary health care system, South Africa's White Paper on the transformation health system endorsed primary health care within an integrated health care system at district level.

According to the KwaZulu-Natal Department of Health (2006), the District Health System is a way of referring to a model for planning and organising a health system using districts as the basic unit. Hence the primary health system would enable the integration of the community, facilitate family involvement and reduce the stigma of mental illness. As such, communities could be actively involved in mental health services as envisioned in the Alma Ata Declaration.

In 2002, the new mental health legislation was passed in line with the provision of mental health services within South Africa's constitution which prioritises the protection of human rights (Government Gazette, 2002). According to the Mental Health Act, No. 17 of 2002 (Government Gazette, 2002) the user should have a 72 hour admission, assessment, and subsequent provision of involuntary care, treatment and rehabilitation that was assigned to district hospitals, so that mental health care users can access

assessment, care and treatment near their families and communities. In addition, a 72 hour observation period provides an opportunity to assess medical or psychiatric disturbance, and a number of users qualify for discharge within 72 hours.

There were, however, challenges that are common in district hospitals related to the implementation of the 72 hour assessment of mental health care users which include: insufficient knowledge and skills of health workers, a lack of resources, a poor infrastructure and limited funding.

The plan was introduced in the effort to remedy the challenges. The strategic plan (2003) was formulated by the Department of Health. The plan for the delivery of mental health services at primary health care level is in line with the Mental Health Care Act, No. 17 of 2002 which aims to provide care, treatment and rehabilitation of persons who are mentally ill. In addition, the plan was set out the different procedures to be followed in the admission of such persons, as well as the establishment of Review Boards in respect of every health establishment, and the determination of their powers and functions. Further, the plan provides for the care and administration of the property of mentally ill persons, the repeal of certain laws, and provides for matters connected therewith (Government Gazette, No.24024, 2002).

Chapter Three of the Mental Health Care Act (Government Gazette, 2002) describes the rights and duties relating to mental health care users. Issues addressed include respect, human dignity, and privacy; consent to care, treatment and rehabilitation services and admission to health establishments; unfair discrimination; exploitation and abuse; determination concerning mental health status; the disclosure of information; limitations on intimate adult relationships; the right to presentation; the right to discharge reports and to have knowledge of one's rights (Government Gazette No. 24024, 2002).

The application of Chapter Three of the Act was based on two main points which are fundamental to the Act. Firstly, the rights of the mental health user and the duties of the health provider are founded in terms of international law. Secondly, in exercising these rights, and in performing these duties, decisions must be taken for what is in the best

interests of the mental health care users. The intention of the Act is not to intimidate the health workers who are caring for mental health care users, but to emphasise in light of the historical abuse and violation of the rights of people suffering from mental illness, the rights of these people, protecting their dignity and humanity (Mkhize & Kometsi, 2005).

2.5 The reintegration into the community of mental health care users: a global perspective

People living with psychiatric disabilities are among the most marginalised in society (WHO, 2001). Despite over 20 years of government policies promoting community reintegration of mental health care users, the majority of people with psychiatric disabilities remain socially isolated and excluded from role opportunities, rights and responsibilities, including employment, education, family, social support and an active community life (Lloyd, Waghorn, Best and Gemmell, 2008).

In support of this, Granerud and Severinsson (2006) found that internationally, deinstitutionalisation policies and improved treatments have shifted the focus of care from institutions to community-based settings for people with psychiatric disabilities. Padmavati (2005) stated that the community mental health service providers recognised the importance of monitoring three health outcome domains such as clinical recovery, functioning and quality of life. Similarly, Corrigan (2004) found that recovery is commonly defined in terms of a personal post-illness journey, where active participation in the community is an accepted indicator of recovery.

In contrast, Gale and Lambert (2006) found that despite the different picture of community reintegration of mental health care users, there are improvements in clinical settings, such as treatment protocols, guidelines, information technology and clinical screening tools that have significantly enhanced the potential increase to access, and have improved the quality of mental health care services in rural communities particularly among under-served populations. However, the stigma associated with mental illness has

resulted in an inaccessibility of mental health care which hinders the utilisation of existing services (Corrigan et al 2004).

2.6 Reintegration of mental health care users into the community in South Africa

In South Africa, the emphasis has shifted to appropriate community-based care, rehabilitation and reintegration into the community (Uys, 2009). These changes are reflected in the mental health legislation that was passed by parliament in 2002, promulgated in Government Gazette No. 24024 as the Mental Health Act, No. 17 of 2002. In addition, the legislation seeks to affirm the rights of mental health care users. In agreement, Mkize and Kometsi (2005) state that integration of mental health care into primary health care system within the framework of the biomedical model is insufficient, there is a need to incorporate the social, economic, psychosocial and cultural aspects in reintegration of mental illness individuals.

According to the Psychosocial Rehabilitation Policy (2006), services must be appropriate to culture, as each rural and remote region is unique. Conversely, the opportunities and barriers for the implementation of community reintegration of mental health care users vary. There are issues around service provision in rural and remote areas such as population needs, geographic factors and resources. Flexibility is a requisite of service models to ensure that appropriate services are provided in rural and remote areas. Padmavati (2005) concurred that cultural factors are fundamental to the acceptance of any mental health care programme and states further that the co-existing traditional religious ritualistic practices and the adoption of a medical model on management of mental disorders has proven to be successful.

However, in most provinces in South Africa, considerable effort and energy has been devoted to preparing a strategic plan for providing more effective community and district mental health services in line with the Mental Health Act, No. 17 of 2002 (Kautzky and Tollman, 2002). Janse van Rensburg (2005) concurs with this by virtue of his finding of a number of factors that were obstacles to the provision of mental health care services in the community, such as individual insight and functionality; compliance; dependence; the

course of illness and occurrence of symptoms; length of stay in hospital; family and community resources and service provision infrastructure impacted on the successful outcome of a long term service user in the community.

Mkhize (2001) found the need for integration of faith and traditional healers into the health system. In addition, the health professional should embark on educating the faith and traditional healers about the concept of mental illness in order to prevent delays in the referral system. Mkhize suggested that further rehabilitation services should be provided along with the availability of crisis support protected housing and sheltered employment. WHO (2005) stated that the involvement of other key groups in the integration of mental health into primary health care, for example, stakeholder involvement, consumer groups, family groups, advocacy organisations, academic institutions, professional societies and foundations are required to support the development of mental health in primary health care.

2.7 Discharge planning

Discharge planning is an important aspect in the reintegration into the community of mental health care users. Webster and Harrison (2004) found that there is a need for improved communication, care and coordination between all stakeholders involved in the care and planning of the discharge of people with mental disorders. In agreement with this, Lauber, Lay and Rossler (2005) recognised that there are barriers to efficient discharge planning that have an impact on the discharge process and limit the involvement of users, families, caregivers and community care providers. Furthermore, homelessness has become a serious public health problem.

Chen, Kazanjian, Wong and Goldner (2010) suggested that community-based rehabilitation models provide a low cost integrative framework for individuals with chronic mental disabilities. Similarly, Kigozi (2007) supported the integration of the primary health care model and psychiatric rehabilitation models. However, although developing regions such as sub-Saharan Africa and South Africa have implemented the

integration of mental health care into community-based rehabilitation, there is a lack of cost-effectiveness and sustainability of these approaches to psychiatric rehabilitation in these regions (Patel, Araya, Chatterjee, Chisholm, Cohen, Silva, Mc Guire, Rojas and Ommeren, 2007).

Mkize & Kometsi (2005) stated that when discharge planning begins earlier during hospitalisation barriers related to time, ward factors and communication will have less of a negative effect on the outcome of discharge planning. Discharge planning becomes more effective when communication is more efficient, since sufficient time is given to prepare. In addition, the relevant stakeholders, including hospital and community health care professionals, the patient and the family become involved earlier in the discharge planning process. However, good discharge planning and the facilitation of continuity of care are regarded by mental health professionals as the responsibility of all stakeholders at all levels, thus including the organisation, mental health workers, individuals, their family and friends.

CHAPTER THREE

Methodology

3.1 Research approach

The approach adopted in this study was of a qualitative nature. The researcher decided to use a qualitative approach because at present there seems to be insufficient research to provide information concerning the lived experiences of mental health care users' reintegration into the community of the Libode district. In this study, the researcher encouraged the participants to relate, in-depth, the experiences and descriptions of mental health care users regarding their reintegration into the community.

In this study little was known about the experiences of reintegration of mental health care users, and the researcher could not use a conceptual framework because of the need to look at the data without preconceived ideas or influence, as this study is based on phenomenological methodology. According to Brink (2002; p.31), "in pure qualitative research the problem may not be explained in terms of theoretical or conceptual framework". Phenomenological studies attempt to describe lived experiences. The researcher focused on the lived experiences of mental health care users who attend primary health care services relating to their reintegration into the community in the Libode district. The study was also explorative. According to Polit and Hungler (1999), exploratory research is used when little information is known about the research topic. There was information available on the lived experiences of the reintegration into the community of mental health care users in the Libode district, and it was for this reason the researcher chose to conduct this study.

Qualitative researchers tend to be concerned with quality and experiences rather than with the identification of the cause and effect relationship. In this study, the researcher was interested in the nature of the qualitative research approach as it focuses on four aspects of lived experiences that are of interest to the phenomenologist, which are the following: Lived space, which refers to the environment the subject is living in, for

example, the hospital, clinic, home; lived body, which refers to the physiological changes that affect the individual, for example, feelings, living alone, work, and finance; lived time, which refers to the period of sickness, for example, the period of admission or discharge from a mental institution, and lived human relations, which refers to the way a person relates to his/her family, relatives, friends and community members (Creswell, 2009). This is agreed with by Hussler (1980), a phenomenologist who asserted that human existence is meaningful and interesting because of people's consciousness of that existence. The researcher believes that the qualitative research approach gave her a better understanding of the experiences of the reintegration of mental health care users attending primary health care services into the community. The researcher approached the study from a phenomenological point of view in which rich descriptions of different individuals' immediate experiences were sought (Burns & Groove, 2005). The aim was to understand the experiences of reintegration into the community as felt, perceived, experienced and actually lived by mental health care users attending primary health care in the Libode district. The phenomenological approach was adopted because of its focus on the lived experiences of the research participants, and the meanings that they attribute to these experiences.

In the human sphere, phenomenology normally translates into gathering deep information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation, and presenting it from the perspective of the research participants. A phenomenologist views the person as the integral part of the environment (Burns & Groove, 2005). The world is shaped by the self and also shapes the self. The person has a world which is a meaningful set of relationships, practices and language that we have by virtue of being born into a culture. These are powerful for understanding subjective experience, gaining insight into people's motivations and actions.

The goal of phenomenological inquiry is to fully describe the lived experiences and perceptions to which it gives rise. A phenomenologist believes that lived experiences give meanings to each person's perception of a particular phenomenon. In this process, the researcher bracketed out the world and any presuppositions, in an effort to confront the data in pure form, or set aside her own experience in order to understand those of the

participants in the study (Creswell, 2009). Bracketing refers to the process of identifying and holding in abeyance preconceived beliefs and opinions about the phenomenon under study (Polit & Beck, 2008). Burns & Groove (2005) state that a person is self-interpreting; therefore the only reliable source of information to describe is the person. In agreement, Creswell (2009) stated that understanding human behaviour or experience requires that the person interpret the action or experience for the researcher, and that the researcher must then interpret the explanation provided by the person. The interpretations of those experiences are referred to as interpretive phenomenology (Burns & Groove, 2005).

3.2 Research setting

The research setting is defined as the physical location and conditions in which data collection takes place in a study (Polit & Beck, 2008). This study was conducted at the Mental Health Clinic, in the Libode district, Eastern Cape (EC), because this is the local clinic in a rural area accessible to many community members, and it is within the health care unit that provides 72 hour assessment and care for mental health care users. The area has a population of 450 000 people according to South Africa statistics (2001), most of them living in the rural areas, and is served by 14 primary health care services.

3.3 Population

The target population for this study was all the mental health care users attending the Mental Health Clinic who were discharged from mental health hospitals, because these people might have had an experience of reintegration into the community after discharge from the mental hospital.

3.4 Participants

In this study, purposive sampling was used to invite the participants, because the participants would be typical of the population, or knowledgeable and informative about the phenomenon under study (Polit and Hungler, 1999). The researcher used purposive sampling to select mental health care users who were attending mental health clinics according to inclusion criteria as mentioned below. The researcher and sister-in-charge

identified potential participants. The researcher approached the users personally in order to invite them to participate willingly in the study. During the meeting with the potential participants, the researcher explained the purpose of the research, the objectives, as well as the ethical considerations. According to the principle of theoretical saturation which is applied in qualitative research, data continued to be collected until no new information occurred (Polit & Beck, 2008).

In this study, the sample size was initially comprised of two mental health care users attending a mental health care clinic in the Libode district. The selection of participants was continued until saturation was reached with six participants.

3.4.1 Inclusion criteria for selection of participants were the following:

- Mental health care users aged 18 years and above.
- A history of previous admission to a mental hospital.
- Newly discharged mental health care users. In this study, this refers to users who had been discharged for a period of six months to a year because these users might have had the experience of reintegration into the community.

3.4.2 Exclusion criteria:

- Mental health care users unable to give informed consent, such as those with acute psychosis.

3.5 Data collection procedure

Prior to the commencement of the data collection, the researcher contacted the Clinic Supervisor of the Libode Community Health Care Service Area in order to gain entry into the mental health care service. Permission to collect the data was then requested and obtained from the Middle Manager of the Libode Mental Health Unit (see Annexure F). When permission was granted, the researcher went out to introduce herself, and explained the study to the sister in charge of the Libode mental health unit and the nursing staff, so as to gain co-operation and support. Data collection was done on Tuesdays and Fridays

because on these days an outpatient clinic was held with the sectional doctor who consulted with mental health care users from home. The sister-in-charge had a list of mental health care users who had been discharged from mental hospitals and had been given appointment dates to revisit the doctor for review. The potential participants who were to participate in the study were selected by the researcher and the sister-in-charge who played a role in advocating for the users. The participants were interviewed after the users had been seen by the doctor to avoid delaying the daily routine and the running of the clinic. The researcher read the files of those who were selected for the interviews to obtain more background on them. An initial introduction between the users and the researcher was carried out. The users were informed about the research, its purpose, confidentiality and the participants' informed consent to participate (see Annexures A and B) and their right to refuse to participate if they so wished. Written consent was given by all participants to use an audio-recorder and to take notes during the course of the interview, to ensure that no information was lost. The number of interviews and times that they took varied from a participant to another. With some participants one or two interviews were carried out whereas with others there were three due to the level of functioning. Each interview was done individually and took approximately one hour, to one and half hours. The interviews were conducted in a private room that was used as an office for the staff to ensure privacy, and to prevent disturbance. Participants had to queue in the waiting room for the doctor's consultation first, and then wait for the researcher once they had been seen by the doctor. This was done effectively, without any delays.

3.6 Description of the participants

The six participants who agreed to participate in this study consisted of Xhosa-speaking males who had gone for review at the Libode Mental Health Clinic. The six participants were all males, but this was not intentional. The participants all lived in rural areas. Their ages varied from 22 to 36 years. Their names were not used to ensure confidentiality. According to the principle of saturation which is applied in qualitative research, data continued to be collected until no new information could be gathered (Polit & Hungler, 1999). In this study, the researcher collected the data until saturation was reached with six

participants. The participants came from a poor socio-economic background. The participants' levels of education ranged from illiterate to Grade 11, and all were unemployed. The description of these participants can be found in Table 1 below. Participants will be referred to by participant numbers 1 to 6 for the purpose of confidentiality.

Participant	Gender	Age	Marital status	General comments
P1	Male	26	Single	Lives in Mantusini location which is a rural area. He is illiterate and stays with his mother and uncle. He was discharged from the mental hospital in February 2010. He has been receiving a disability grant since November 2009 which is the only source of income in the family. He reported a lack of care and support from his family members. This has resulted in poor medication compliance and defaulted treatment, because he does not visit the clinic regularly. He has been engaging in household chores at home and social interaction with community members.
P2	Male	22	Married	He lives with his supportive mother at Gxulu location. He is married, but does not stay with his wife because she works very far from home. He passed Grade 9, but left school thereafter because there was no money for further education. He has a history of defaulted treatment because there is no money for transport for him to visit the clinic. He relapsed and was readmitted in 2009. There is also a history of history of substance abuse which resulted in violence and aggression and he was readmitted for treatment. He has been involved in household chores at home and socialises with community members and friends.
P3	Male	31	Single	He lives with his parents and siblings at Marubeni location. He has been diagnosed with schizophrenia, and was admitted and discharged from the mental hospital in April 2010. He was excited on discharge, because his condition had improved. His parents and siblings were supportive. He has a history of defaulted treatment and relapses. He also abuses alcohol and substances. He does not involve himself in indoor household chores because he likes outside chores like fetching water from the river and horse-riding, but attends to his room and personal hygiene. He is not working, nor does he receive a disability grant. He passed Grade 10 and

				then left school because of illness.
P4	Male	36	Married	He lives alone in Mafini location. He is married but does not live with his wife because she works very far from home. His three children stay with his wife. He was discharged from hospital in 2009, and has been attending the mental health care clinic for medication. He is illiterate, and was working in Durban in the construction industry, but lost his job because of his illness. He receives a disability grant. He does not attend community occasions because of his history of assaulted by neighbours and friends for no apparent reason. He has no support from his family because he has no siblings and his mother lives in Durban. He has a history of being homeless because there is no one to take care of him.
P5	Male	33	Single	He lives with his mother and siblings at Nyandeni location. He is not married and passed Grade 9. He was discharged from the mental hospital in May 2009, and was very excited because his condition had improved. He was welcomed with open arms by his family. He had a history of defaulted treatment in October 2009 and showed signs of relapse; he became violent and destructive and was readmitted. He was discharged in May 2010. He helps with household chores, but does not want to involve himself in community participation because of his difficult behaviour. He receives a disability grant.
P6	Male	29	Single	P6 lives with his aunt, uncle and relatives at Mdlankomo location. He passed Grade 11 then left school because of illness. He felt very excited when he was discharged because his condition had improved. His family members are very supportive and encourage him to take his treatment. He was admitted at Komani hospital and discharged in April 2010. He is not married, nor is he working, and he does not receive a disability grant. He has a history of substance abuse although he is still on psychiatric medication which contributes to signs of relapse.

Table 1: Descriptions of the participants

3.7 Interview process

The process by which interviews were conducted was as follows: The researcher created a therapeutic environment to facilitate the establishment of a good relationship with the participants, to build trust and rapport. Participants were provided with essential information for the informed consent and the option of terminating their participation at any stage of the study. A written consent was obtained from the six participants. Participants accepted that the interviews would be recorded, and that notes would be taken during the interview. The interviews were conducted in Xhosa which was the language used by the participants. The researcher had no problem with the language as she spoke the same language as the participants. Interviews were transcribed verbatim afterwards.

The researcher used an interview guide to explore the lived experiences of reintegration into the community of mental health care users after discharge from hospital. The interview guide with probing questions was used during the interview to avoid losing focus of the purpose of the study (refer to Annexure C).

The participants were made to feel at ease, were reassured and motivated to give honest answers. Some participants were accompanied by their family members for support, and this also provided an opportunity for the interviewer to detect non-verbal cues revealed by the interviewee. For some participants it was not easy to tell their story, due to the level of functioning, lack of understanding and insight of the mental health care users. There was often a need for the questions to be rephrased in a very simple way in order for them to understand the questions that were posed to them.

3.8 Translation and transcription

Data was obtained from the interviews which were held with the six participants. The interviews were audio-recorded and field notes were written up during the interview. The interviews were conducted in Xhosa and translated and transcribed into English. The researcher, who spoke the same language as the participants, had to translate the transcripts from Xhosa into English. The researcher used the English translator to ensure

validity of the data. The participants were given pseudonyms and only pseudonyms were available for the translator in order to maintain confidentiality. All six transcripts were used for the analysis of the data.

3.9 Data analysis

Data analysis is the systematic organisation and synthesis of research data (Polit & Hungler, 1999). The audio-recorded interviews and review of the notes taken during the interviews were translated and transcribed verbatim, and analysis was done according to Tesch's approach (Creswell, 2009). The following steps were followed in order to analyse data.

- Following Tesch's approach, the researcher started the process by obtaining a sense of the whole interview by listening to the recording repeatedly, to internalise the context and transcribe it verbatim. After this, the transcripts were read through carefully and ideas were written down in the margin as they came to mind, so that no data was left out. All the data was important for this study in terms of the principles of trustworthiness.
- After completing this task for all six interviews, a list of all the topics was made. Similar topics were clustered together. Columns indicating major and unique leftover topics were formed.
- Topics were abbreviated as codes. Codes were used to retrieve analytically appropriate segments of text. New categories and codes emerged.
- The researcher found the most descriptive wording for each topic. Topics were then turned into categories. Lines were drawn between the categories to show interrelationships.
- A final decision was made on the abbreviation for each category and codes were alphabetic.

- The data material belonging to each category was assembled in one place and preliminary analysis was then performed.
- The researcher re-coded the existing data where necessary.

After completing the steps as indicated, the researcher identified potential useful verbatim quotations to be included in the findings in order to illustrate key themes. Major and minor themes were then categorised. Each transcript was first analysed individually, after which analysis took place across all the transcripts.

3.10 Trustworthiness

Guba's model for assessing the trustworthiness of the data was used. According to Guba, four strategies can be identified as necessary to ensure trustworthiness. The strategies of trustworthiness include the following: credibility, transferability, dependability and conformability (Lincoln & Guba, 1985).

Credibility is a criterion for evaluating the quality of qualitative data referring to the confidence in the truth of the data (Polit & Hungler, 1999). Credibility is about truth value and truth reality (Lincoln & Guba, 1985). The following strategy will be applied to enhance truth value: The researcher explores the "lived experiences" of the participants.

The researcher applied truth value by allowing sufficient time for interviews, to establish rapport, to build trust relationship, to encourage open conversation without interruption, and to convey to participants how meaningful their contribution was to the process. The researcher was knowledgeable about the area under study, since she has a diploma qualification in psychiatric nursing and recently trained at master's level in mental health, so was able to use her communication skills effectively.

Transferability refers essentially to the generalisability of the data that is the extent to which the findings can be transferred to other settings or groups (Polit & Beck, 2008). The ability to generalise or transfer results is not relevant to qualitative research, but rather to describing the uniqueness of each situation.

The researcher provided sufficient descriptive data of the experiences of the reintegration into the community of mental health care users attending primary health care in the Libode district in the research report.

Dependability refers to the stability of data over time and over conditions (Polit & Hungler, 1999). Dependability was applied based on the following: The researcher conducted the interviews herself. Participants gave voluntary consent. Interviews were conducted in a private room. The same interview guide was used for all participants.

Conformability refers to the objectivity or neutrality of the data so that there is the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning (Polit & Hungler, 1999). The following strategy will be applied to enhance conformability:

The researcher ensured neutrality by confirming the data with the participants through paraphrasing, reflection and summarising what they meant.

3.11 Bracketing

Prior to this study, the researcher was in possession of a Diploma in Psychiatric Nursing obtained from Iris Marwick College, Pietermaritzburg in 2000. After the study period she returned to the Eastern Cape and unfortunately, did not have the opportunity to work in a mental health institution before going to study at the University of KwaZulu-Natal in 2009. The researcher was concerned by the number of mental health care users present in the streets, some of whom were homeless, displayed poor personal hygiene, and were poverty-stricken and unemployed. The researcher was touched by their suffering and abandonment. Campaigns were organised to take the users back to mental health hospitals, yet today they are still on the streets. The researcher saw undertaking this research as a way of speaking out on behalf of the mental health care users who are struggling for their reintegration into the community following discharge from mental hospitals.

3.12 Ethical considerations

Ethical clearance to conduct this research was obtained from the University of KwaZulu-Natal. Permission to conduct the study was obtained from the Libode Mental Health Service. The researcher obtained informed consent from the participants after a written informed consent was requested from each participant for the consent form. The illiterate participants were requested to use a thumbprint when giving consent and a stamp pad was provided to them by the researcher. The sister in charge validated the information that was read to them on the document they signed. The informed consent stated clearly the aims and objectives of the study. The participants were informed that they could withdraw from the study at any stage if they so wished. The researcher ensured that confidentiality was maintained throughout the research process. The researcher ensured that the venue used for the interviews was private. The researcher, as a trained psychiatric nurse, used her skills therapeutically when the need arose. Although the researcher arranged for an independent therapist following up possible emotional discomfort because of questions to the participants; no participant indicated a need to make use of the arrangement. The purpose of the study was explained to the participants.

Interviews were recorded and notes were written up during the interviews with the permission of each participant. The interviews were conducted in Xhosa then later translated into English by the researcher. The tapes and hard copies will be disposed of by incineration five years after the study has been completed.

CHAPTER FOUR

4.1 Discussion of the findings of the study

In this study, and during data collection, the researcher considered the research questions and probing questions that were formulated during the study and the interpretations made during data collection. The aim of the researcher was to produce a description of the lived experience of the reintegration into the community of mental health care users after discharge from hospital. The lived experiences of the reintegration into the community of mental health care users were transcribed verbatim, and analysed using Tesch's approach (Creswell, 2009). The researcher was involved in the intensive process of repeatedly reading and reviewing the notes and audio-tapes. The objective was to identify the thematic content in each transcript based on the words of the participant.

Data analysis was done manually by the researcher and organised according to the research questions which were related to the objectives of the study. The words, sentences and phrases that were related were highlighted. The emerging themes with the same meanings were grouped together and sub-themes emerged. The themes emerged from the responses to the questions that were asked (refer to Annexure C). Within the themes, categories and sub-categories emerged. The codes emerged from the six participants who were given numbers (1-6) to maintain privacy and confidentiality.

In the analysis of the data, three major themes emerged that represented the lived experiences of the reintegration into the community of mental health care users.

- The lived experienced of the reintegration into the community of mental health care users after discharge from hospital.
- Factors that could assist with the reintegration into the community of mental health care users in the Libode district.
- Barriers to the reintegration into the community of mental health care users in the Libode district.

From the multiple readings of the transcribed data, themes and categories emerged. Descriptions of the themes, categories and codes of the lived experiences of the reintegration into the community of mental health care users are presented in Table 2 as follows:

Themes	Sub-themes	Categories	Codes	Participants
Theme 1: The lived experiences of the reintegration into the community of mental health care users after discharge from hospital	Living conditions	Excited, glad, happy, thrilled and joyful to be part of the family	They were welcomed with open arms by family members and friends. Enjoyed being with the family.	1 , 2 , 3 ,5 & 6
		Frustrated, depressed, abandoned and neglected	He was discouraged because there was no family member to take care of him.	4
Theme 2: Factors that assisted mental health care users with their reintegration into the community	Encouragement	Attachment	Family members are supportive and helpful. They take care of everything. There were close family ties, and the family connection was good. Enjoyed being part of the family.	1, 2, 3 & 4
	Help and assistance	Individual functioning	An increased level of individual functioning in personal hygiene and household chores	1, 2, 3, 4, 5 & 6
	Behaviour	Behaviour change	A constructive behaviour change which was sustained	1, 2, 3 & 6

		Asocial and aggressive	for a few months after discharge. Does not want to socialise with friends and community members. Social interaction was poor because of violent behaviour.	1, 2, 3, 4 & 6
	Community participation	Community participation and involvement	Improved community involvement by attending social gatherings.	4 & 5
Theme 3: Barriers to the reintegration into the community of mental health care users	Non compliance to medication	Non-compliance	Difficult to comply with medication requirements due to a lack of knowledge and support.	1, 2, 3, 4, 5 & 6
	Burden of care	Burden of care to their families	There was a lack of skills, training and education to enable them to fully function and become independent people.	1, 2, 3, 5 & 6
	Unemployment	Unemployment	Experienced a lack of a source of income because not all received disability grants.	2, 3 & 6
	Substance abuse	Availability of substances	Easy to access substances like liquor and dagga.	1, 2, 3 & 6

	Stigma	Stigma and discrimination	Assault and violent behaviour.	4
	Housing	Homelessness	Experienced a lack of independency because some lived with their relatives.	6

Table 2. Description of the themes, categories and codes

The findings of this study will be discussed in relation to the Psychosocial Rehabilitation Model (Anthony et al, 2002). As the researcher worked inductively, and did not discuss the model prior to the data collection to avoid biasing the findings with preconceived ideas, it might be useful to discuss the findings of the study here and compare these with the essence of the model. According to Anthony et al (2002), the framework describes the impact of severe mental illness, emphasising that mental illness not only causes mental impairment or symptoms, but also causes the person significant functional limitations, disabilities and handicaps. The World Health Organization developed a model of illness or impairment but also the consequences of the illness (WHO, 2001). The conceptualisation of the negative impact of a severe mental illness has come to be known as the Psychosocial Rehabilitation Model (Anthony et al., 2002). In addition, psychosocial rehabilitation is comprised of two intervention strategies: personal skills development and environmental support development. Hence the focus is on the person with the disabilities, skills needs and environmental supports to achieve his/her goals and fulfil the role demands of his/her living, learning, social and working environments.

Anthony et al. (2002) assert that psychosocial rehabilitation attempts to improve role performance in people’s living, learning, working and social environments. They state further that psychosocial rehabilitation is distinguished through the outcomes of the service provided; one such outcome is the change that may be brought about at a community level. In addition, there will be an increase in the awareness by the

community of mental disorders, and an improvement of attitudes, opinions, and an increase in vocational and social support. As such, it plays a crucial role in the mix of services available to people living with a psychiatric disability, as they undertake their individual journey to recovery (Pepper, 2005). In this study, all participants who were interviewed were accessing care, which was perceived as meaning a renewal of their prescription. However, a lack of knowledge and understanding of the diagnosis, and the medication they were taking. This might suggest that one of the contributing factors to mental health care users defaulting on their treatment is a lack of knowledge and understanding of mental illness (Madianos, 2005). The findings in this study suggest that the barriers to the reintegration of mental health users into the community are the dominance of the medical model, and the use of the curative approach by mental health care professionals. It was evident in this study that at mental health clinics, the primary focus is on medication compliance which was the traditional model of care (Gagne, 2004). According to the models interpretation or understanding the rehabilitation of mental health care users in the four main domains comprised of living, learning, working and socialising was not addressed properly. Mental health care users were encouraged to develop independent functions in their lives, under the supervision of the health care workers.

The findings illustrate what the psychosocial rehabilitation model developed around the changes in rehabilitation of persons with disabilities and community-based care.

4.1.1 Living

In this study the participants were burden of care to their families this was evident, as most participants were still living with their families. The majority of participants were dependent on their families for financial assistance, support, medication compliance, psychosocial functioning and daily activities. There was lack of skills and training to enable them to fully function and become independent people. Koukia and Madianos (2005) found that participation of mental health care users in rehabilitation programmes limits the burden of care among families and relatives. They add that specialised family

intervention programmes in the rehabilitation process could help the user and caregivers in the alleviation of the perceived burden.

4.1.2 Learning

The study indicated that a lack of education, skills and training was a barrier to the reintegration into the community. Most of the mental health care users had a lower level of education and some were illiterate, which could be a contributing factor to inadequate skills development and a lack of vocational activities. The findings in this study suggest the need for the psychosocial rehabilitation intervention strategy which emphasises personal skills development, aiming at developing individual's skills in interacting with a stressful environment (Rossler, 2006).

4.1.3 Working

All participants were unemployed, and lacked a vocational rehabilitation program tailored to individual needs, such as mental health users being taught to do handwork, beadwork and card-making so that these items could be sold to make profit for the mental health user. The findings in this study highlight the psychosocial rehabilitation mode's focus on the importance of vocational rehabilitation in the reintegration of mental health care users into the community. Vocational rehabilitation promotes gains in related areas such as self-esteem and quality of life; as work and employment are a step away from dependency, and a step towards reintegration into society (Spaniol, Wewiorski, Gagne and Anthony, 2002). Consequently, today the most promising vocational rehabilitation model is supported employment.

4.1.4 Socialising

Stigma, discrimination and social isolation were some of the barriers to the reintegration of mental health care users. The majority of mental health care users were reluctant to attend social gatherings due to violence and crime in the communities. The findings in this study suggest that mental health care users should participate in community life with full rights (Government Gazette, 2002). Corrigan, Markowitz and Watson (2004) found that the importance is more likely to be attached to the role of social integration when

there is availability of support, perceived social support predicts outcome in terms of recovery from acute episodes of mental illness, community reintegration and quality of life.

The reintegration process and the challenges of mental health care users were marked by the following themes (refer to Table 2): Theme 1: The lived experiences of the reintegration of mental health care users after discharge from hospital. Theme 2: Factors that assisted mental health care users in their reintegration into the community.

In this study the majority of participants expressed that they were excited, thrilled, joyful and happy to be part of their families and the communities. This was indicated by the smiles on their faces when they spoke about the day they were discharged from the mental hospital. Most of the participants could even remember the day, month and year because of the excitement it brought to them. After discharge from hospital, most participants felt that they were welcomed by their family members and community. Their families are supportive and take care of them. The feelings expressed by mental health care users on their reintegration into the community are marked in Theme 1 (refer to Table 2).

One participant felt stressed and frustrated on discharge because his family was not going to live with him. He stated that he was living alone and was homeless because his wife and children worked very far away, while his mother also worked in Durban and he had no siblings. This was evident from his statement in which he said, *“kundiphatha kakubi ukuhlala ndondwa kuba akukho mntu undikhatheleleyo”*. This means *he did not like the discharge from hospital because he was not going to stay with his family*. He is living alone, nobody cares for him. He only communicates with his wife telephonically. The most traumatic experience he had was being abandoned by his mother in Durban when he was fourteen, and having to go to work in the Durban construction industry for a living, then losing the job because of his illness.

These experiences expressed by mental health care users in this study are not unique, similar findings were highlighted in a study conducted by Granerud & Severinsson (2006) who found that participants experienced shame and fear of exclusion in their

struggle to become reintegrated in the community. They state that the mental health care users in their study had a sense of loneliness, had to struggle for equality and experienced neglect. The days passed very slowly for them, and they reported a lack of financial resources. WHO (2005) states that the main objectives of rehabilitation are empowerment, the elimination of discrimination and stigma, the enhancement of individual social competence and the improvement of the social support system. Furthermore, WHO (2001) states that persons with mental health problems should be encouraged and empowered to achieve independence, and to make decisions regarding their own lives. In this study, the feelings expressed by some mental health care users revealed that there is a lack of support received from their families and communities (refer to Table 2).

The participants reported varied experiences of reintegration into the community. The majority of the participants indicated that they experienced an increased attachment with the family members. They felt they were well connected to their families. This was evident when they were speaking about the things that occurred when they were hospitalised.

All participants expressed an increased level of individual functioning in personal hygiene and chores. Participants felt that they were being helpful in doing household chores and outdoor activities. This is in line with the goal of the Mental Health Care Act No. 17 of 2002 (Government Gazette, 2002) which states that every mental health care user must be provided with care and rehabilitation services that improve the mental capacity of the user to develop full potential to facilitate his/her integration into community life (Government Gazette, No.24024, 2002).

Most of the participants experienced a constructive behaviour change which was sustained for a period of a few months, and then they defaulted on their treatment after discharge from hospital, and signs of relapse like anger, aggressive and violent behaviour appeared again. This was evident from the number of readmissions that were on the files. Some participants were readmitted for the second or third time to mental hospitals. In this study, the behaviour changes presented were probably due to the mental health care

users' poor compliance with their medication requirements and the lack of support from their families.

Janse Van Rensburg (2005) agreed that adequate community-based services were not developed, thus contributing to increased admission rates to mental hospitals, more frequent relapses, homelessness and criminalisation of mental health care service users. Lamb & Bachrach (2001) supported these findings when they observed that community mental health care is potentially more humane and more therapeutic than hospital care, but that this potential is only realised when certain preconditions have been met. These preconditions include: realising that deinstitutionalisation is a social process with secondary consequences, tailoring the service planning to individual needs, facilitating access to hospital care, ensuring cultural relevance of services, involving mentally ill persons in service planning, and maintaining flexibility of services and continuity of care in the community

The study showed that due to the lack of community resources, mental health care users were not occupied constructively and were unemployed, so they became bored and resorted to abuse of substances. Most participants expressed their active involvement and participation in their communities. This was indicated by the statement of one of the participants who said, "*asinangxaki nabantu ekhaya naselalini siyahlala sithethe izinto zelali, sincokole, sitshaye, sisele nothywala sonwabe*", meaning that he was not experiencing any problems in the community as he attended social gatherings, socialised, smoked and drank alcohol. He did not experience problems with family and community members, he socialised well, and drank and smoked when they got together because he had become bored staying at home doing nothing. In this study, the mental health care users tended to abuse substances more. This was evident from their fingertips that were dark, as if burned by cigarettes, and their red lips which were the signs of alcoholism, although some denied abusing substances.

In keeping with this, participants in this study did not benefit from community resources because these were scarce or did not exist in their communities. These programmes have also been proposed by Padmavati (2005) who suggested that provision of support

services, psychosocial rehabilitation programmes, crisis centres to assist skills development and counselling services is essential. There also seems to be a need for a holistic approach to meet the needs of mental health care users.

One participant had negative experiences with his reintegration into the community. He described this, “*andisafuni ukuya kwindibano zase lalini kuba ndabethwa ngabamelwane ngaphandle kwesizathu*”, meaning that he does not want to socialise with friends and the community because of the experience he had of being assaulted by neighbours without any apparent reason. He does not attend social gatherings because he had once been beaten by friends and neighbours. Mirza, Gossette, Burford and Hammel (2008) support these findings. They assert that living with a mental disorder often entails being stigmatised and negatively stereotyped by the general community, which, in turn, often leads to discrimination, alienation and a sense of isolation. Furthermore, mental disorder has also been associated with unemployment, alcohol or drug abuse, homelessness and excessive institutionalisation (WHO, 2005).

All participants indicated that it was good to be back home in their communities, but that there are still challenges which need to be addressed. Borbasi, Bottroff, Williams, Jones and Douglas (2008) supported these findings in their study when they confirmed that participants were clear that they would definitely not go back to the institution, but that the relocation experience was not without difficulties. It is imperative in this study that mental health care users be provided with adequate services to meet the needs of the individuals.

The barriers to the reintegration into the community of mental health care users were marked as Theme 3 (refer to Table 2).

4.2 Medication compliance

Poor compliance with medication requirements was indicated by all six participants who revealed that they have difficulty taking their medication regularly. The reasons for poor medication compliance included side-effects and the non-availability of transport to visit the clinic. There was a tendency by mental health care users to have frequent relapses a

few months after discharge; this was illustrated in their follow-up cards after discharge from hospital. All participants had a history of defaulted treatment, having relapsed and being readmitted. Non-compliance with medication requirements was one of the reasons for the increased relapse rate resulting in readmission.

However, it appears that the non-compliance in mental health care users is indicative of their lack of insight, understanding of their mental illness, and the stigma attached to mentally ill individuals. Another contributing factor may relate to the lack of regular follow-ups and support from mental health professionals. In support of this, Naidoo (2004) stated that there has been always inadequate continuity of mental health care services in the community, hence, the fragmentation of mental health services and community-based care has resulted in many mental health care users getting lost in the system following their discharge from hospital (WHO, 2003). This study showed that mental health care users remain a responsibility for their families who have to support them and monitor their compliance. The follow-up services were limited to medication compliance which was the traditional model of care offered by the services (Rossler, 2006). It is important that their families are empowered with the knowledge and information to provide care and support for their mentally ill individuals.

Gale & Lambert's (2006) findings that mental health care users were not sufficiently educated about their prescribed medication, its action, possible side-effects and alternative interventions confirmed the aforementioned limitations. The provision of such information is particularly significant because the onset of side-effects is one of the reasons why mental health care users default on treatment and thus increase the risk of relapse. Furthermore, Janse van Rensburg (2005) states that factors such as: individual insight and functionality; compliance; dependence; the course of illness and recurrence of symptoms; length of stay in hospital; family and community resources and service provision infrastructure impact on the successful outcome of long term service in the community.

This study suggests that mental health care users' non-compliance is indicative of a lack of insight and understanding of their mental illness, which could also be attributed to the

stigma that is generally attached to mentally ill individuals. In addition, the lack of regular follow-up care and support on discharge from hospital might be a contributing factor to relapse. However, mentally ill individuals need support and care like any other people suffering from physical chronic conditions.

It was also evident in this study that family members did not receive psycho-education about the importance of their relatives taking their treatment regularly. This was revealed by one participant in the statement that expressed that there was no money for transport to visit the clinic. Compliance with medication needs should not be a problem in primary health services centres where plans and structures could be put in place to ensure that people are provided with adequate support to take their medication, for example, mobile clinics to follow-up on long term mental health care users who had been discharged from hospital to community centres (Lieberman and Silbert, 2005).

4.3 Burden of care in their families

The burden of care mental health care users placed on their families was reported as a barrier to reintegration into the community by the majority of the participants who were interviewed. Family life is important for mental health care users; in so much as it is necessary for individuals who are mentally healthy (Ostman, 2004). In this study, it is evident from most participants that they received emotional support and care from their family members. Most participants were living with their family members or relatives after discharge from hospital. There was one participant who lived alone because his wife worked far from home.

The burden of care of mental health care users was evident in all participants who were interviewed. This was apparent in the statement of one who said, “*ndixhomekeke kuncedo lwabazali kuba andiphangeli, andifumani nodanke*”, meaning that he is dependent on his parents because he is unemployed and does not receive a social grant. He stated that he could not live an independent life and be able to have his own family because he was not working nor receiving a grant. Mental health care users appeared to be frustrated and stressed because they add more responsibility to their families for financial assistance and support. Most mental health care users were still living with their families. Gale and

Lambert (2006) stressed that community resources might be essential in decreasing the burden of care associated with people with mental disorders. These include workshops and vocational centers. Borbasi et al. (2008) found that without these community resources, the placement of mental health care users with their families could not be sustained because families are busy with their own lives, with working and daily activities which results in a lack of supervision. In this study, due to the lack of community resources, mental health care users were not occupied constructively, and were unemployed.

4.4 Individual functioning of mental health care users

All participants indicated that there were constructive behaviour changes in individual functioning after discharge. All participants were able to function independently when doing household chores and seeing to personal hygiene. It is not clear whether mental health care users are functioning at their optimal level, because the majority of the participants were occupied during morning sessions by doing household chores; it was not clear whether they were occupied for the whole day.

4.5 Inadequate skills, training and education

Lack of skills, training and education appears to be a challenge facing mental health care users because two participants were illiterate, and four participants had a highest level of education of Grade 11. The majority of participants had varied reasons for leaving school. Some had had no money to continue with their education, and some had left school because of illness. The abuse of dagga and alcohol might be a contributing factor affecting their education and their relapse rate, although most of them denied substance abuse, saying they had stopped using these substances. Liberman and Silbert (2005) found that community-based services require adaptation and acquisition of new skills on the part of both users and staff. In this study, the lack of skills training was a barrier to the reintegration into the community of mental health care users. However, training the community workers to implement simple rehabilitation measures focused on vocational rehabilitation using simple techniques could be a service provided to mental health care users.

4.6 Unemployment and vocational activities

Unemployment and a lack of vocational activities was a challenge in their reintegration into the community. All participants were not working, and most were not meaningfully occupied even at home. The majority of the participants indicated that they were involved in household chores, and one refused to do anything. He said, “*andiyithandi imisebenzi yasendlini*”, meaning *that he does not like to work indoors*. Most were dependent on a social grant which was the only source of income in the family. This partly contributed to the high unemployment rate. Granerud & Severinsson (2006) agreed when they stated that employment is an affirmation that one is an active member of society. In this study all of the participants were unemployed, and this has resulted in the low self-esteem of individuals with mental health problems.

4.7 Stigma and discrimination

The stigma attached to mental health care users was a barrier to their reintegration into the community. This was expressed by one participant who had been assaulted by neighbours for no apparent reason. He said, “*andithandi ukuya emathekweni kuba abantu bayalwa basosela uthywala*”, meaning *that he does not want to attend social occasions because people assault other people when they are drunk*. According to Granerud & Severinsson (2006), people who are stigmatised have problems being recognised as individuals with both positive and negative characteristics. Stigmatisation leads to altered self-esteem, as well as to changes in one’s social situation. In addition, the impact of stigmatisation on people with mental illnesses can lead to an avoidance of social contact and an attempt to conceal their true selves. Stigmatisation deprives people of their dignity and hinders their full participation in society.

In this study, other participants reported stigmatisation, but it appears that family members and communities lack a knowledge and understanding of mental illness. One way of addressing stigma and discrimination is to ensure that more information is available to families, friends and the general public, thus enabling a better understanding of mental health problems (Lloyd, Waghorn, Best and Gemmell, 2008).

4.8 Social relations

Social relations of mental health care users with their families and community members were a barrier to their reintegration into the community. Four mental health care users indicated that they do not experience problems socialising with friends, families and community members. Two participants experienced challenges with socialising. They were reluctant to attend social occasions because of crime and violence in the community. They stated that they preferred to be indoors because of physical abuse by community members. Participants expressed the opinion that communities have a high crime rate to the extent that there are community forums in their communities to deal with the suspects. The problems of antisocial behaviour and aggression were experienced by some mental health care users, especially when they had defaulted on their treatment.

A lack of the ability to sustain relationships was one of the problems experienced by mental health care users. However, it was evident from the interviews that the reintegration of mental health care users into the community had an impact on family life, as some mental health care users felt that the relations were strained. This was expressed by the participant who felt that he does not benefit from the grant he receives because it does not meet his needs; instead, it is used to buy groceries. WHO (2005) highlights the importance of actively promoting social integration among, and expanding the social network of persons with mental health problems, in order to enhance their wellbeing. There appears to be a link between social support and psychological wellbeing.

Problems with family relationships are nothing new, even for mentally health individuals because of unrealistic expectations and the lack of understanding of family members. Family members lack knowledge and information on mental illness, and are therefore unable to understand the limitations placed on mentally ill individuals, and their ability to achieve an optimal level of functioning like mentally health individuals (Ostman, 2004).

4.9 Impact of reintegration into the community of mental health care users

All participants who were interviewed indicated that they had experienced improved behaviour changes with individual functioning. Four participants indicated that their

social relations and social behaviour had changed. They expressed that they had no problems in social interactions with the community members. Four participants were able to participate in community activities and social gatherings.

For some mental health care users, non-compliance contributed negatively because of destructive behaviour such as breaking windows, which resulted in a financial burden to their families. Mental health care users were stressed and frustrated because of their level of independence. They cannot assist their families financially because they cannot find jobs. Some wish they could receive a disability grant so that they could take care of their needs and be able to assist their families financially.

4.10 Community resources

A lack of community resources has increased the burden of care mental health care users place on their families. Facilities such as half-way houses, vocational centres and sheltered employment would help them become independent. These resources are of great importance to mental health care users for daily activities, employment and placement, so they are able to keep themselves occupied and adequately supervised (Read, 2009). The provision of support centres such as counselling centres, crisis centres, and psychosocial rehabilitation services for skills development in the communities are essential for individuals and their families.

Janse Van Rensburg (2005) highlighted some concerns regarding the community placement and reintegration of service users from long term mental health care facilities that include issues such as sufficient parallel development of community-based services in view of the emphasis of the Mental Health Act (2002); adequate supervised facilities such as day-care centres to accommodate service users discharged from long term facilities; availability of mental health professionals to provide services in alternative facilities or programs; the overcoming of the fragmentation of continued rehabilitation options after discharge; the provision of an adequate budget allocation for the implementation of policy, and processes to monitor the outcome of these policy developments.

CHAPTER 5

Summary of the findings, limitations of the study, recommendations and conclusion

5.1 Summary of the findings

This study was conducted with the aim of exploring the lived experiences of the reintegration into the community of mental health care users in the Libode district. The data collection was conducted with six participants. The summary of the findings is based on the three objectives of the study: firstly, to explore the lived experiences of the reintegration into the community of mental health care users; secondly, to explore any barriers to their reintegration into the community in the Libode district; and lastly, to explore anything that could assist their reintegration into the community in the Libode district.

5.2 Experiences of reintegration into the community

The findings of this study have shown that the participants had varied experiences of reintegration into the community. The findings indicated that there were limited positive aspects of reintegration into the community experienced by the mental health care users. The findings revealed that mental health care users enjoyed being part of their families and their communities. The study showed that the majority of participants were supported and taken care of by their families. All participants reported constructive behaviour changes and individual functioning, although this was only sustained for a short period after discharge.

5.3 Barriers to their reintegration into the community

The study revealed that mental health care users experienced many challenges in their reintegration into the community. Mental health care users reported facing the challenges of complying with medication. It was evident that there was a lack of support, insight and understanding of the condition of mental illness. It seems in this study that there is no system in place to follow-up on defaulters.

It appears that there is inadequate continuity of mental health care services in the community. The lack of follow-up care services has resulted in a high relapse and readmission rate. Fragmentation of mental health care services and community care for the community resulted in mental health care users becoming lost in the system after discharge from hospital. A lack of support from friends and neighbours was indicated by the physical abuse of one of the participants who was assaulted by friends and neighbours.

A lack of vocational skills and training resulted in mental health care users being unemployed. This study has revealed that one participant was able to live independently, being able to take responsibility for his own needs, such as maintaining a house, cooking and cleaning because he was living alone. He received a disability grant which was his only source of income. However, the majority of mental health care users were not constructively occupied. It appears that they were occupied during the mornings by doing household chores.

The availability of substances such as alcohol and dagga in the community has created problems for mental health care users. Most participants abused substances. This was also reported as a factor which contributed to users defaulting on their treatment and their relapse. This was indicated by the participant who expressed that he drinks alcohol while on medication. Some participants denied the abuse of substances although signs like dark finger tips and red lips could be observed.

Stigma and discrimination attached to mental health care users by community members was a barrier to their reintegration into the community. The study revealed that there is still a lack of insight and understanding in the awareness of the mental health care users' psychiatric condition. This was indicated by the positive behaviour change when they are discharged from hospital, as also the fact that these changes did not continue for long after discharge. Non-compliance with medication requirements was also indicative of a lack of knowledge on the part of the families and relatives. Families and communities still lack an understanding of psychiatric conditions.

The participants placed a heavy burden of care on their families, as the majority of them were living with their families. Mental health care users make varied contributions to their family life. Mental health care users revealed that there was a positive change in them regarding individual functioning such as undertaking household chores and that their family relations were good. Most of the participants indicated that the change did not last for long, as their functioning decreased as they began to present problematic behaviour such as defaulting on treatment and substance abuse. The signs of relapse caused a negative impact as mental health care users presented with destructive behaviour such as breaking windows, aggression and violence towards their families and friends. This odd behaviour created problems and disharmony in their lives.

Furthermore, the findings showed that, by the mental health care users' burden of care on their families after discharge from hospital, it was evident that mental health care users were not able to function well, and were unable to adapt to living in the community. The study reveals that the environment was not conducive to assisting them in ensuring that they were successfully reintegrated into the community. It appears that there is a lack of a support system between mental health care users and community care.

The inability of mental health care users to adapt to family life might be due to the fact that they are not independent financially. Reintegration into the community of mental health care users has placed more strain on a health system which is already short-staffed, lacks resources and experiences major financial difficulties.

5.4 Limitations of the study

This study reflects the experience of only six participants who volunteered to participate in the study. The data obtained from the interviews were limited to what the participants were willing to share about their experiences of reintegration into the community. The fact that the interviews focused on mental health care users who had varying degrees of mental illness was a challenge. Some users were able to tell their stories meaningfully, while others found it difficult to do so. An effort was made to structure the questions as simply as possible, as the researcher is a qualified psychiatric nurse. Furthermore, in this study, all the participants shared the same gender, culture and race. All participants were

male, Xhosa, and from a poor socio-economic background. The researcher could not determine whether the results would have been different had both males and females participated in the study.

5.5 Recommendations

5.5.1 Recommendations for practice

5.5.1.1 Outreach programme

The study revealed that there is a high relapse rate due to treatment defaulters. There is still a need for health professionals to participate in outreach programmes on awareness campaigns and psycho education in order to empower individuals, families, and communities. Educational aspects such as the nature of the condition, causes, signs and symptoms, the importance of taking medication and signs of relapse should be focused on in the educational programmes.

5.5.1.2 Home visits

Participants have suggested that home visits should be carried out by health professionals at least once a month. This would enable individuals, families and relatives who care for the users to prepare to cope by applying acquired skills when mental health users exhibit difficult behaviour. Relatives need to be educated about the importance of mental health care users taking their medication to ensure medication compliance. Leave of absence should gradually be increased until the user is discharged, so that the mental health care user becomes acquainted with community life.

5.5.1.3 Involvement of stakeholders

Efforts should be made at institutional level to ensure that mental health care users are being discharged with vocational skills to allow them greater access to the job market. Sheltered workshops could assist with this. The importance of the involvement of various stakeholders such as family members and community members in the discharge preparation of mental health care users cannot be overemphasised.

5.5.1.4 Support groups

Mental health care users as well the families who care for the mentally ill individuals must be involved in support groups. Support groups would facilitate the sharing of information, advice and coping mechanisms. Awareness campaigns should be conducted to eradicate the stigma associated with mental illness. Intersectoral collaboration with other sectors like the South African Police Services should be pursued in an attempt to prevent the availability of substances in the community such as at shebeens, taverns and the easy accessibility of dagga.

5.5.1.5 Recommendations for policy

The Department of Health, the Department of Welfare and relevant Non-Governmental Organisations should work together to provide services which will ensure continued services for mental health care users enabling them to function at their optimal level in the community. Government must ensure, through legislation, that vocational and job opportunities for service users are addressed to provide employment for mentally challenged individuals.

There is a need for an increased budget to facilitate rehabilitation and community resources in order to support community-based care with resources such as residential facilities, half-way houses and group homes. These facilities have been established in other provinces in South Africa, like KwaZulu-Natal, and a small number, if any, in the Eastern Cape. Government must ensure that the budget allocation for mental health is increased, so that it meets the needs of community-based care. Psychosocial Rehabilitation Services should be improved and should include crisis centres, sheltered employment and half-way houses.

5.5.2 Recommendations for education

The curriculum should focus on Community-Based Education and Problem-Based Education in order to focus on a rehabilitative aspect so as to meet the changing needs of communities and societies.

Education and training of traditional healers, *isangoma* and faith healers by mental health care professionals should take place, as well as training on the referral system.

5.5.3 Recommendation for future research

In South Africa, despite the good intentions of legislation and the policies that are in place, mental health care users are still struggling. This study explored the experiences of the reintegration of mental health care users in the Libode district. It would, perhaps, be useful for further research studies to extend their base to include a bigger population size.

5.6 Conclusion

In conclusion, it could be stated that the process of gaining the findings from the participants regarding their experiences of reintegration into the community was difficult for them. The participants need to be followed-up after discharge. The main challenges are poor compliance with medication requirements, and a lack of family and community support. This was evident from the high relapse and admission rate after discharge.

All participants indicated that they were not living an independent life as they were a burden of care on their families. This suggests that the process of reintegrating mental health care users back into the community needs to be reviewed. Prior to discharge, mental health care users are encouraged to take a leave of absence more regularly in order to assess the mental health care users' adjustment to the home and community environment. This will also determine the suitability of mental health care users for discharge back into the community. However, it would appear that this is not carried out effectively enough.

With regard to the barriers to their reintegration, most participants faced many challenges such as medication compliance, vocational skills, unemployment, and stigma, being a

burden to their families, crime and violence. Mental health care users in this study were not able to maintain themselves to their optimal level of functioning; instead, they were a burden of care on their families. It is apparent that the community-based care of mental health care users is dependent on their families. There is a need to improve the quality of life of mental health care users in the communities.

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ANNEXURES

ANNEXURE A

INFORMATION SHEET ABOUT THE STUDY

Title of the study: The lived experiences of mental health care users concerning their reintegration into the community by attending primary health care services in the Libode district.

Researcher: Nokukanya Bokleni –Master’s Student in Nursing (Mental health)
University of KwaZulu-Natal

I wish to explore and describe the experiences of mental health care users concerning their reintegration into the community by attending primary health care services in the Libode district. I will be conducting interviews with the aim of exploring and describing the experiences of mental health care users concerning their reintegration into the community by attending primary health care services. The interviews will be audio-recorded which will take about 30 minutes, and will be conducted in a private place and only the researcher will have access to these records used for the purpose of this study.

Before participation, you will be asked to complete a form which indicates that your willingness to participate in this study is totally voluntary. You are free to withdraw from the study at any time. The participants will be asked to give permission for the interview to be audio taped as part of the data collection process. You may ask for clarification for a better understanding on any aspect of this research.

Researcher: Nokukanya Bokleni- contact details 203520520@ukzn.ac.za
Tel.0835397502

Research supervisor: Charlotte Engelbrecht-e mail engelbrecht@ukzn.ac.za
Tel.0312602513

HSS Ethics Committee contact person: Phumelela Ximba-e mail ximbap@ukzn.ac.za
Tel.0312603587

ANNEXURE B

VOLUNTARY CONSENT TO PARTICIPATE IN THE STUDY

Attached is the form for obtaining written consent from the participant.

I..... consent to participate in the research study of the lived experiences of the reintegration into the community of mental health care users attending primary health care services in the Libode district.

I understand that my participation in this study is voluntary and that I am free to withdraw at any time.

Signature of the participant.....Date.....

Research supervisor contact details. University of KwaZulu-Natal. School of Nursing office: 031 2602513

ANNEXURE C

PART 3.BIOGRAPHY/ DEMOGRAPHIC DATA

Gender:	Title:
Age:	Diagnosis:
Area:	Marital status:
No of children:	Highest level of qualification:
How often have you been admitted to hospital?	How long is it since you were discharged from hospital?
Are you working or getting a grant?	When did you start attending the clinic?
How often do you attend the clinic?	

INTERVIEW GUIDE

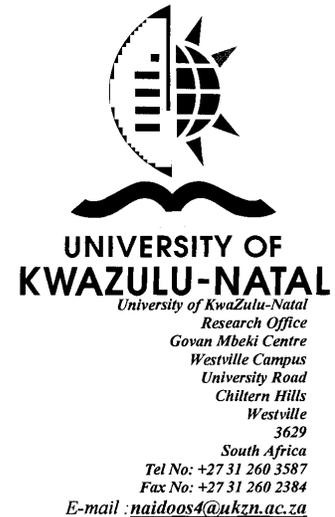
Tell me about your experiences concerning your reintegration into the community after your discharge from hospital?

Probing in the following areas:

What made it easy for you to be part of the family and community?

What made it difficult for you to be part of the family and the community?

ANNEXURE D



21 July 2010

Ms N Bokleni
33 Minelso Gardens
30 Prains Avenue
Berea
4001 DURBAN

Dear Ms Bokleni

PROTOCOL: An exploration and description of the experiences of reintegration into the community of mental health care users attending primary health care services in Libode district

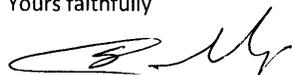
ETHICAL APPROVAL NUMBER: HSS/0807/2010 : Faculty of Health Sciences

In response to your application dated 19 July 2010, Student Number: **203520520** the Humanities & Social Sciences Ethics Committee has considered the abovementioned application and the protocol has been given **FULL APPROVAL**.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



Professor Steve Collings (Chair)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

SC/sn

cc: Ms C Engelbrecht (Supervisor)
cc: Mr. S Reddy

ANNEXURE E

P.O. Box 600
Libode
5160
14 June 2010

The Manager
Libode Mental Health Clinic
Libode, 5160.

Dear Sir,

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH STUDY AT YOUR INSTITUTION:

I hereby apply for permission to conduct a research study at your institution. I am conducting the study for the fulfillment of the requirement for the Master's degree in Mental Health Nursing (Coursework) and I need your assistance and cooperation. My research topic is: The lived experiences of the reintegration into the community of mental health care users in the Libode district.

The knowledge gained will help increase understanding of the experiences of reintegration into the community of mental health care users in order to enhance the planning of mental health care services. Confidentiality will be maintained, and all the information will be held in strictest confidence. Please find attached the research proposal, consent form and interview guide.

I hope that my request will receive your favourable consideration.

My supervisor's contact details are the following:
Charlotte Engelbrecht
Tel: 031 260 2513, engelbrecht@ukzn.ac.za

Yours truly,
N. Bokleni (Ms)

ANNEXURE F

PROVINCE OF THE EASTERN CAPE

IPHONDO LEMPUMA KOLONI



DEPARTMENT OF HEALTH
LIBODE MENTAL HEALTH
LIBODE

Telephone: 047-5551011/12

Enquiries: M. Madlebe

ISEBE LEZEMPILO
P.O. BOX 15
5160

Fax: 047-568 7100

083 522 7979

29 JUNE 2010

To whom it may concern
University of KwaZulu Natal

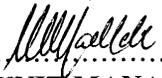
Dear sir / madam

INTERVIEWS WITH M. H.C. USERS: MISS N. BOKLEIN.

This serves to confirm that Miss. N. Boklein was granted **permission** to conduct interviews with the users at Libode Mental Health Unit.

Thanking you.

Sincerely,


.....

UNIT MANAGER: LMHU

ANNEXURE G

Participant One

Age: 26

Marital status: Single

Number of children: None

Occupation: Unemployed

The interviews were carried out at the Libode Mental Health Clinic. The mental health care users who were willing to participate in the study were selected by the sister-in-charge while they were still waiting in the queue for consultation with the doctor. The researcher introduced herself and explained the purpose as well as the objectives of the study. The information sheet about the ethical considerations and voluntary participation in the study was given to all participants. After receiving these, the informed written consent was obtained from each of the participants. The researcher asked for permission to audio-tape the interview. After receiving permission, the researcher read all the files of the participants. The interviews were to continue until data saturation.

The interviews were conducted in a private room within the clinic which was organised by the clinic supervisor. The interviews were conducted in isiXhosa which was the participants' language so they could understand it, and it was then translated into English after the interviews. Using the researcher's experience in communication skills, the questions were made easy for the participants to understand. The researcher also explained the fact that the participants could withdraw from the study, if they did not feel comfortable and that confidentiality would be maintained. After signing the consent, the users were asked to provide biographical information such as age, sex and marital status. The interview was to explore the lived experiences concerning the reintegration of mental health care users into the community. The names used in the interviews are pseudonyms to maintain privacy and anonymity.

Interview One

Researcher : Good morning Lindile.

Lindile : Good morning Sister.

Researcher : Are you nervous?

Lindile : Yes, a little bit.

Researcher : Do not worry; I will try to make the interview as easy as possible for you. I would like to discuss with you the lived experiences concerning the reintegration into the community of mental health users. You are free to tell me if you do not understand the question or if you do not feel comfortable talking about the topic.

Lindile : Okay.

Researcher : Lindile, tell me about your experience of reintegration into the community after discharge from hospital?

Lindile : I was discharged at the beginning of the year, in February 2010. I was very happy and excited on the day of discharge because I felt like a free man. I am living with my parents, grandfather, my older brother, his children and his wife. I am not married and do not have children. My parents are not supportive, it is as if they do not love or care about me. The only people who support me are my grandfather and my brother's wife. My grandfather made me feel at home. My brother's wife is supportive because she understands my illness. She encourages me to take my medication and checks my doctor's reviews with the clinic. I had no problem with reintegration into the community because I had no problem socialising with friends and community members because they did not isolate themselves from me. I have been receiving a disability grant from November 2009 till today. The grant helps me to contribute financially to my family. I am unemployed, but I keep myself busy during the day by helping at home. I help my brother with outside activities like fencing and gardening.

Researcher : What made it easy for you to be part of the family and the community?

Lindile : I was willing to help wherever I could at home and was contributing financially. I also attended community meetings and am involved with community services when I feel well.

Researcher : What made it difficult for you to be part of the family and the community?

Lindile : Unemployment, because it made me unable to live an independent life. I am not able to start my own family. I had no problem being part of the community.

IHLELO LOKUQALA: ULWAZI NGENCUKACHA EZIZOKULANDELA

Ndingumfundi kwi University yaKwa Zulu- Natal e Thekwini, ndifundela ukuphuhlisa ulwazi banzi ngendlela abantu abadibana nazo xa bebuyela kwindawo zabo zokuhlala emva kokuba bephumile kwisibhedlela sabagula ngengqondo. Iziphumo zolulwazi zizosetyenziswa ukuphuhlisa ulwazi ngokugula ngezengqondo. Uyacelwa ukuba uphendule imibuzo ozakuyibuzwa. Impendulo zakho ngale mibuzo izakubhalwa phantsi ngulowo uzakuba uthetha naye. Okuthethileyo kuyohlala kuyimfihlo phakathi kwakho nalowo uthetha naye. Ukuba awusathandi ukuqhubeka nemibuzo ungatsho okanye uyeke xa ungasathandi ukuqhubeka.

Ndakuyivuyela intsebenziswano ukuze siqhubeke kakuhle.

Ndim ozithobileyo.

Nokukhanya Bokleni inkcukacha zonxebelelwano 20352020@ukzn.ac.za Umnxeba:
0835397502

Research supervisor: Charlotte Engelbrecht inkcukacha zonxibelelwano
engelbrecht@ukzn.ac.za Umnxeba: 031 2602513

HSS Ethics Committee: Phumelela Ximba inkcukacha zonxebelelwano:
ximbap@ukzn.ac.za Umnxeba: 031 2603587

IHLELO LWESIBINI: ISIVUMELWANO ESISANIWEYO

Mna..... ndiyavuma ukuthatha inxaxheba kwinkcaza ngendlela abantu abathi badibane nazo nendlela abaphatheka ngayo xa bebuyela kwindawo ebehlala kuzo emva kokuba bephuma kwisibhedlela zabagula ngengqondo. Ndiyathembisa ukuphendula yonke imibuzo. Ndiyathemba ukuba endikuthethileyo koba yimfihlo phakathi kwam nondithethe naye. Ndiyazi nokuba xa ndingasathandi ukuqhubeka nokuphendula imibuzo ndivumelekile ukuba nditsho, lilungelo lam.

Ndim obebhala.....

Umhla.....

IHLELO LWESITHATHU: IMIBUZO NGOKUBHEKISE KUWE

Isini:	Isihlonipho:
Indawo ohlala kuyo:	Ubudala:
Abantu ohlala nabo ekhaya:	Amabanga onawo:
Utshatile?	Ixesha ungenile nokuphama esibhedlela?
Uyasebenza okanye wamkela udanke?	Uqale nini ukuza eklinika?
Uza kangaphi ekliniki?	Lwalunjani usuku lamhla uphuma asibhedlela?

IMIBUZO OZAKUYIPHENDULA NGOLWAZI LWAKHO

Ndixelele zonke izinto ozaziyo nowazivayo ngendlela owaphatheka ngayo xa wawuphuma kwisibhedlele sabagula ngengqondo ubuyela kwindawo ohlala kuyo?

Imibuzo ephuhlileyo ngale ngxoxo:

Zintoni ozenzileyo ukuzama ukuhlala kakuhle ekhaya umzekelo ingxaki zemali nomsebenzi?

Zintoni othe waziqaphela ngexesha ubuyela kubahlali?

Zintoni ongathi uxwayise ngazo abantu abasazakuphuma kwisibhedlele sabagula ngengqondo?