IMPLEMENTATION AND EVALUATION OF A PSYCHIATRIC REHABILITATION PROGRAMME IN A CORRECTIONAL SERVICE UNIT, EASTERN CAPE PROVINCE.

SUBMITTED BY

AYANDA BONANI

DECEMBER 1995 :DURBAN

Submitted in partial fulfillment of the requirements for the degree of MCur in the Department of Nursing,University of Natal,1995.

ACKNOWLEDGEMENTS

My sincere appreciation is expressed to the following :-

My supervisor Ms Hasina Subedar, for her guidance, support and invaluable suggestions.The consultation over the weekends and holidays is greatly appreciated.

Professor Leana Uys, co-supervisor for availing material and for her support.

My parents for their encouragement and support.

Mrs Mahaye and family - thank you for your assistance and moral support.

Michael for his valued comments,assistance and support throughout the duration of my study; and most of all

Olwethu for her patience and understanding.

ABSTRACT

A study of implementing and evaluating a psychiatric rehabilitation programme in a correctional service department unit was undertaken at the Medium A Prison in East London.

The objectives of the study were to develop and implement a psychiatric rehabilitation programme.To increase the knowledge of the mentally ill persons about mental illness,to develop skills that will help them to cope with the psychiatric symptoms and lastly to evaluate the effectiveness of the programme by assessing the knowledge of the participants about mental illness, their level of psychiatric symptoms and the presence of relapse rate.

The Brief Psychiatric Rating Scale (BPRS) and the Knowledge About Mental Illness Questionnaire (KAMI) were administered prior and after the implementation of the programme.

The sample in the study comprised ten psychiatric patients selected from the prison population and assigned randomly to either the control group or the experimental group.
Psycho-education was done with the experimental group only, while the control group only focused on recreational activities.

The KAMI questionnaire results were statistically significant ($t = 0,03$ $p < 0,05$). The experimental group therefore performed better than the control group after implementation of the programme.

Although the psychiatric symptoms of the experimental group decreased after the intervention they were not statistically significant.This could be attributed to the fact that the sample was quite small.The findings as well could not be generalized due to the limited sample.

This therefore suggests that psycho-education needs to be conducted as an ongoing programme and, to be able to evaluate the effectiveness of the study, a more permanent programme needs to be developed for the Correctional Services Department.It was also suggested that the psychiatric rehabilitation programme should be intertwined with the criminal rehabilitation programme.

TABLE OF CONTENTS

LIST OF TABLES

FIGURES

CHAPTER ONE

1. INTRODUCTION

In South Africa major political changes are in the process of being instituted.Transformation in various South African institutions is still at a conceptual stage.The Correctional Services Department being one of these institutions need to change its policies, including changing the mental health policy for its large population of people with mental disorders.

Generally psychiatric services or institutions for the lower-class or black in-patient offer custodial care.Correctional services is no exception in this regard and to move away from this care, psychiatric rehabilitation programmes need to be developed and implemented.These programmes need to be informed by research to address the needs of the mentally-ill persons in a prison.

Withdrawal,apathy and minimal social interaction have long been recognised as major features of persons with schizophrenia and other long-term mentally-ill patients (Goldstein, 1981).South African mental health workers should strive to prevent what happened in America during the deinstitutionalization movement which initially seemed a success.Discharged individuals from the hospital to the community were inadequately prepared to meet even the routine minor demands of daily living.As some had been hospitalised for many years and during this time, were socialized into the "Good Patient" role.This did not prepare them to meet the demands of the real world.This later led to the "Revolving door Syndrome", i.e. with patients moving in from hospitals into the community and vice versa (Goldstein, 1981).

The challenge for rehabilitation in a prison setting is greater due to the dual rehabilitation demands, i.e. criminal and psychiatric rehabilitation.The psychiatric nurse therefore has a major role to play in facilitating psychiatric rehabilitation programmes.The number of known psychiatric patients at Medium A prison where the study is being conducted is approximately 50.Many mental health settings have commenced with the development of psychiatric rehabilitation programmes to enhance or replace the existing traditional programmes (Callen and Velesco,1980,Bachrach,1982,in Farkas and Anthony, 1989).

It is therefore imperative that the department of correctional services join these in articulating the best way to assist the consumers or individuals with varied limitations to achieve a satisfying life and to learn basic skills to meet basic demands of the outside world when they are released.

In most South African prisons multidisciplinary teams exist but do not function effectively as such.These professionals tend to concentrate on matters that concern their different disciplines, thus fragmenting care.The other problem that is encountered in South African prisons is the language barrier. Demographics of

the South African prisons reveal that the majority of inmates are African and the majority of professionals are unable to speak African languages. For the department to provide a holistic and a client-friendly environment, it would need to promote the effective functioning of multidisciplinary teams and address the language imbalance.

SIGNIFICANCE OF THE STUDY

Given the complexity of implementing a psychiatric rehabilitation programme in a prison setting,this study will attempt to provide answers to address similar problems within the correctional service department.

PSYCHO-EDUCATION

It is the teaching of knowledge and skills that will enhance psycho-social functioning of the trainee or client. It can either be individual or small group teaching, and makes use of a variety of methods including skills training and health education (Uys, 1991).

SOCIAL SKILLS TRAINING

It is the planned, systematic teaching of the specific behaviours needed and conscientiously desired by the individual in order to function in an effective and satisfying manner, over an extended period of time (Goldstein,1981).

PSYCHIATRIC REHABILITATION PROGRAMMES

It consists of an overall rehabilitation programme mission whose structure promotes the process of rehabilitation to occur in specific environments. The psychiatric rehabilitation mission is to help a person increase his or her ability to function successfully and satisfactory in an environment of choice with the least amount of ongoing professional intervention (Anthony, 1977).

COPING SKILLS

These refer to the use of coping mechanisms to alleviate or remove stressors or threats in one's life (Uys,1991).

RELAPSE

Is an increase in the patient's symptoms of the psychiatric illness such as an increase in hallucinations and delusions, or an increase in non-specific symptoms such as sleep disturbances or muscle tension which result in admissions to hospital or the need for increased medication (Falloon 1984, in Lukoff,Liberman and Nuechterlein,1986).

STUDY OBJECTIVES

1. To develop and implement a psychiatric rehabilitation programme.

2. To increase the knowledge of mentally ill persons about mental illness.

3. To develop skills that would help them to cope with the psychiatric symptoms.

4. To evaluate the effectiveness of the programme,by looking at increased knowledge, symptom reduction and relapse rate.

HYPOTHESIS

Psycho-education focusing on knowledge about mental illness would increase the patients'knowledge.

Psycho-education focusing on managing psychiatric symptoms would improve the patients'symptoms.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 INTRODUCTION

Identifying methods which would enable individuals with severe or chronic psychiatric disabilities to live more satisfying lives has been a difficult goal to achieve.The public policy of transferring large numbers of state hospital residents to" the community" was introduced as one of the means of realizing this goal.While many had agreed that the "deinstitutionalization" philosophy was one that was worthy of advocacy, its implementation became tangled in the politics and economics of the 1970's and early 1980's" (Bachrach,1983).

Problems encountered in achieving deinstitutionalization included the lack of adequate services,the lack of housing, the lack of support and a general lack of public awareness (Bachrach,1986,Keisler,McGuire,Mechanic,Mosher,Nelson,Newman,Rich and Schulberg,1983,Talbort,1979 in Farkas and Anthony,1989).

2.2 PSYCHIATRIC REHABILITATION

The field of psychiatric rehabilitation has emerged as a promising direction for all professionals, consumers and family members concerned with the future of individuals with severe psychiatric disabilities (Farkas and Anthony,1989).

According to Anthony,(1990) psychiatric rehabilitation is guided by the basic philosophy of rehabilitation which states that disabled persons need skills and environmental support to fulfil the role demands of their living, learning ,social and working environments.

Anthony and Nemec (1984) define psychiatric rehabilitation as treatment that teaches chronically mentally ill individuals the physical,emotional and intellectual skills necessary to live, learn and work in their own particular environments.

Bennet (1983) suggests that the term has been stolen by psychiatry from physical medicine.He also states that there has been six stages in the development of the concept psychiatric rehabilitation.The stages according to Bennet (1983) are:-

1a." Attempting to modify an individual's psychiatric disability.

b. Compensating for the disability by developing other abilities and then placing them in an environment in which these abilities can be used.

3. Restoring psychiatrically disabled persons to their former state, making them better, specifically by taking them out of the psychiatric institutions.

4. Returning or integrating the psychiatrically disabled persons into a home, school,work and community by developing his or her skills.

5. Improving the psychiatrically disabled person's capabilities and competencies with the emphasis on coping not curing.

6. The process of helping the psychiatrically disabled person to make the best use of his or her residual abilities in order to function at an optimum level in as normal social context as possible" (Ekdawi and Conning 1994, p.16).

Anthony,Cohen and Farkas (1990) define psychosocial rehabilitation as the improvement of a person with a psychiatric disability in a specific environment. The authors further explain that it focuses on the present and the future. It assesses present and needed skills and support.In its intervention,primary techniques that are used include :- increasing skills and skill use,increasing understanding and support and increasing resources and resource use.

Psychiatric rehabilitation programmes evolved out of a number of previous responses to the problems of the psychiatrically disabled (Anthony and Liberman,1986).

Psychiatric rehabilitation programmes are effective means of preventing relapse and improving the social functioning of patients with chronic mental illnesses (Beaumont and Hampshire 1989,in Kaplan).

Farkas and Anthony (1989) state that a psychiatric rehabilitation programme comprises three elements which are the mission,the process and the environment.The mission has concepts which are based on the rehabilitation values, while the rehabilitation process consists of three phases namely the diagnostic phase,the planning phase and the intervention phase.The rehabilitation environment consists of the network of environments, meaning - the range of settings in that environment,and the context of the environment, meaning the manner in which the environment is organised.

Goldberg et al.(1977) in Lukoff,Liberman, and Nuechterlein suggests that patients who enter rehabilitation programmes with low levels of psychopathology generally benefit from the intervention.However patients with high levels of symptomatology levels had high rates of relapse.

The merit of this approach is that it treats the disabled persons holistically and as individuals.This view also does not determine to the client what should be done but intervention is based on a functional assessment.

2.3 AIM OF PSYCHIATRIC REHABILITATION

The overall aim of psychiatric rehabilitation is to help persons with psychiatric disabilities to increase their ability to function so that they are more satisfied and successful in their environment of choice, with the least amount of ongoing professional intervention (Anthony et al,1990).

According to Bellack (1984) the goal of psychiatric rehabilitation is to ensure that the disabled person possesses the physical,emotional and intellectual skills needed to live, learn and work in his or her own particular environment.He also states that the treatment focuses on the skills and the environmental resources needed by a client to function in a specified environment.

The aim of psychiatric rehabilitation is to resettle psychiatrically disabled persons in economic employment"an unrealistic and inappropriate aim to achieve for many persons"(Bennet,1983 in Ekdawi and Conning,1994 chap.2)

There is merit in Bellack's view that if the psychiatrically disabled persons could possess and master the needed and necessary skills, they could be independent, responsible, self sufficient and productive in their environments without being a burden on the country's welfare system.

2.4 APPROACHES TO REHABILITATION

The need for a comprehensive rehabilitation approach can be seen in the wake of the admitted failure of traditional treatment to successfully rehabilitate the psychiatrically disabled. The mental health system's rehabilitation efforts have been characterized as plagued by poor outcome figures,saddled with inefficient treatment approaches, distracted by an irrelevant diagnostic system and burdened by a fragmented and unresponsive community based treatment system (Anthony,Cohen and Cohen's report cited in Bellack,1984).

The South African health system's policy document on mental health services mention rehabilitation under the functions of the National Health Department only in terms of informatics.It is crucial therefore that with the development of the psychosocial rehabilitation policy in South Africa, clarification on the fact that rehabilitation is part of the health care be also made, as the lack of ownership will continue to impede the development of adequate services (Uys,1994).

The articulation of the psychiatric rehabilitation approach has made it possible to specify what is needed to implement programmes that will effectively impact on outcome for the severely psychiatrically disabled population (Farkas and Anthony,1989).

The psychiatric rehabilitation approach integrates the philosophy and principles of physical rehabilitation with various techniques of the psychotherapeutic approach.The emphasis is on client involvement. Empathy and a trusting relationship between the client and the psychiatric rehabilitation practitioner is essential (Carkhuff and Rogers in Bellack,1984).

Uys (1994) suggests that psychosocial rehabilitation requires a multidisciplinary approach and is synonymous with tertiary prevention of illness.She also claims that since tertiary prevention is part of the health system, so is psychosocial rehabilitation.Rehabilitation however according to this author requires intense co-operation amongst mental health workers,the welfare system and the labour sector.

2.4.1. BEHAVIORAL APPROACHES

Ekdawi and Conning (1994) state that the behavioral approaches have made valuable contributions to rehabilitation by bringing a way of thinking based on the theories of learning.

The behavioral model emphasizes that response capability is acquired through learning.The learned response components comprise a behavioral repertoire that the individual can use in social encounters.Individuals who lack a particular skill or who have social skill deficiencies can learn those skills through training (Bellack,1984).

According to Ekdawi and Conning (1994) behavioral programmes clearly identifies behavioral goals to be achieved by each individual. Achievement of a goal would then be rewarded.Perkins and Dilks (1992) suggest that behavioral techniques play an invaluable part in managing difficult behaviours and that a behaviour management programme can be an appropriate means of providing such limits.

Research done by Hall,Baker and Hutchinson (1977) on behavioral programmes demonstrated that the improvements in the patient's functioning were a result of social rewards which came in the form of praise and pleasant interaction with the staff.The authors further state that behavioral techniques play an invaluable part in managing difficult behaviours and that a behaviour management programme can be an appropriate means of providing such limits.

2.4.2 THE MEDICAL OR CURATIVE MODEL

This model has been adapted from physical medicine and its

emphasis is on cure,and the only desirable outcome expected from the approach is cure (Pilling,1991).The model also implies that the individual is sick and therefore must give up his or her normal roles and passively accept treatment.The positive aspect of this model is that some patients and their carers are comforted by being given a diagnosis, as it gives a reason for the symptoms they have observed and provides reassurance that they have been understood (Ekdawi and Conning,1994).

2.4. 3 THE DISABILITY MODEL

Wing (1978) states that the model comprises three levels discussed as follows|-

-Primary or intrinsic factors which are the direct result of the "illness". These include positive symptoms such as hallucinations,delusions and negative symptoms such as flatness of affect and social withdrawal.

-Secondary impairments which are the result of the responses of significant others such as professionals,family and public figures.The impairments include features such as lack of confidence ,poor self esteem,lowered motivation and poor coping strategies

-Tertiary or intrinsic handicaps which are disadvantages that may have resulted from primary and secondary disabilities such as poverty,unemployment,bad housing and poor social network which could have played a role in the development of the illness.

2.4.4 THE SKILLS MODEL

The skills model evolved from the works of Anthony and his colleagues in the United States.Implicit in this model is the idea that patients have lost or have never developed skills that are essential for surviving outside psychiatric institutions.The model further explains that if patients can be taught the necessary skills,then they will be able to survive (Anthony, 1977)

The author suggests a three stage process for developing skills viz|-

Identifying skill deficiencies preventing the client from functioning effectively in his or her environment.

Assessing the patient's present and required level of functioning for each skill.

Intervening to eliminate discrepancies between the present and the required level of skill by breaking the skill down into small steps,teaching the skill to the patient, allowing the patient to perform each skill in an appropriate environment in the community,receiving feedback

and differential reinforcement based on the skill performance.

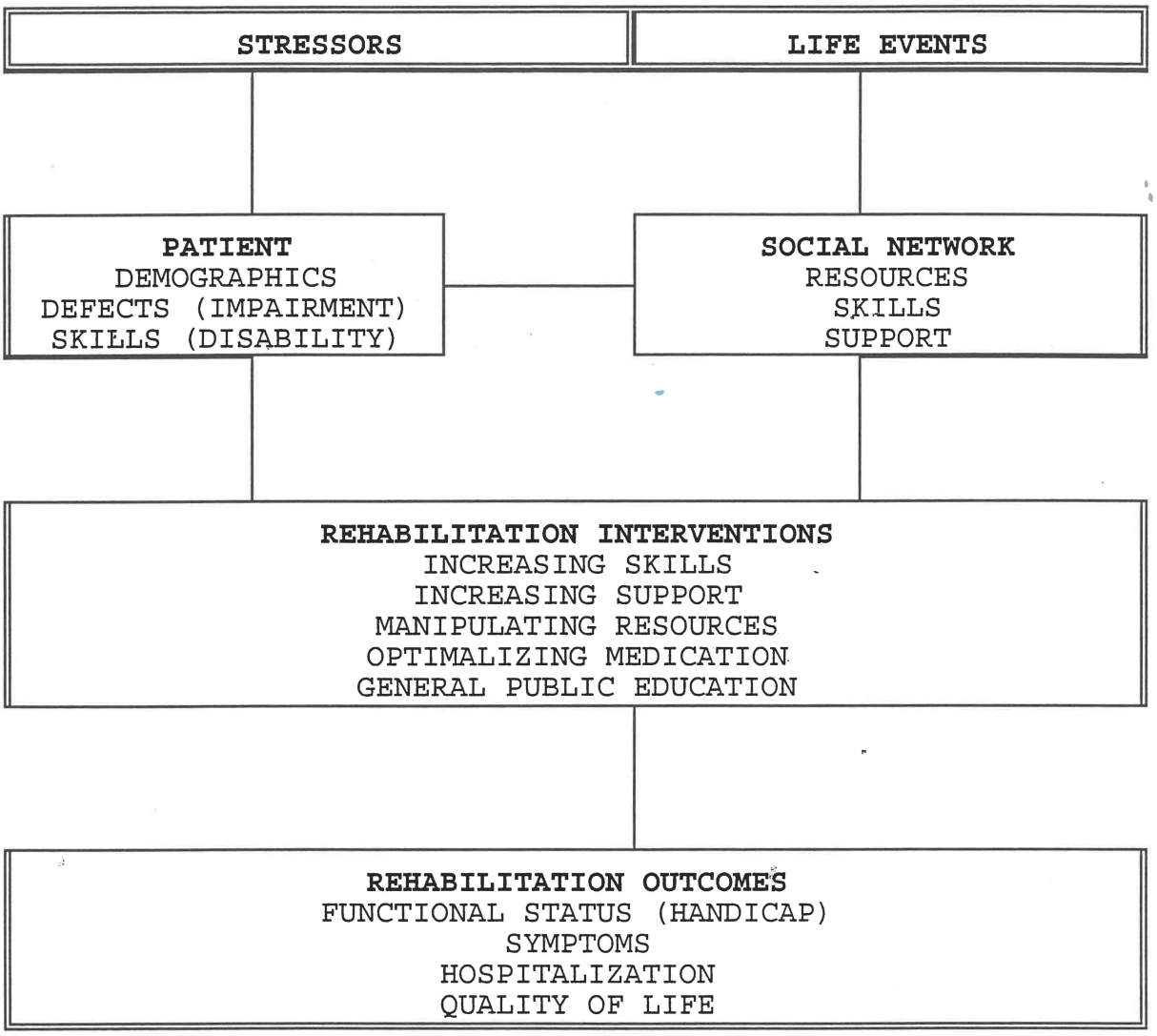
Anthony and Liberman (1986) suggested that patient skill development should go hand in hand with environmental resource development.By so doing one looks at changing the patient's environment to support and accommodate his or her disabilities,for example by providing sheltered work.

The advantages of the skills approach to psychiatric rehabilitation are that it provides individualized treatment and uses very practical means to achieve its goals.

The model's disadvantages are that it does not differentiate between lacking a skill and having a skill but not using it. It also assumes that changes will always be in the forward direction (Ekdawi and Conning, 1994).

2.5 A THEORETICAL FRAMEWORK FOR PSYCHIATRIC REHABILITATION

Uys (1991) proposes a framework for psychiatric rehabilitation which is based on the rehabilitation model proposed by Anthony et al (1990),the vulnerability, stress,coping and competence model of mental disorders by Anthony and Liberman (1986),the stress diathesis model of schizophrenia by Falloon,Boyd and McGill (1984) and the interactive model of schizophrenia proposed by Liberman et al.in (Bellack,1984).The framework describes the process of relapse, intervening variables, interventions and outcomes.



(Uys,1991,p.2)

In the framework there is a relationship between stressors and life events.A life event is seen as stressful by the patient who sees a discrepancy between his or her resources and the demands of the situation.

Uys (1991) suggests that demographic factors such as age and gender have been shown to influence rehabilitation outcomes as supported by Conyne,(1985).

Impairment which refers to the actual loss or abnormality in psychological,physiological or anatomical structure may be affected by optimalizing medication during intervention.

Disability which refers mainly to deficiencies in coping skills,social skills and vocational skills may be improved by psycho-education according to this framework.

Social network factors such as resources, skills and support determine how much stress an individual can absorb. Interventions such as psycho-education, resource manipulation and public education are said to effectively increase the above.

Rehabilitation interventions in the framework include increasing skills of the patient and the family, resource manipulation, optimalizing medication, psycho-education, increasing supports and general public education.

Rehabilitation outcomes in the framework include improving functioning and preventing handicap through interventions, symptom reduction, minimizing hospitalization and improving the client, s quality of life by living a satisfactory life following interventions.

There is widespread support for the fact that stressful events play a precipitating role in mental illness (Kaplan and Saddock, 1988).

In this framework there is also a relationship between individual factors and social network factors and these determine how much stress a patient can absorb before relapsing or before an illness episode occurs. Age and gender, impairment and disability such as lack of coping skills, social skills, vocational skills and social network factors such as social support and skills to cope with the illness may lead to an illness episode. The action taken to prevent the illness from occurring is the rehabilitation intervention mentioned earlier. Rehabilitation outcomes according to this framework are measured by the patient's functional status, the symptoms present, the number of hospitalizations and the quality of life enjoyed by the patient.

2.6 FUNCTIONAL ASSESSMENT

From the above framework it is evident that functional assessment is an essential component of psychiatric rehabilitation. It forms a base line that informs rehabilitation interventions. It also provides a means of measuring the extent to which the intervention has influenced a person's functioning.

Granger (1982) states that functional assessment is any systematic attempt to measure objectively the level at which a person is functioning in a variety of areas such as physical health, self maintenance, quality of role activity, intellectual status, social activity, attitude towards self and emotional status.

According to Anthony and Farkas (1989), Liberman (1982), Anthony and Cohen (1984) and Cohen and Nemec (1986) functional assessment involves the individual's competencies, identification of the environmental demands and support and the implementation of the treatment methods that will improve competencies, reduce demands

and increase supports.They further suggest that the success of this process depends as much on the reliability and validity of the assessment instruments used and on the effectiveness and efficiency of the available treatment methods.The assessment information identifies the incompetent coping responses for which treatment will be necessary and provides the empirical basis for evaluating the success of the process both for individual and for the entire programme.

Bellack (1984) states that functional assessment is a process that yields behavioral and descriptive information about the disabled client's current skills and the skill level demanded by the community in which he or she wishes to function.Such information enables the rehabilitation practitioner to work with the client to develop a treatment plan designed to increase the client's skill and to identify and develop an environment which is more supportive to the client's functioning.

According to Ekdawi and Conning (1994) functional assessment is to establish the current social functioning and environmental factors that may have affected the performance of social roles. The main objectives according to the authors are to identify the person's disabilities and strengths based on the assessment in order to set agreed rehabilitation goals and to choose interventions which may achieve the goals.

Functional assessment is therefore an imperative component of psychiatric rehabilitation and rehabilitation interventions need to be based on it to achieve effective rehabilitation outcomes.

2.7 REHABILITATION INTERVENTIONS

The practice of rehabilitation frequently involves directly teaching clients the specific skills they need in order to function successfully in their own particular environments (Curren and Monti,1982,Goldstein,1981,Liberman,Eckman, Kuehnel,Rosenstein and Kuehnel,1982).

Bellack suggests that a more formalized direct teaching experience is required where the skill deficits of the more severely disabled persons resulted from a lack of opportunity to learn the skill,or from a lack of practise of the skill.On many occasions clients have the skills in their repertoire but are unable to use them in the needed environments. In this particular incidence a rehabilitation programme is developed and will specify how the client need to utilise the existing skill to realize his or her goals.

The basic elements of rehabilitation in the literature are discussed in the following manner:-

2.7.1 OPTIMALIZING SYMPTOM CONTROL

The aim of prescribed drugs in rehabilitation is to prevent a relapse.In the long-term the effort to prevent a relapse once the acute symptoms are controlled justifies months of considered trial of drugs since the consequences of a relapse are disastrous (Crammer and Heine,1991).

According to Uys (1991) optimalization of medication refers to a medication regime that fits the patient best and is responsive to changes in the client's condition.Education of the client and carers about medication and its use is essential to them to ensure optimal use.The author further states that the overall status of the psychiatric symptoms of the patient is a good indicator of the health status, especially in terms of disability and impairment.

2.7.2 PSYCHO-EDUCATION

The psycho-educational intervention presented by Ascher-Svanum and Krause (1991) is designed specifically to provide patients with schizophrenia and other long-term mentally ill patients with a systematic and thorough programme that informs them and addresses their illness rated fears, concerns and faulty cognitions. Psycho-education also attempts to improve the quality of community management of long-term and schizophrenics,decrease patient relapse and rehospitalization rates.

According to Goldman and Quinn (1988) although research on the efficacy of programmes as well as other psycho-educational interventions is still in its infancy,there are indications that patients' experience a decrease in their negative symptoms.

Psycho-education is the preferred approach for skill development.It enhances the psychosocial functioning of the trainee.Consumers are taught about mental illness,its treatment and management,so that they can cope better with the community based care.Vague terms such as "nervous breakdown" are still being used frequently and therefore psycho-education educates clients and families about the actual conditions, management and to cope better with the conditions (Uys,1994).

2.7.3 INCREASING SKILLS

An increase in skills whether general life skills or specific vocational skills assists the whole network to cope better with stress or in some instances can prevent stress (Uys,1994).

She also states that the better the patient's social and vocational skills, the fewer life events will be seen as stressful by the client.Environmental stress is moderated by an increase in the client and the family's coping skills and communication skills.

The above statement is supported by therapists such as Bowen with his focus on differentiating patients from the family ego mass.

Social skills training is an effective means of teaching patients from varied walks of life and educational backgrounds to communicate emotions and needs accurately and allow them to achieve interpersonal goals.Skills training is a broad spectrum of behavioral therapy and has become an innovative and effective avenue for treatment and rehabilitation of a wide variety of psychiatric patients (Liberman,DeRisi and Mueser,1989).

Social skills are comprised of an extensive set of verbal and nonverbal responses,elements which are combined into complex repertoires such as conversational skills.Once learned these skills become part of the individual's behaviour repertoire.As the individual develops, new behaviours are learned and these are added to the behaviour repertoire i.e.the stock of skills or action from which individuals draw upon in different situations (Bellack and Hersen,1979).

According to Bellack (1984) social skills training must be preceded by a careful systematic assessment.The best rule of thumb in identifying patients for social skills training according to this author is to determine the ability to follow instructions and to pay attention in a structured learning process.

Controlled clinical research has demonstrated that social skills training can be effective both in enhancing the social competence of patients and reducing their vulnerability to debilitating psychiatric symptoms such as depression, delusions,hallucinations and problems with impulse control.Several studies have found that social skills training significantly reduces symptoms and relapse in both long-term inpatients and outpatients (Liberman et al.1989).

Goldstein (1981) states that structured learning or training techniques in social skills consists of five elements which are modelling,roleplay,feedback and positive reinforcement,homework and transfer training.

2.7.4 INCREASING SOCIAL SUPPORT

Guerin (1976) states that an increase in family support influences the rehabilitation process.Social support can be increased using psycho-education,resource manipulation and general public education (Uys,1991).Many programmes implemented to improve family support have been tested and found to be very successful (Hagarty et al.1986,Strachan,1986 Goldstein,1981 in Bellack,1984).Any action which can increase the support that the patient and family receives, assists in preventing breakdown and promoting health.This refers to entitlements, material assistance and psychosocial support (Uys,1994).

All persons giving support need to be supported. Family members in particular have made it clear that they require respite and some support to continue providing their disabled family member with support. Without that support consumers and professionals alike suffer "burn out"Farkas and Anthony,1982).

According to Liberman et al.(1989) social support can reduce the noxious effect of stress on vulnerability by either reducing stress itself or by helping to minimize its negative effects on the patient.

Anthony and Nemec (1984) state that stressful demands, incompetent coping,a high degree of vulnerability and inadequate support systems summate to produce an episode of illness.They also state that by increasing the amount of environmental support,environmental demands and illness may be reduced.

Support is a critical type of intervention and success in rehabilitation terms is not only a function of skill use but also a function of availability of people.Providing support to help people obtain and maintain their environments of choice implies that the support is continuous and is directly related to client goals.The type of support given by support programmes need to be flexible and tailored to the ongoing but changing needs of the clients served (Farkas and Anthony,1982).

Mullis and Beyers (1987) suggests that there is a reasonable amount of tested evidence that points to the positive relationship between social support and mental health.This relationship is explained by three schools of thought.

The first school of thought explains support as having a direct effect on mental health and the strength of this view is in the preventive aspect.In this view well-being is seen to be a result of strong social support influencing and enhancing growth and development,and reducing social isolation
(Litwin and Auslander,1990).

The second view suggests that social support acts as a buffering agent by mediating and moderating stress.Social support has been found to reduce the need for rehospitalization due to the mediating effect it has on life stresses (Solokove and Trimble,1986).

The third school views support as meeting certain needs and states that it is in the presence of social support that requirements are met when certain tasks are performed.Support according to this school is therefore given and gained in the process of carrying out tasks (Mullis and Beyers,1987,in Ngubane and Uys 1994).

2.7.5 VOCATIONAL REHABILITATION

According to Ascher-Svanum and Krause (1991) different services should be available to the disabled individual that has enthusiasm in keeping a job in the market place.Vocational rehabilitation services offer vocational assessment to identify skills and ability, vocational counselling to identify which job is best suited to an individual and vocational training. Patients are encouraged to learn methods of dealing with problems that threaten job security.They further suggest that a request from a social worker,therapist or case manager will be more likely to help in initiating the application process with the relevant agency.

Uys (1994) suggests that the process of vocational rehabilitation enables the disabled person to secure,retain and advance in suitable employment.This means that the person at least works for a minimum salary or better,with non-disabled co-workers,at a job which provides room for advancement.The favoured way of achieving this according to the author is through supported employment (SE), whether this is available in South Africa is another issue that needs assessment.

2.7.6 MANIPULATING RESOURCES

This refers to actions aimed at making available to the patient and his or her family the appropriate resources in the community.Resource manipulation includes resource coordination which means matching the patient to the resource or creatively combining different resources to meet the patient's particular needs,resource modification which means improving or proposing a change to an existing resource to make it more accessible and effective and resource development which means creating a service where none are available (Uys,1991).

Uys (1994) states that manipulating resources "may include aspects such as marketing the patient to a service or marketing a service to the client.

2.7.7 GENERAL PUBLIC EDUCATION

General public education refers to continuous mass health education to promote understanding of psychiatric conditions. Successful reintegration of the client into society depends to a large extent on the attitudes of the general public and specific groupings within the general population such as family members and employers.A change in attitudes needs to be addressed specifically and purposefully (Uys,1994).

2.7.8 CASE MANAGEMENT

This is an approach to long-term care which addresses all the needs of the disabled person,and is aimed at assessing such

needs,linking the person to a variety of services,and co-ordinating service use to achieve a successful outcome.Although there are different models of case management,it would seem that the generalist model is most appropriate for the South African situation.In this model one person,who may belong to any of the helping professions,deals with the problems of the patient without keeping strictly to professional boundaries (Levine and Flemming,1987).

2.7.9 FAMILY INTERVENTION PROGRAMMES

According to Goldstein (1981) family intervention programmes emerged from an experimental programme designed to assist families and their disturbed relatives to modify family patterns in order to foster rehabilitation.

The awareness that family members are increasingly responsible for the after care of relatives with schizophrenia and that specific attributes of the family environment may be particularly pernicious has led to renewed enthusiasm in family intervention programmes.These programmes are designed to support the family system,prevent relapse and foster the social recovery of the patient (Bellack 1984).

Bellack further suggests that these programmes are designed to help patients out of hospitals and return them to a productive life in the community. Working together with medication programmes, family programmes teach patients and families about their mental disorders and their management. These programmes also look at treating the family as a resource rather than as a stressor.

2.8 CONCLUSION :

In this chapter various issues including the shift from "deinstitutionalization"to the emergence of rehabilitation have been discussed extensively.The framework that underpins this study has also been discussed as well as the relationship that exists among its components.This study uses the rehabilitation as a theoretical framework.Functional assessment,rehabilitation interventions,the role and the importance of social support have also been discussed.

CHAPTER THREE

3. METHODOLOGY

3.1 STUDY DESIGN

A quasi-experimental design was used in this study.The instruments that were used were the Brief Psychiatric Rating Scale (BPRS) developed by Overall and Gorham (1962),the schizophrenic assessment questionnaire developed by Ascher-Svanum and Krause (1991) and adapted by the researcher to the knowledge about mental illness. assessment questionnaire (KAMI).There were two groups of participants in the study, group 1 was called the experimental group and group 2 was called the control group.Group 1 had 5 patients and Group 2 also had 5 patients.Both groups were assesssed using the (BPRS) and the (KAMI) questionnaires.After the instruments were administered to the two groups,the experimental group (group 1) was exposed to the psychiatric rehabilitation programme for a period of 5 weeks.During this five week period the control group (group 2) was only involved in recreational activities.After the programme was completed, both groups were again assessed using the same instruments.

3.2 THE SETTING

The East London prison is situated at approximately 5 kilometres from town. The complex is comprised of three prisons and medium A prison was selected for the purpose of the study for reasons outlined earlier. Another reason for selecting the hospital unit of this prison was that the hospital has psychiatric patients in its wards who find it difficult to cope in the sections outside the hospital but has no psychiatric programmes.The total number of prisoners between February and October was approximately 1300.

3.3 POPULATION

The population includes psychiatric patients who are twenty one years old and above admitted in the hospital unit and those attending the hospital as outpatients. The population of known psychiatric patients is approximately 50 and ten of them were involved in the study.The majority of the prison population is African and they are all of the male gender.

3.4 SAMPLING

Participants were selected according to their proximity to the hospital unit.Ten patients were selected and were randomly assigned to two groups of five.Patients who were due to be transfarred to other prisons were not included in the study.In both groups only two participants had been in prison for a period less than 12 months.

DATA COLLECTION INSTRUMENTS

3.5 SYMPTOM REDUCTION

The instrument used for symptom reduction was the brief psychiatric rating scale (BPRS) with the 18 item version. The factor analysis of this version revealed five factors which include the anxiety depression factor,the anergia subscale,thought disturbance,activation and hostile suspiciousness (Guy,1976).Each item is rated on a scale of 1 to 7 in the order of increasing severity.Ratings of 2 or 3 represent nonpathological intensity,ratings of 4 to 7 indicate pathological intensity.A rating of 1 indicates an absence of symptoms.

This scale has been used effectively in previous studies for an example Herz and Melville's 1980 sample reported experiencing a similar prodromal pattern before each relapse. It was used effectively by O'Conner in a study where symptoms of schizophrenics were monitored to prevent relapse.Two useful strategies for identifying early signs of symptoms increase are regular administration of the scale and watching for previously identified target symptoms.The instrument was administered to both groups of patients before and after implementation of the programme.

	Pre test	Post test
Group 1	5	5
Group 2	5	5

3.6 KNOWLEDGE ABOUT MENTAL ILLNESS Illness

A knowledge questionnaire was developed by the researcher to test knowledge about mental illness.The development of this questionnaire was based on information of an assessment questionnaire of schizophrenia developed by Ascher-Svanum and Krause (1991).Ascher-Svanum and Krause's questionnaire could not be used in this study due to the fact that it was difficult to comprehend and was inappropriate.This questionnaire had 8 questions,of which the first four were constructed to detect knowledge about signs and symptoms of mental illness or psychotic conditions and what to do once they are detected.The last four questions assessed knowledge about support systems, the importance of medication in mental illness and the effects of drugs on the mentally ill persons.

The questionnaire was administered to both groups of participants prior and after the implementation of the programme. The questionnaire was translated to Xhosa by the researcher and was

translated back by another professional in the unit and adjustments were done.The researcher was assisted by another professional nurse in administering the instruments.

3.7 RELAPSE

The relapse rate will be detected by monitering an increase in the participants' psychiatric symptoms,by monitoring their medication presriptions and by checking the admission register for new admissions.

3.8 DEVELOPMENT OF THE PROGRAMME

The purpose of the programme is in keeping with the study and is to ensure that knowledge about mental illness and symptom reduction will improve following exposure to the programme.The programme focused on structured learning using psycho-education and social skills training.

Discussions with psychiatric patients were also held to elicit problems they encountered in their environment.Some of the problems mentioned were lack of knowledge as to how to express feelings of frustration and anger,lack of assertiveness and a lack in problem solving skills.

The programme was then developed to meet the study objectives and to empower the participants with the necessary survival skills in their environment.

3.9 IMPLEMENTATION OF THE PROGRAMME

The programme was implemented over a period of five weeks where three sessions were held per week.Therapeutic activities that were included in the study are as follows:-

individual therapy
psycho-education
skills training
stress management

GROUP 1

WEEK 1 The brief psychiatric rating scale was administered to both groups at different intervals.

The knowledge about mental illness questionnaire was administered to both groups at different intervals.

WEEK 2 Psycho-education was done with the experimental group where mental illness was discussed with the involvement of the group for an example a question was posed to the group as to what they know about mental illness.The causes of mental illness were discussed, common mental illness conditions such as schizophrenia,depression,substance abuse and their symptoms were discussed.

Psycho-education was continued and diagnosis of mental illness was discussed, recognition of symptoms was discussed as well as the symptoms experienced by the participants and infact whether they were aware of those symptoms.Measures to be taken after symptoms are recognised were also discussed.

Psycho-education was the focus again and support systems, medication management and the effect of drugs on the mentally ill was discussed.

WEEK3 Individual therapy was conducted with the participants of the experimental group.

Skills teaching was done with the focus on communication skills to assist the participants in initiating and maintaining communication in their environment.This was done in a form of a role play.

Stress management skills were taught to the participants of the experimental group.

WEEK4 Skills training was done again where the participants were taught about assertive behaviour, the skill was then modelled and role play was done.Homework was given at the end of the session.

The session was opened with role play from the homework,thereafter problem solving skills were taught to the group.

Management of mental illness was discussed.A summary of psycho-education was done,participants were granted another opportunity to ask questions on mental illness again.

WEEK 5 A summary of all the activities was done in this session with the experimental group.

Instruments were administered again to both groups as the programme was completed.The BPRS was administered first.

The questionnaire on knowledge about mental illness was administered to both groups.

GROUP 2

The second group which is the control group did not have any structured learning.It was only involved in recreational activities such as playing cards, chess, snooker and general discussions on activities occurring in the prison.Activities in

this group were also flexible for an example participants were given a choice on activities to engage in.

3.10 ETHICAL CONSIDERATIONS

Permission for conducting the study was granted by the prison authorities.All participants were informed about the study ,its purpose, its duration,and the right to refuse. Participants agreed freely to take part.There is a possibility that some of the participants felt that they were bound to participate in the study because they are in a prison setting, and are most of the time expected to conform to the prison rules.The case of a" free choice" in a captive setting is more complex than in other settings and probably is an issue that needs further assessment.Anonymity of all the participants will be maintained.The participants and the department of correctional services will be informed about the results.

CHAPTER FOUR

4. RESULTS

4.1 INTRODUCTION

Data were collected over two consecutive days,that is the 2nd and the 9th October 1994.The study included 10 outpatients and inpatients admitted in the prison hospital.Some of the patients who were interested to participate could not participate.This was due to lack of staff to escort them to the hospital unit.

The participants were interviewed individually initially.This proved to be extremely difficult due to a number of factors viz :- early meal times,visits to the parole board,searches conducted unexpectedly,visits by officers taking complaints and the fact that on cold days we had to use the doctors consulting room where interruptions were unavoidable.Some of the participants suggested that they felt honoured to have somebody who was interested in their psychiatric conditions.

Table 4.1 Demographic characteristics of the participants

	Exp. Group	Control Group	Total
20 - 29	4	2	6
30 - 39	0	2	2
40 - 49	1	0	1
50 - 59	0	1	1
	5	5	10

In this sample all the participants are males.As reflected in Table 4.1 60 percent of the sample fell within the 20-29 year age range.This suggests that a significant percentage of the sample consists of young adults.

Table 4.2 Number of years of schooling and marital status

Years of Schooling	Exp. Group	Control Group	Total
NIL	0	1	1
0 - 4	3	2	5
5 - 9	2	2	4
Marital Status			
Single	2	4	6
Married	3	1	4
	5	5	10

As indicated in Table 4.2 , 50 percent of the sample received 1-4 years of schooling,40 percent received 5-9 years of schooling and 10 percent received no formal education.
Sixty percent of the sample were single.

Table 4.3 Mental conditions and year diagnosed

Mental conditions	**Exp. Group**	**Control Group**	**Total**
Schizophrenia	2	1	3
Depression	2	3	5
Manic Bipolar	1	0	1
Antisocial Personality Disorder	0	1	1
Year diagnosed			
0-4 Years Ago	2	2	4
5-9 Years Ago	3	3	6
	5	5	10

Table 4.3 indicate that 50 percent of the sample suffer from depression,followed by 30 percent which suffer from schizophrenia and 20 percent suffer from manic depression and antisocial personality disorders. In both groups the 60 percent of the participants have been diagnosed as 5-9 years ago as having a psychiatric illness.

4.2 DATA ANALYSIS

Statgraphics 5.1 software package has been used to analyse the data. The t-test and the Wilcoxon Signed Ranks test were done to analyse the results.

4.3 SYMPTOM REDUCTION FINDINGS

Table 4.4.1 indicate pre-test and post-test symptom scores of both the experimental and the control group.Ratings between 2-3 indicate nonpathological intensity while ratings between 4-7 indicate pathological intensity.A rating of 1 indicate an absence of pathological symptoms.

Table 4.4.1 Pre-test and post-test pathology symptom scores of the experimental and the control group

		Pre-test Rating (2-3)	Post-test Rating (2-3)	Pre-test Rating (4-7)	Post-test Rating (4-7)
	1	0	0	8	3
Experimental Group	2	0	0	6	6
	3	5	3	2	3
Rating Prior Assessing Change	4	1	0	8	5
	5	6	5	5	3
Percentage		24	16	58	40
	1	6	5	2	2
Control Group	2	3	2	3	2
	3	3	2	3	2
Rating Prior Assessing Change	4	3	4	3	4
	5	2	2	3	3
Percentage		34	30	30	32

Table 4.4.2 Total symptom scores prior and after implementation of the psychiatric rehabilitation programme

Participants	Experimental Group		Control Group	
	Pre	Post	Pre	Post
1	52	38	33	34
2	46	39	35	32
3	41	37	39	40
4	46	39	32	39
5	45	36	35	33
Average	46	37.8	34.8	35.6

In table 4.4.2 symptom scores of both the experimental and the control group and their average scores are indicated.

The t-test was done to determine whether there was a significant difference Pre and Post testbetween the experimental and the control group. The result was nonsignificant (t= 0,35 p > 0,05).

A comparison of the experimental group prior the implementation of the programme and after the implementation of the programme using the Wilcoxon Signed Ranks Test showed a significant difference (0,03 < 0,05).The pre-test and post-test results of the control group using the Wilcoxon Signed Ranks Test were found to be nonsignificant (0,78 > 0,05).

The symptom scores in Table 4.4.2 are translated in a graphic form in figures 4.4.3. and 4.4.4.

Figure 4.4.3 - Totals Of Pre-test And Post-test Pathology Rank scores

CONTROL GROUP

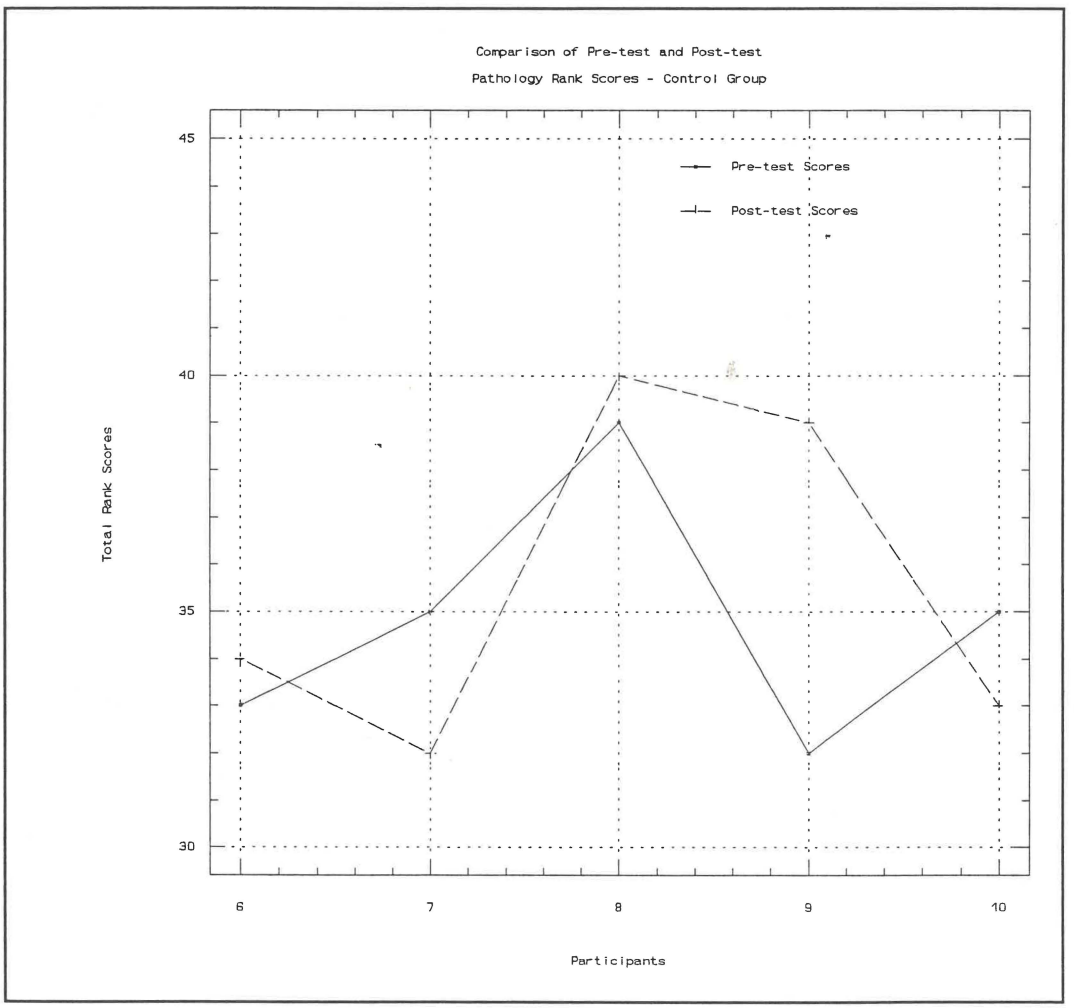


Figure 4.4.3 Totals of Pre-test and Post-test Pathology Rank Scores obtained by each participant in the control group.

EXPERIMENTAL GROUP

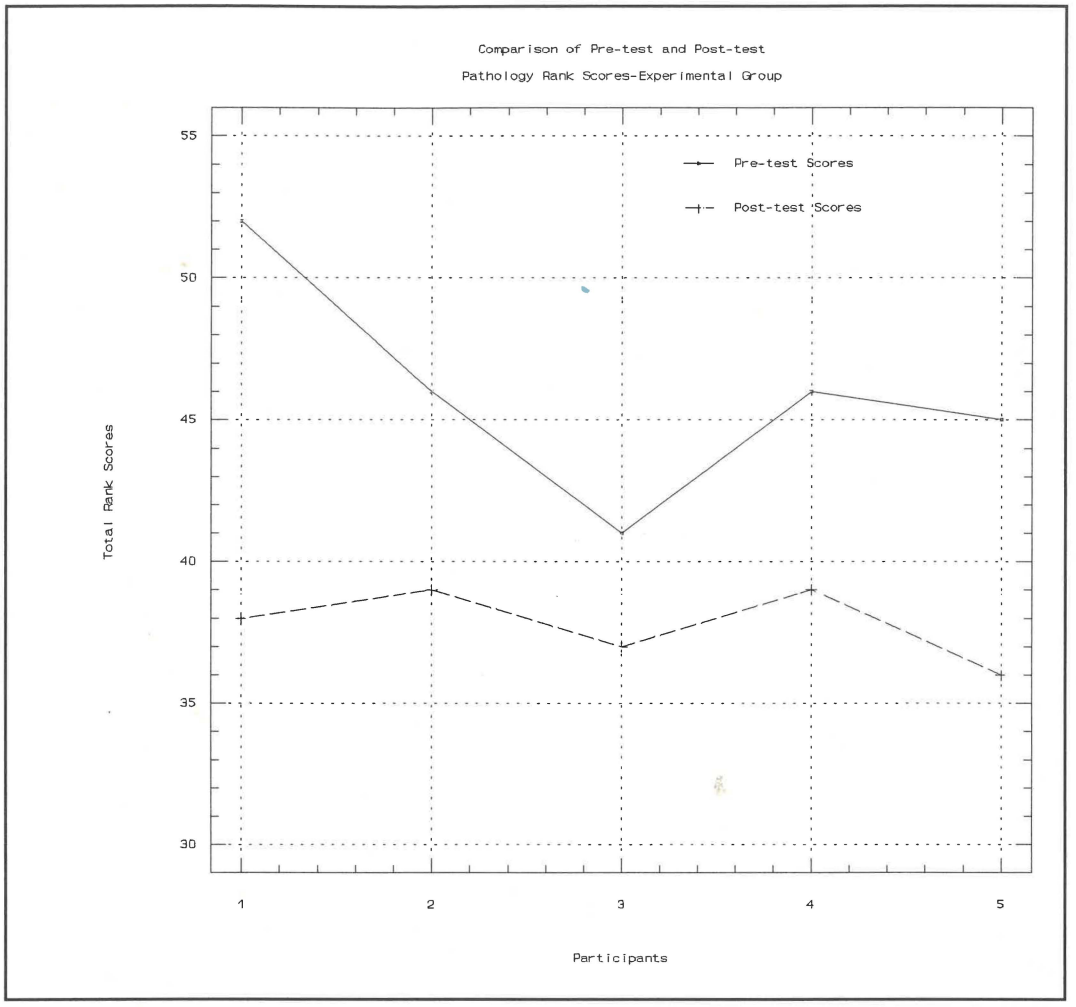


Figure 4.4.4 Totals of Pre-test and Post-test Pathology Rank Scores obtained by each participant in the experimental group.

4.5 KNOWLEDGE ABOUT MENTAL ILLNESS QUESTIONNAIRE RESULTS

Table 4.5 Pre-Test and Post Test Total Scores Of The KAMIQ

Participants	Experimental Group		Control Group	
	Pretot	Postot	Pretot	Postot
1	8	8	1	4
2	7	8	6	7
3	1	6	6	3
4	5	4	2	3
5	5	5	1	1
Average	5.2	6.2	3.2	3.6

Table 4.5 indicate the pre-test and post-test total scores of the experimental and the control group.The pre-test and post-test average scores show an improvement in both groups.

The above pre-test and post-test total scores are illustrated graphically in figures 4.5.1 and 4.5.2.

There is some improvement in the post-test scores when they are compared to the pre-test scores in the control group, this is illustrated in Figure 4.5.1.

Marked improvement in the individual post-test scores of the experimental group when compared to the pre-test scores is illustrated in Figure 4.5.2.

Figure 4.5.3. illustrates the performance of both the experimental and the control group to each question.There is marked improvement in the experimental group's performance after the programme was implemented.

The t test was done to compare the test scores of the experimental and the control group.The results were statistically significant ($t = 0,03 < 0,05$).

CONTROL GROUP

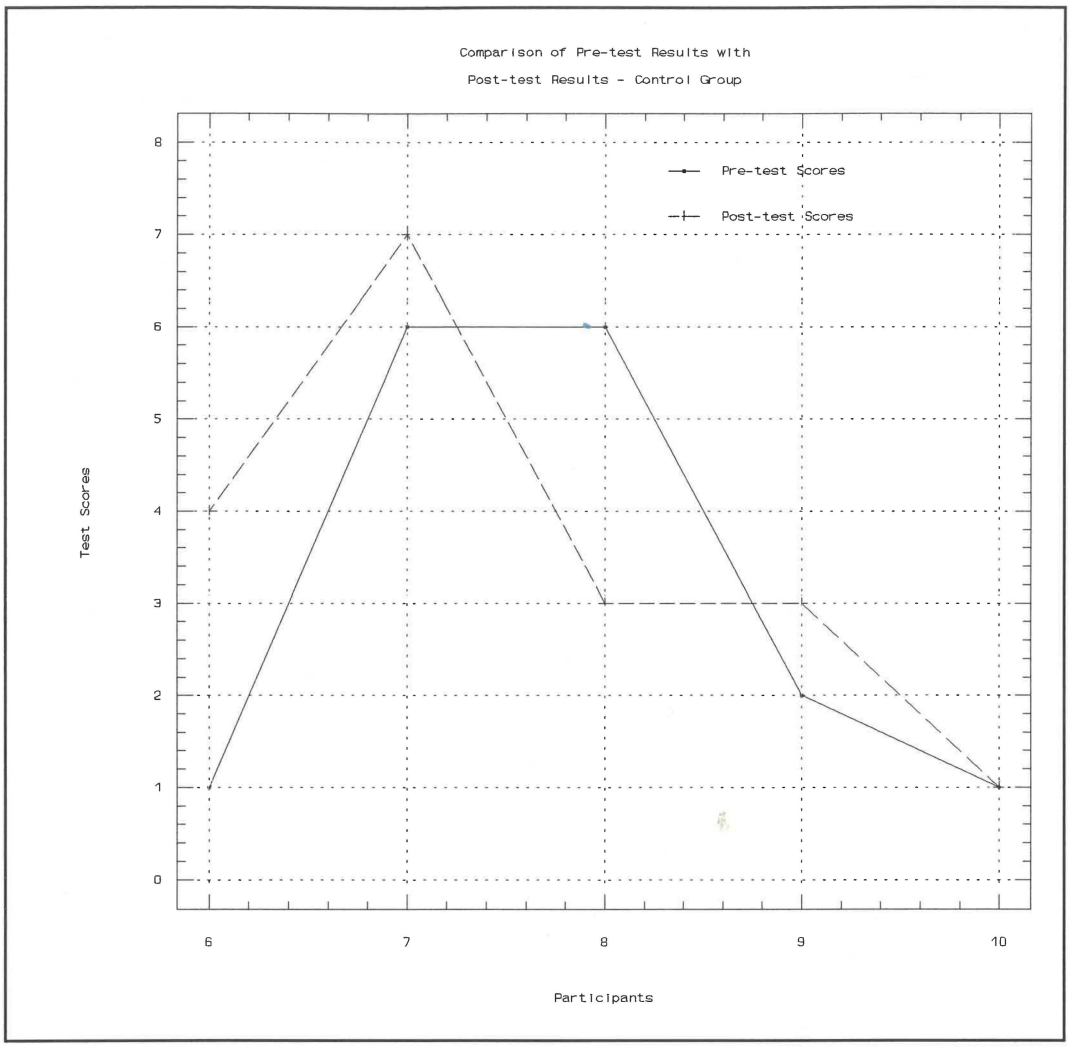


Figure 4.5.1 Pre-test and Post-test results scored by the participants in the control group.

EXPERIMENTAL GROUP

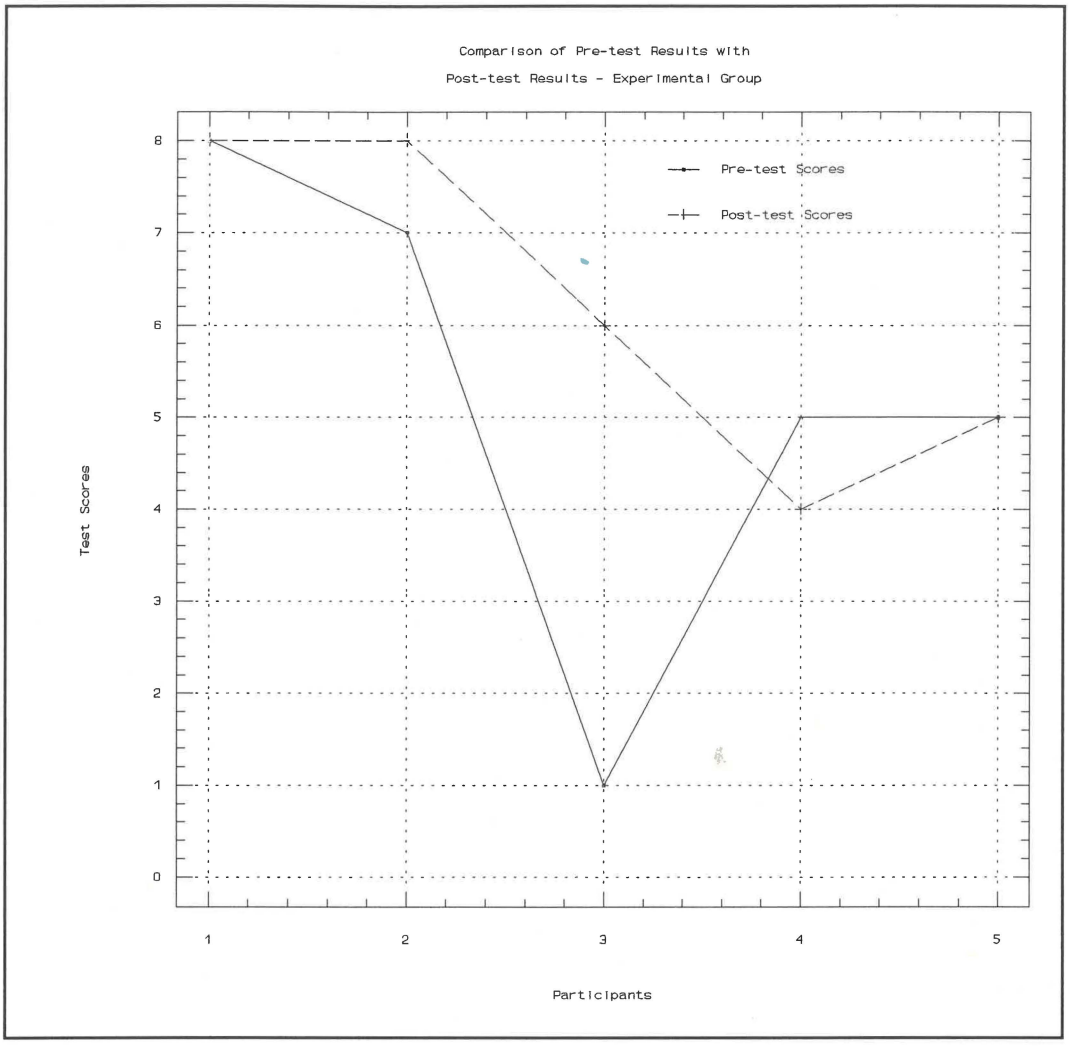


Figure 4.5.2 Pre-test and Post-test results scored by the participants in the experimental group.

Figure 4.5.3 Pre-test and Post-test group perfomance results of the experimental and the control groups.

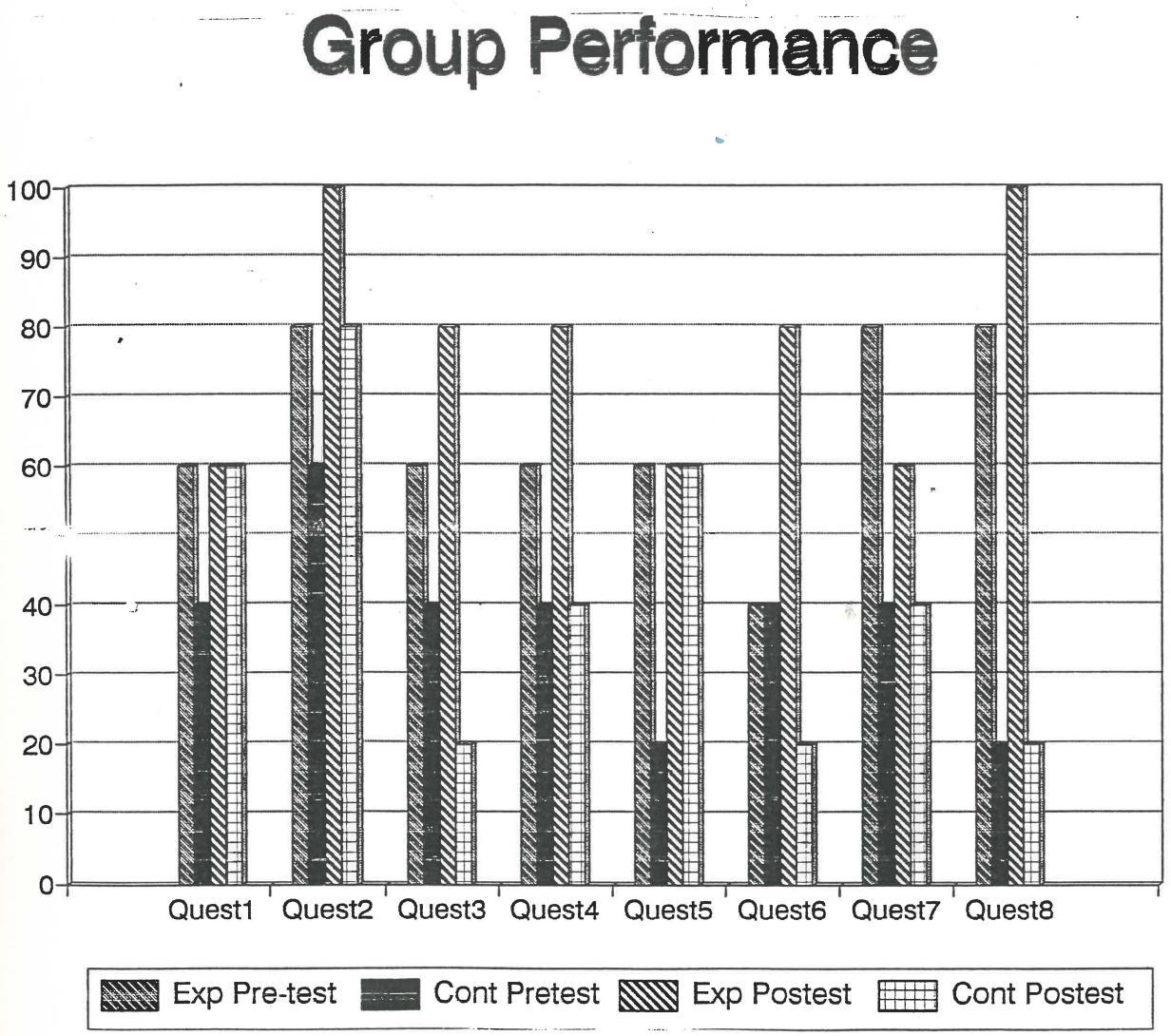


Figure 4.5.3 Illustrates the Pre-test and Post-test group perfomance of both the experimental and the control group to each question.

CHAPTER FIVE

5. DISCUSSION AND RECOMMENDATIONS

In this study the sample were all males and were relatively young adults.Sixty percent of the sample were between the ages 20-29.This is due to the fact that the study was conducted in a male prison.The age structure appears roughly to be representative of the prison population as well.This is representative of the prison population as mentioned in chapter 3.

The selection of participants for this study was difficult as some participants expected rewards for participating.This was further complicated by the access to the hospital unit as some of the outpatients needed escorts to enter the hospital unit.Due to the shortage of staff and lack of co-operation from some of the staff members,expecting the participants to visit the hospital unit three times a week proved to be difficult.

Sixty percent of the sample were single and forty percent were married.Sixty percent of the sample had 0-4 years of schooling and forty percent had 5-9 years of schooling.This suggests that a significant portion of the sample were single and were functionally illiterate.The low education level of the sample had implications for the programme as visual aids were required to facilitate their understanding.

Sixty percent of the sample were diagnosed as having mental illness 5-9 years ago.Fifty percent of the sample suffered from depression.In the control group alone,this constituted sixty percent,while schizophrenia constituted thirty percent of the total sample.

There was an equal number of participants with depression and participants with schizophrenia in the experimental group. Twenty percent suffered from manic depression in the experimental group and in the control group twenty percent suffered from antisocial personality disorders.

This could suggest that the majority of the psychiatric patients in the prison suffer from depression and that they came to prison with diagnosed psychiatric conditions already, as the longest period served by the sample so far was 4 years.

SYMPTOM REDUCTION

In table 4.4.1 the pre-test nonpathological rating scores (between 2-3) of the experimental group and the control group were 24 and 34 percent respectively.The control group had higher non-pathological symptoms.The pathological symptom rating scores

group had more participants with the pathological symptoms than the control group before they were exposed to the psychiatric rehabilitation programme.The experimental group improved by 18 percent after the programme was implemented (post-test).

The improvement or reduction in pathological symptoms particularly the scores between 4-7 in the experimental group could be attributed to the intervention.The psychiatric rehabilitation programme focused on knowledge about mental illness and the development of skills to enable the participants to cope with their illnesses,to deal with stress and problems which could lead to an increase in psychiatric symptoms.The positive results could also be attributed to the increase in social support given by the researcher to the participants and the support they experienced by being together.This positive finding meets the second and the third objective of this study.

The findings i.e the reduction in symptoms is supported by Uys (1991) who suggests that psycho-education is an effective intervention strategy in the reduction of psychiatric symptoms and improving disability such as coping skills, social skills and vocational skills.

Lukoff,Liberman and Nuechterlein (1986) also suggest that increased support and surveillance improve the client's symptoms and assist the client in returning to the previous level of functioning and also prevent relapse.

With the control group there was a 4 percent decrease in pathology scores between 2-3 and there was a 2 percent increase in the pathology ratings between 4-7.The improvement in the control group could be attributed to the attention and the increased support given and experienced by the participants.The improvement could also be attributed to the "Hawthorne effect" which describes positive findings where there was no intervention as a response to the researcher's attention, to being observed or to being part of a study (Seaman,1987).

The 2 percent increase in the 4-7 pathological symptoms although is not significant could have been an indication of a relapse of one or more participants.This is supported by Falloon et al (1984) in Lukoff,Liberman and Nuechterlein (1986) who suggests that an increase in the pathological symptoms could lead to a relapse.

The experimental group as illustrated in Table 4.4.2 had higher pathological symptoms than the control group prior implementation of the programme.While the literature suggests that persons with scores between 4-7 should not be included in intervention programmes as it could increase the chances of relapse,this did not happen.

After the implementation of the programme,the symptoms of each participant decreased dramatically although their average is

still 3 percent higher than that of the control group.There were no changes in the medication prescriptions of the participants and none of the participants were admitted in the psychiatric ward during the study.

The Wilcoxon Signed Ranks Test was statistically significant when the pre and the post-test results of the experimental and the control group were compared.These significant results supports the hypothesis of this study.

The positive finding could be attributed to psycho-education where the psychiatrically disabled have been helped to make the best use of their residual abilities in order to function at an optimum level.In this study the participants in the experimental group utilized the knowledge and skills imparted to them in the psycho-education programme to their advantage.
The positive finding also meet the third objective of the study.

This view is supported by Anthony (1990) where he suggested that psychiatric rehabilitation is guided by the philosophy which state that disabled persons need skills and environmental support to fulfill the role demands of their living, learning and social environments.

The articulation of the rehabilitation approach in the development of the programme and in its implementation could have contributed to the positive findings as well.
This is supported by Farkas and Anthony (1989) who state that the psychiatric rehabilitation approach assisted them to specify what is needed to implement programmes that will effectively impact on rehabilitation outcomes for the psychiatric population.

Research done by Hall,Baker and Hutchinson (1977) on behavioral programmes demonstrated that the improvements in the patients' functioning were a result of social rewards in the form of praise and pleasant interaction with the staff.This could have been the case in this study as both psycho-education and skills teaching involved a lot of praise, support and pleasant interaction.In a prison setting support and praise are absolutely minimal if at all present.

Litwin and Auslander (1990) suggests that social support is a critical type of intervention which has a direct effect on mental health.The improvement of symptoms in the group after the implementation of the programme could have been the result of the support received by the group.

Social support is a critical type of intervention which has a direct effect on mental health.The improvement of symptoms in the experimental group after the programme was implemented could have been a result of the support received by the group.This is supported by Litwin and Auslander(1990).

KNOWLEDGE ABOUT MENTAL ILLNESS QUESTIONNAIRE RESULTS

The t-test was done after the programme was implemented and the results were statistically significant ($t=0,03$ $p < 0,05$) i.e the experimental group versus the control group.

The scores on Table 4.5 are illustrated graphically on figures 4.5.1 and 4.5.2

Figures 4.5.1 and 4.5.2 indicate individual Pre-test and Post-test results of the experimental and the control group respectively.There is marked improvement in the Post-test results of the experimental group when compared to the Pre-test results.

Participant number 4's Post-test results decreased by 12 percent,while participant number 5's results remained the same for both the Pre and Post-test.These findings could not be accounted for.

In the control group there is also some increase in Post-test results and this could be attributed to the "Hawthorne Effect" Participant number 4's results were reduced by 12 percent Post-test, while participant number 5 had the lowest results which remained the same Pre and Post test.This could be attributed to the fact that his pathological symptoms had in creased as well and probably the patient was on the verge of a relapse.This statement is supported by Falloon (1984) in Lukoff,Liberman and Nuechterlein (1986) where he suggests that an increase in pathological symptoms indicate a possibility for a relapse

KNOWLEDGE ABOUT MENTAL ILNESS QUESTIONNAIRE PRE-TEST AND POST-TEST GROUP PERFORMANCE RESULTS.

Figure 4.5.3 indicate the Pre and Post test group performance results to the individual questions of the KAMI questionnaire.

There is a 60 percent improvement which is evident in the post-test group performance results of the experimental group.A 24 percent reduction in response to question 2 is also evident.The reduction could be attributed to the acknowledged feeling experienced by the participants after smoking dagga which was expressed during psycho-education.This could mean that more attention needs to be given to dagga and substance abuse programmes.In the control group the response to the question was the same Pre and Post test.

The control group's response to question 8 in the pre-test was very poor and remained the same in the Post-test.This could suggest that the group did not see or understand the importance of medication when treating psychiatric conditions. This area would however require further investigations as a possibility for informing future psycho-education programmes.

LIMITATIONS

The study was contextualized to East London Medium A Prison and the sample had only 10 participants therefore the findings could not be generalized.

The sample consisted of 9 Xhosa speaking males and 1 English speaking Coloured who were the only participants available in the initial stages of the research.

The study results could have been affected by the amount of distractions during the programme for an example, knocking and opening of the steel doors and the washing of dishes in the hospital kitchen.

Limited physical resources such as sharing of the doctors consulting room on cold days resulted in delays and postponement of the control group's session which resulted in the sessions not being held on the same day or at the same time.

The shortage of staff which resulted in a go slow during the study and the attitudes of some of the staff members who labelled the participants as being too assertive since they started participating in the study, resulted in some arguments between the staff and the patients and sometimes resulted in delays before the programme could resume.

Reliability and validity of the instruments had been tested as the BPRS has been used effectively in several studies before in other countries.

The KAMI questionnaire although has been adapted and adjusted from a reliable and valid instrument,its reliability needs to be tested in the South African context.

Despite the limitations of the study,it could be argued that the results of the investigation were quite useful and encouraging to rehabilitation workers in the correctional services.

RECOMMENDATIONS

Psycho-education needs to be conducted as an ongoing programme and periodic monitoring of the symptoms is essential to be able to see the exact difference in the symptom ratings and the meanings thereof.

Although the results of this study were significant,the study had a limited sample and time frame to test its effectiveness.A more permanent programme needs to be developed for the Correctional Services.

Psychiatric rehabilitation programmes and criminal rehabilitation programmes need to be intertwined as they could address a lot of common problems and manage them holistically.

Inservice training needs to be embarked on as education of the staff members is needed prior to conducting any studies or prior to implementation of programmes in a prison setting, to try and thaw their attitudes and to get their co-operation and support.

The prison setting lacks social support, environmental support and is not conducive to psychiatric rehabilitation, therefore the available resources and support systems to the prison population need to be encouraged and empowered to promote the above.

CONCLUSION

Although the reliability of the KAMI Questionnaire has not been tested in the South African context,in this study the instrument has been found to be useful. The knowledge about mental illness in the experimental group did improve after the programme was implemented and the results were statistically significant. In the control group there was some improvement which was attributed to the "Hawthorne Effect"but was not statistically significant. Although 60 percent of the sample had only 0-4 years of education, they were able to answer the questions and this therefore suggests that the instrument is easy to understand and is cost effective, as it does as not require to be administered by a skilled professional.

This study has attempted to meet all its objectives which are:- to develop and implement a psychiatric rehabilitation programme, to increase the knowledge of the mentally ill persons,to develop skills that would help them to cope with their psychiatric symptoms and to evaluate the effectiveness of the programme by looking at increased knowledge,symptom reduction and the relapse rate. The statistically significant results of the t-test and the Wilcoxon Signed Ranks Test also supports the hypothesis of this study.

While the findings of the BPRS were positive, the study indicated that it needs to be administered periodically to be able to see the exact difference in the symptom ratings.

Social support has been found to have played a significant role with regards to the positive findings of this study, and this has been supported by various authors mentioned in the literature of this study.

Inservice training has been identified as a needed programme for the staff members of the Correctional Services Department. Empowerment of the rehabilitation professionals has also been suggested to promote positive change.

Implementation of the psychiatric rehabilitation programme that is intertwined with the criminal rehabilitation programme has also been suggested.

BIBLIOGRAPHY :

Anthony, W. (1990). Psychiatric rehabilitation : Psycho-educational programmes. Boston : Boston University

Anthony, W. A. (1977). Psychological rehabilitatioin : A concept in need of a method. American Psychologist, 32, 658 - 662.

Anthony, W. A, Cohen, M. R. and Cohen, B. F. (1984). Psychiatric rehabilitation. Orlando :Grune and Stratton.

Anthony, W.A., Cohen, M. and Cohen, B (1983). The Philosophy, Treatment and Principles of the Psychiatric rehabilitation Approach. New Direction in mental health. University Park Press.

Anthony, W. A. and Farkas, M. D. (1982). A client outcome planning needed for assessing Psychiatric rehabilitation interventions. Schizophrenia Bulletin, 8, 13 - 36.

Anthony, W. A. and Liberman, R. P.. (1986). The Practice of Psychiatric rehabilitation. Historical conceptual and research bas. Schizophrenia Bulletin, 12, 542 - 554.

Anthony, W. A. and Margules, A. (1974). Toward Improving the Efficiency of Psychiatric Rehabilitation : A Skills Training Approach. Rehabilitation Psychology, 21, 101 - 105.

Anthony, W and Nemec, P. B (1984). Psychiatric Rehabilitation Department of Rehabilitation counselling. Boston : Boston University , in Berkowitz, L (ed.).

Ascher - Svanum, H. and Krause, A. K (1991). Psycho-education Groups for Patients with schizophrenia : A guide for Practitioners,Guithersburg : Aspen Publishers.

Bachrach, L A. (1986). Deinstitutionalization. Hospital and community psychiatry, 37, 18 - 21.

Baker, R. and Hall, J. N. (1983). Rehabilitation Evaluation of Hall and Baker (rehab).Scotland : Vine publishing Ltd.

Basford, P. (1987). How to Use Roleplay. Journal of Psychosocial Nursing, 28 (6), 21 - 22.

Bellack, A. S. (1984). Schizophrenia, Treatment, Management and Rehabalitation. Sandiego, New York : Grune and Stratton Incorporation.

Bellack, A. S. Hersen, M., Kazalin, A. E. (1982). International Handbook of Bahaviour Modification and Therapy. New York : Plenum Press.

Bellack, A. S. Mueser K. T. Wade, J., Sayers, S. & Morrison, R. C. (1992). British Journal of psychiatry, 160, 473 -480.

Bellack, A. S. and Hersen, M. (1979). Research and Practice in Social Skills Training, New York : Plenum Press.

Bennet, D. H., (1983). The Historical Development of Rehabilitation Services : In theory and practice of psychiatric rehabilitation. Chichesters : John Wiley and Sons.

Bond, M G. (1988), Assertive Training Techniques. Journal of Psychosocial nursing, 39, (5) 10 - 15.

Bolton, Cohen, M. Farkas, M. & Cohen, B (1986). Functional assessment. Boston : Boston University.

Bolton, B. (1987). Handbook of measurement and evaluation in rehabilitation. London : Brooks Publishing Company.

Coursey, R. D. (1977). Program Evaluation for Mental health. Methods, Strategies, Participants. New York : Grune and Stratton Inc.

Curran, J. P. (1979). Social skills : Methodological issues and future directions. In A. S. Bellack and M. Hersen (eds), Research and Practice in Social Skills Training, New York.

Curran, P. and Monti, P. M. (1982). Social skills training : A practical handbook for assessment and treatment. New York : The Guilfond Press.

Dougan, B. Dembo, R., Lenanan, K., Makapela, R., Gama, J. and Moutinho, D. (1986). Life Skills for Self Development. Johannesburg, South Africa : National Council for Mental Health Printers.

Ekdawi, M. Y. and Conning, A. M (1994). Psychiatric Rehabilitation : A practical guide. London : Clapman and Hall, Inc.

Farkas, M. D. and Anthony, W. A. (1981). Rehabilitation : A Response to the Shortcomings of Deinstitutionalization. Boston : Boston University, Center for Psychiatric rehabilitation.

Farkas, M. D. and Anthony W. A. (1989). Psychiatric Rehabilitation Programs. London, Beltimore : The John Hopkins University Press.

Goldman, H. H., Gahozzi, A. & Tamba, C. A. (1981). Defining and Counting the Chronically Mentally ill. Hospital and community Psychiatry, 32, 27 - 27.

Goldsmith, J. B. and Mcfall, R. M. (1975). Interpersonal skill training for psychiatric patients. Journal of assessment Psychology, 84 (1), 51 - 58.

Goldsmith, J. B. and Mcfall, R. M. (1975). Development and evaluation of a interpersonal skills training programme for psychaitric inpatients. Abnormal psychology, 84, 51 58.

Goldstein A. P. (1981). Psychological skill training : The strucured learning technique. New York : Pergadion Press.

Granger, C. V. and Gresham, G. E. (1984). Functional Assessement in rehabilitation medicine. Baltimore, London.

Goldstein, A. P., Carp E.P. Davidson, W. S. & Wehr, P. (1981). In Response to Aggression. New York : Pergamon Press Inc. Hoffman (1993) The round table in a community based out-patient. Bellack - Acta Psychiatric Scandanavia, 87, 153 - 159.

Hagarty, G.E. , Anderson, C.M. Reiss,D.J. ,Kornblith,S.J. Greenwald,D.P.,Javna,C D.&Madonna,M.J.(1986). Family Psycho-education,Social Skills Training and Maintanance Chemotherapy In The After Care Treatment of Schizophrenia. Archives of General Psychiatry. 43, 633 -640.

Hume,C. and Pullen,I. (1986). Rehabilitation in Psychiatry.New York :Churchil Livingstone.

Jack,L.W. (1987). Use of Play in Psychiatric Rehabilitation.Journal of psychosocial nursing. 26, 7 21 - 22.

Kaplan, I.H. and Saddock,B.J. (1988). Synopsis of Psychiatry,Behavioral Sciences. Clinical Psychiatry.Baltimore :Williams and Williams.

Lark, S. (1989). Teaching Health education. Nursing times. vol. 85, No. 50, pp. 43 - 44.

Liberman, R. P. De Risi, W.J. & Mueser, K. T. (1989). Social skills training for psychiatric patients. New York : Pergamon Press.

Liberman, R. P., Lillie, F. J., Falloon, I. R. H., Harpin, E. J., Hitchinson, W. and Stoyte, B. A. (1984). Social skills training for relapsing schizophrenia : An experimental analysis. Behaviour modification, 8. 155 - 179.

Litwin, H. and Auslander, G. K. (1982). Evaluating informed support. Journal of Psychiatric nursing and mental health services, 20, 42 - 57.

Lukoff, D., Liberman, R. P. and Nuechterlein (1986). Symptom monitoring in the rehabilitation of schizophrenic patients, 12, (4) 578 - 591.

Mercier, C. and Ring, S. (1994). A latent variable causal. Model of the quality of life and community tenure of psychiatric patients. Psychiatric scandanavia, 89, 52 - 77.

Murphy M.F. and Moller, M.D.(1993). Relapse Management in Nuerobiological Disorders : The Moller -Murphy symptom Management Assessment. Archives of psychitric nursing, 7,(4), 226 -235.

Ngubane, G. and Uys, L.R. (1994). The social network support for Black Psychiatric inpatients. Curationis , 17 (2)

O'Connor, F. W. (1991) Symptom monitoring for relapse prevention in schizophrenia. Archives of psychiatric nursing, 5 (4) 197 - 201.

Offanse, D. D. (1985). Therapeutic support during inpatient groups. Journal of psychosocial nursing, 4, 12 -18.

Pilling, S. (1991). Rehabilitation and community care. New York, Routledge.

Quinn, P. and Richman, A. (1980). The contribution of a structured rehabilitation approach. Rehabilitation Counselling Bulletin, 24, 118 - 129.

Seaman, C. (1987). Research Methods, Principles, Practice and Theory for Nursing. California : Appleton and Lange.

Spaulding, W. Storms, L. Goodrich, V. & Sullivan, M. (1986). Applications of experimental psychopathology to psychiatric rehabilitation. Schizophrenia bulletin, 12, 560 - 577.

Sokolove, R. L. and Trimble, D. (1986). Assessing support and stress in the network of chronic patients. Hospital and community psychiatry, 37, 370 - 372.

Salokongas, R. K. R., Palo - Oja, T., Ojanen, M. & Jalo, K. (1991). Need for community care Planning. Psychotic out-patients. Acta Psychiatric Scandanavia, 84 ,191 -196.

Treece, W. and Treece, J. 1982). Elements of Research in Nursing.London :C. V. Mosby.

Trower, P. (1980). Situational analysis of the components and processes of behaviour of sociology skilled and unskilled patients. Journal of counselling in Clinical Psychology, 48, (3), 327 - 339.

Uys, L.R. (1991). A Theoretical Framework for Psychiatric Rehabilitation. Curationis, 14, (3), 3-5.

Uys, L.R. (1994). Psychosocial Rehabilitation. Unpublished Lecture Notes.

Wallace, C. J. and Liberman, R. P. (1985). Social skills training for patients with schizophrenia. A controlled clinical trial. (Psychiatry Research), 15, 239 - 247).

Warner, R. and Huxley, P. (1993). Psychopathology and Quality of life among mentally ill patients in the community. British Journal of Psychiatry, 163, 505 - 509.

Wing,J.K. (1978). Clinical Concepts of Schizophrenia,in Schizophrenia : Towards a New Synthesis. London :Academic Press.

APPENDIX :

Programme implementation time table

2/ 10	administration of instruments prior the implementation of the programme.
4 /10	administration of instruments continued
6 /10	psycho-education group
9 /10	psycho-education group
11/10	psycho-education group
13/10	individual therapy
16/10	skills training (communication skills)
18/10	stress management skills
20/10	skills training (assertive behaviour)
23/10	skills training (problem solving)
25/10	stress management
27/10	summary of psycho-education
30/10	summary of all activities
31/10	administration of instruments on completion of the programme (BPRS)
1 /11	administration of the instruments continued (Knowledge about mental illness questionnaire).

APPENDIX

ASSESSMENT FORM

KNOWLEDGE ABOUT MENTAL ILLNESS QUESTIONNAIRE

INSTRUCTIONS: Please read the questions below and choose the correct answer from the alternatives given.

E.G. Which of the following are parts of the body?

A. Picture

B. Arm

C. Keys

D. Newspaper

Answer: (b) Arm

1. A person suffering from mental illness may present with:-

   a) Inability to perform things he or she used to do easily before Social withdrawal, e.g. avoiding meeting friends and other people.
   b) Social withdrawal, e.g. avoiding meeting friends and other people.
   c) Thought disorder, e.g. cannot think clearly or straight anymore.
   d) Hearing or seeing things no one else can see or hear.
   e) All of the above

2. How can a person with schizophrenia which is a complex mental illness be helped?

   a) Can be cured rapidly by hypnosis
   b) By taking the correct medicine for the illness
   c) Will get better eventually without help
   d) None of the above

3. Depression is a mental disorder where an individual experiences the following:

a) Feeling sad most of the time
b) Being tearful most days
c) Feeling hopeless and useless
d) Cannot eat or sleep and feels tired most of the time
e) All of the above

4. What are the early warning signs of mental illness?

a) Start hearing voices that nobody else can hear
b) Being unable to sleep
c) Feels irritable and fighting with people around you
d) All of the above
e) None of the above

5. What should a person do when he or she starts experiencing the early warning signs of mental illness?

a) Stay at home and wait until she or he gets ill, then go to a clinic or hospital
b) Speak to a friend or family member about the symptoms
c) A and B
d) Go to the clinic or hospital and explain what you are experiencing
e) B and D

6. Support systems are a person's resources such as:-

a) Friends and family
b) Services in your community such as clinics, shops, libraries etc.
c) Professionals available in a prison e.g. nurses, social workers, minister, psychologist an teachers.
d) All of the above
e) None of the above

7. Drugs and alcohol can do the following to an individual

a) Make your symptoms worse, e.g. hear voices speaking more often or see things that are not there more often.

b) Cause problems with work, family and the law

c) Make you feel good and happy

d) A and B

e) A and C

8. Medication is important to people who are mentally ill because:

a) Medication reduces or eliminates symptoms of mental illness

b) Relapses when taking medication are less severe

c) If you stop your medicines, you increase your chances of relapsing

d) All of the above

e) None of the above

IFOMU YEMIBUZWANA EKHANGELA ULWAZI LWAKHO NGESIFO SOKUGULA NGEGQONDO.

Imigaqo : Funda lemibuzwana ilandelayo wandule ukukhetha impendulo elungileyo phakathi kwezi zilandelayo.

Umzekelo :Liliphi ilungu lomzimba kwezimpendulo zilandelayo ?

A Umfanekiso
B Ingalo
C Izitshixo
D Iphepha lokufunda

Impendulo elungileyo (b) Ingalo

1.Umntu onokuphazamiseka ebuchotsheni ubonakala ngo :-

(a) Ngokungakwazi ukwenza izinto abeqhele ukuzenza
(b) Ngokuzikhetha kwabanye abantu kwakunye nezihlobo zakhe
(c) Ngokuphazamiseka engqondweni umzekelo : angakwazi ukucinga into ecacileyo kwakhona
(d) Ngokuva nokubona izinto ezingabonwayo ngabanye abantu
(e) Zinyanisile zonke iimpendulo ezingasentla

2. Isikizofreniya sesinye sezifo ezimbaxa zokugula ngengqondo,kwaye umntu onaso angancedwa yenye yezi zinto zilandelayo :

(a) Angaphila ngokwenziwa athethe engekho zingcingeni zizezakhe ngumntu osebenza ngezifo zengqondo (ukuhipunothayizwa)
(b) Angaphila ngokusela amayeza esigulo sakhe
(c) Angasuka aziphilele ngaphandle koncedo
(d) Ayikho impendulo enyanisileyo kwezi zingentla

3. Idipreshini sisifo sokuphazamiseko engqondweni apho umntu ava enye okanye ezinye zezizinto zilandelayo :

(a) Uziva elusizi amathuba okanye amaxesha amaninzi
(b) Uziva efuna ukukhala amathuba amaninzi
(c) Uziva engathi akaloncedo mntwini ,angabi nalo nethemba
(d) Akatyi, akalali kwaye usoloko ediniwe amaxesha amaninzi
(e) Ayikho impendulo enyanisileyo kwezi zingentla

4.Ziziphi iimpawu abonwa ngazo umntu oqalwa kukugula nge ngqondo ?

(a) Uqala ngokuva amazwi athethayo angaviwayo ngabanye abantu
(b) Kuba nzima ukulala ebusuku
(c) Uye abenolaka alwe , okanye axabane nomntu wonke okufuphi kuye
(d) Zinyanisile zonke iimpendulo ezingentla

5.Kufanele ukuba enze ntoni umntu xa esiva iimpawu zokugula ngengqondo ?

(a) Kufanele ukuba ahlale endlini alinde ukuba agule, aze andule ke ukuya ekliniki emva koko
(b) Kufanele ukuba axelele isihlobo okanye umntu wakowabo ngempawu ezo azivayo
(c) Impendulo eku (a) kunye neku (b) zinyanisile
(d) Kufanele ukuba ahambe aye ekliniki okanye esibhedlele afike achaze yonke into ayivayo
(e) Impendulo eku (b) neku (d)

6 Ziziphi izinto ezixhasa umntu neziluncedo kwezi zilandelayo?
(a) Izihlobo okanye abantu bakowenu
(b) Iindawo ezikwalapha ekuhlaleni ezifana neekliniki, iivenkile,iilayibrali (apho kubolekwa iincwadi zokufunda)
(c) Iingcaphephe ezifanoogqirha, amanesi, onontlalontle, ootitshala, abafundisi nabanye ebaluncedo abafumaneka etolongweni
(d) Zinyanisile zonke iimpendulo ezingentla
(e) Ayikho impendulo enyanisileyo

7. Izidakamiswa kunye notywala zenza ezizinto zilandelayo emntwini :-
(a) Zandisa impawu zokugula umzekelo : - uve izinto ezithethayo okanye ubone izinto ezingabonwa mntu amaxesha amaninzi
(b) Zenza ukuba ube nengxaki emsebenzini, ekhayeni kwakunye nabantu bomthetho
(c) Zikwenza uzive udlamkile kwaye wonwabile
(d) Impendulo (a) no (b) zinyanisile
(e) Impendulo (a) no (c) zinyanisile

8. Ukusela amayeza kubalulekile ebantwini abagula nge ngqondo kuba :-
(a) Amayeza anciphisa okanye anqanda impawu zokugula ngengqondo
(b) Ukumana ugula xa usela amayeza akuzi ngamandla
(c) Xa uwayeka amayeza wandisa amathuba okumana ugula
(d) Zinyanisile zonke iimpendulo ezingentla
(e) Ayikho impendulo enyanisileyo kwezi zingetla

BRIEF PSYCHIATRIC RATING SCALE

PATIENT'S NUMBER :

SECTION / UNIT :

DATE : **INTERVIEWER :**

DIRECTIONS :Allocate an appropriate number to indicate the level of pathology next to each symptom.Numbers from 1-3 indicate nonpathological symptoms while numbers 4-7 indicate pathological symptoms.

1 = **Not Present**,2 = **Very Mild**, 3 = **Mild** ,4 = **Moderate**
5 = **Mod.Severe**, 6 =**Severe**, 7 = **Extremely Severe**.

1. SOMATIC CONCERN - preoccupation with physical health,fear of physical illness,hypochondriasis.

2. ANXIETY- worry,fear, over-concern for present or future uneasiness.

3.EMOTIONAL WITHDRAWAL -lack of spontaneous interaction, isolation in relating to others.

4.CONCEPTUAL DISORGANIZATION -thought processes confused,disconnected, disorganised,disrupted.

5.GUILT FEELINGS -self-blame,shame,remorse for past behaviour.

6.TENSION -physical and motor manifestations of nervousness,over-activation.

7.MANNERISMS AND POSTURING -perculiar,bizzare unnatural motor behavior (not including tic).

8.GRANDIOSITY -exaggerated self opinion,arrogance,conviction of unusual power or abilities.

9.DEPRESSIVE MOOD -sorrow,sadness,despondency,pessimism.

10.HOSTILITY -animosity,contempt,belligence,disdain for others.

11.SUSPICIOUSNESS -mistrust,believe others harbour malicious or discriminatory intent.

12.HALLUCINATORY BEHAVIOUR - perceptions without normal external stimulus correspondence.

13.MOTOR RETARDATION -slowed weakened movements or speech,reduced body tone.

14.UNCOOPERATIVENESS -resistance,guardedness,rejection of authority.

15.UNUSUAL THOUGHT CONTENT -unusual,odd,strange,bizzare thought content.

16.BLUNTED AFFECT -reduced emotional tone,reduction in formal intensity of feelings,flatness.

17.EXCITEMENT -heightened emotional tone,agitation,increased reactivity.

18.DISORIENTATION -confusion or lack of proper association for person,place or time.