DEINSTITUTIONALISATION OF SCHIZOPHRENIC PATIENTS FROM TOWER HOSPITAL: An evaluation of the impact thereof on community psychiatric services.

BY

SIPOKAZI JEMSANA

Submitted in fulfillment of the requirements for the degree of

MASTER OF SOCIAL SCIENCES

in the subject

PSYCHOLOGY

in the faculty of

MANAGEMENT, DEVELOPMENT AND COMMERCE

UNIVERSITY OF FORT HARE

SUPERVISOR: PROF. H. M. VERHAGE

APRIL 2004

DECLARATION

I, Sipokazi Jemsana, hereby declare that the work contained in this dissertation is entirely my own work with the exception of such quotations or references that have been attributed to their authors or sources by means of complete references. It has never been submitted by anyone else at any university for a degree.

SIPOKAZI JEMSANA

DEDICATION

I dedicate my work to all those who have been my pillars of support throughout my life and during my recent years of study, especially my mother and my two daughters for their unfailing support and encouragement.

ACKNOWLEDGEMENTS

I extend my sincere appreciation and gratitude to all the people who gave me their support and assistance in many ways while I was working on my research.

My special thanks to my supervisor Professor H M Verhage for his guidance and encouragement throughout and until the completion of this study.

I wish to acknowledge with appreciation the contributions from the following:

1. Mr C Chipunza who has been very supportive and sacrificed his time to assist whenever called upon
2. The Medical Superintendent of Tower Hospital and staff especially those who worked at the clinics where the data was collected. They all made it possible for me to conduct this study
3. My colleagues for their support and understanding
4. Mrs Formson for assisting with the editing of the final document

Finally, I wish to thank the almighty God for giving me the strength to see this project to the end.

ABSTRACT

Worldwide deficiencies in the institutionalised care of psychiatric patients gave rise to the latest trend, deinstitutionalisation, both internationally and in South Africa. In most countries this movement was done with little or no proper planning for continued care in the community. The result was failure to support and sustain these patients in the community. This led to homelessness an increase in crime and constant re-admissions, the revolving door phenomenon.

This study examined the impact deinstitutionalisation of patients from Tower Hospital had on community psychiatric services. Focus was on what community services were available to these patients after discharge and whether these were utilized. The clinics used were those servicing these patients after discharge. Availability sampling was used. Twelve nurses formed the sample and were given questionnaires to fill in and records were also perused.

The results, broadly, showed that the community psychiatric and support services were inadequate for proper rehabilitation of chronic psychiatric patients in the community.

TABLE OF CONTENTS

LIST OF TABLES

APPENDIX

Appendix A: Questionnaire

CHAPTER ONE: BACKGROUND OF THE STUDY

1.1 Introduction

This chapter presents the background of the research problem, the statement of the research problem, the objectives of the study, the delimitation of the study and the rationale of the study. Key concepts are also defined here.

1.2 Background information of the study

In South Africa, just as it was in other countries, the care of the mentally ill was in the hands of the family. History indicates that during the colonial era patients from wealthy families were taken care of at home, while those who were poor were sometimes placed with families who were reimbursed by the church. Dangerous patients and slaves were kept in prison where they were visited by deaconesses. When general hospitals were opened, some of these patients were admitted to hospital (Mzimela, 2001).

During the 19th century a number of institutions for the mentally ill were built throughout the world. A large number of patients were admitted to these institutions. It was felt that these patients were a danger to the public and so, incarceration was seen as the best option for their care, South Africa, was no different. According to Mzimela (2001) the Robben Island prison was turned into an institution for mentally ill patients, lepers and the chronically ill in 1846.

Later on psychiatric institutions were established throughout the country and legislation for the management of psychiatric patients was passed. However, as time went by it became evident throughout the world that institutionalisation was

not working as was anticipated. A number of problems arose as a result of institutionalisation, which led to the idea of deinstitutionalising patients who had eventually become "permanent residents" of these institutions.

Listed below are some of the problems and reasons for this move:

- An ever increasing number of mentally ill patients and the overcrowding of institutions leading to the poor delivery of custodial care (Weiten, 1995) Thus, institutions were failing to provide a therapeutic milieu
- Critics noted that prolonged institutionalisation reduced patients to a passive state in which many of them could no longer take responsibility for themselves
- Prohibitive institutional costs incurred by the government in caring for the ever increasing number of long-term in-patients
- The emergence of effective drug therapies
- The changing concept of mental illness
- Human rights for all advocates who wanted to give the mentally ill their rights and freedom.

On the whole, the deinstitutionalisation move has revolutionalised the care of the mentally ill, especially in European countries and North American states. But the major criticism has been poor planning and the haste with which patients were moved into the community. Patients who were not ready to function in the community were discharged into communities that were not ready to integrate them which, in many countries, resulted in failure to retain patients in the community. The process, however, has nowadays been improved and better planned (Mzimela, 2001). More attention is paid to preparing the patients, personnel and the community for the move. Community services are also provided to ensure retention of these patients in the community. It seems availability and accessibility of community psychiatric services is an important aspect of successful deinstitutionalisation.

According to Mzimela (2001) in countries where deinstitutionalisation has been implemented, a number of problems have been experienced in relation to staff, patients, care givers and the community. Staff members were anxious about redeployment to community services away from the comfort of the hospital environment. Patients have experienced problems such as homelessness, poor accessibility of medical services, poor social support, unemployment, crime, suicide and many more. For care givers and the community, among other things, family conflicts and isolation, lack of guidance on patients' illnesses and management and severe shortage of essential community services, were cited.

In a case study conducted in Mhala in Gazankulu, Freeman (1990) found that the following problems existed in the delivery of community psychiatric services:

- More people with psychiatric/psychological disorders existed than those being treated
- There was an over-reliance on purely medical solutions to all problems, hence there was no psychotherapy
- There was very little preventive and promotive mental health care available at clinics
- No emergency mental health care services were available at clinics
- At times the community psychiatric nurse was unable to provide monthly service, so patients were left without medication for that month
- Patients themselves who had to miss a monthly visit to the clinic due to unforeseen circumstances, were left with no supply of medication for that month
- There was a high rate of non-compliance to medication
- Relationships between most patients and the community psychiatric nurse was superficial
- Very few home visits were made

- There was no consultancy support from a psychiatrist or psychologist

Studies on the effectiveness of community-based care following deinstitutionalisation did not only yield negative results, there have been positive results as well. Many people have benefited by avoiding disruptive and unnecessary hospitalisation (Weiten, 1995).

1.3 Community psychiatric services at the Tower Hospital

Community services at the Tower Hospital consisted of one community psychiatric services unit, six satellite clinics and a number of mobile sites. These satellite clinics were the Primary Health Care (PHC) clinics in the district. The community psychiatric nurse from the Community Psychiatric Unit visited these clinics and mobile sites once a month to dispense medication, assess patient progress and to adjust treatment or refer patients when necessary to the doctor in hospital. Only one of these PHC clinics had a resident community psychiatric nurse. Nurses in the other five clinics were general nurses who basically attended to the patients' physical ailments. No psychiatric medication was kept in the PHC clinics where there were no psychiatric trained nurses. Psychiatric patients came in for medication once a month when the community psychiatric nurse was due to come.

Against this background, the present study sought to examine the impact of deinstitutionalisation of chronic psychiatric patients into the community on community health services. It also sought to establish whether these services have the necessary structures to support the process of deinstitutionalisation.

1.4. Statement of the problem

What are the effects of deinstitutionalisation of schizophrenic patients from Tower Hospital on the community health services?

1.4.1 Sub-problems

- Are the community services adequately supporting the deinstitutionalisation process?
- Do the attitudes of community health providers support the deinstitutionalisation process?
- Are the community health services accessible to and utilised by the patients and their families?
- What are the barriers to successful deinstitutionalisation?

1.5 Objectives of the study

The objectives of the study are:

- To identify available community resources and support services for the care of chronic psychiatric patients outside the hospital environment
- To determine accessibility of the services to the patients
- To determine whether the services are utilised by the patients
- To assess staff attitudes towards care for chronic psychiatric patients in the community
- To identify barriers to successful deinstitutionalisation.

1.6 Rationale of the study

Experience with the deinstitutionalisation process, both in South Africa and other countries, has shown that before patients can be moved out of institutions, supporting services in the community must be developed. While the clinical and financial benefits of community-based care are well documented in some countries, there were negative aspects of deinstitutionalisation (Viger, 2001). Patients often needed more support than the community could provide, resulting in patients not receiving treatment, becoming homeless or being re-hospitalised.

Thus, the mentally ill in the community needed a flexible range of services suitable for their needs (Viger, 2001).

This study sought to identify the community services presently supporting the discharged patients, identify shortfalls and recommend possible solutions, following deinstitutionalisation at Tower Hospital. It is hoped that this study will contribute to the development of appropriate and comprehensive community mental health services that would, as far as possible, ensure retention of patients in the community,

1.7 Definition of terms

Deinstitutionalisation: refers to "transferring the treatment of mental illness from inpatient institutions to community-based facilities that emphasise outpatient care" (Weiten, p627, 1995).

According to Dartnall, Lee, Modiba and Porteus (1999) deinstitutionalisation means the movement of patients from hospitals to less custodial environments and the development of more appropriate forms of care in the community.

Barham and Hayward (1995, p1) define deinstitutionalisation as "the inclusion into social life of a category of people who, for a century or more, have been exiled in the Victorian asylums"

Schizophrenia: in this context, denotes a patient diagnosis of schizophrenia given by health service personnel. It refers to "a class of disorders marked by disturbances in thought that spill over to affect perceptual, social and emotional processes" (Weiten, p582, 1995).

Chronic psychiatric patients: in this context the term refers to patients with the diagnosis of schizophrenia because of the nature and prognosis of the disorder.

1.8 Delimitation of the scope of the study

This study focused on one psychiatric institution in the Eastern Cape, that is, the Tower Hospital and its community services.

1.9 Outline of the rest of the study

Chapter Two deals with the review of literature intended to provide the theoretical background for the study. The areas covered in this chapter include the background on metal illness and the changes in perception and treatment over the years, deinstitutionalisation of patients and the move towards community psychiatric care. This is followed by the presentation of the methods and procedures used for collection of data in Chapter Three. In Chapter Four the results of the study are presented. Conclusions, recommendations and limitations of the study are presented in Chapter Five.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Before mental institutions were established, care of the mentally ill was in the hands of their own family members in the community. Disruption of family life, ill-treatment of these patients at home and in the community, violence and crime led to changes in the care of these patients, hence the establishment of mental institutions. These institutions continued to play an important role in the care of the mentally ill until the mid-nineteen fifties. Experts realised then that indefinite institutionalisation of patients often compounded the problem of mental illness rather than cured it. Then deinstitutionalisation became an option. The objective of modern treatment of persons with a major mental illness is to enable them to maintain themselves in the community and to save them from the debilitating effects of institutionalisation as much as possible (Mzimela, 2001).

2.2 Background on mental illness

2.2.1 Nature and treatment of mental illness

The nature and treatment of the mentally ill have changed over the centuries. The commonly held beliefs regarding the mentally ill have changed from being "possessed by demons" to a form of social deviancy which causes the victim to be different, weak, or dangerous but not responsible for his condition and thus in need of care (Vlok, 1984).

During the Middle Ages the mentally ill were regarded as sinful people possessed by demons. Treatment thus was geared towards driving out demons. Mentally ill patients served as scapegoats in the practice of witchcraft. Until the end of the eighteenth century the mentally ill were treated as social outcasts, objects of contempt or morbid curiosity. Those who were dangerous were

incarcerated with other unwanted people such as criminals. They were treated with unbelievable cruelty such as taunting and chaining (Vlok, 1984).

With the advent of the French and American Revolutions came the era of rationalism and humanism. Mentally ill patients began to be viewed as sick people who needed compassionate hospital care. Pinel (1745-1826) instituted far-reaching reforms in Paris. He removed the shackles and chains from patients and kindness was extended to the patients. He suggested that the mentally ill needed treatment not punishment. Thus, places of refuge for the mentally ill came into existence. However, with institutionalisation, that is, commitment of patients into mental institutions, came the isolation and maltreatment of mental patients (Vlok, 1984).

Until the middle of the twentieth century, mental hospitals were custodial in nature. At times, patients were abused and dehumanised. During this period abuses were exposed by, inter alia, Dix (1802-1887), an American teacher and Beers (Vlok, 1984).

Dix was forced into early retirement as a result of ill-health. In 1941 she began to teach in a women's prison. Through this contact she became acquainted with the deplorable conditions in jails, almhouses, and asylums. As a result of her findings, Dix engaged in a zealous campaign that aroused people and legislatures to do something about the inhuman treatment accorded the mentally ill. Through her efforts, the Mental Hygiene Movement grew in America. Suitable hospitals were also built. She is credited with establishing 32 mental hospitals (Carson & Butcher, 1992).

Furthermore, Beers, who was a patient in an American hospital, wrote a book about his experiences, *A mind that found itself* , in 1907. The book called public attention to the poor conditions experienced by hospitalised patients. This gave impetus to the Mental Hygiene Movement in the United States of America and led to the establishment of the National Association for Mental Health. This

association worked for hospital reform and introduced preventive programmes through public education (Vlok, 1984).

Additionally, in England, it was Tuke (1732-1822), who helped change the conditions for the mentally ill. He established the York Retreat, a pleasant country home where mental patients lived, worked and rested in a kindly religious atmosphere (Carson & Butcher, 1992).

The success of Pinel and Tuke's humanitarian experiments revolutionalised the treatment of mental patients throughout the Western world. In America this revolution was reflected in the work of Rush(1745-1813), the founder of American Psychiatry. Rush encouraged more humane treatment of the mentally ill. He wrote the first systematic treatise on Psychiatry in America *Medical inquiries and observations upon the diseases of the mind* (1812). He was also the first American to organise a course in Psychiatry (Carson & Butcher, 1992).

Thus, the nineteenth and early twentieth centuries witnessed a number of scientific and humanitarian advances. The work of Pinel, in France, Tuke, in England, and Rush and Dix in America prepared the way for several important developments in contemporary abnormal psychology. Among these developments were the gradual acceptance of mental patients as afflicted individuals who needed and deserved professional attention and the growth of scientific research into biological, psychological, and socio-cultural roots of abnormal psychology (Carson & Butcher, 1992).

A new trend during the past few decades has been to change mental hospitals into therapeutic centres, to rehabilitate patients by the use of group therapy and psychotropic drugs and to reduce the mental hospital population by returning patients to the community. This new development is called Community Psychiatry and mental hospitals are now generally known as Psychiatric Hospitals (Vlok, 1984).

2.2.2 Deinstitutionalisation

Psychiatric hospitals continued to play an important role in the delivery of mental health services. However, since World War II, institutional care for the mentally ill underwent a series of changes and is still doing so. By the 1950s, it had become apparent that these institutions were not fulfilling their goals very well. Experts began to realise that hospitalisation often contributed to the development of pathology instead of curing it. Part of the problem was that the facilities were usually under-funded and overcrowded. Hospital staff were under-trained and overworked, resulting in their delivery of minimal custodial care (Thornicroft & Bebbington, 1989; Weiten, 1995).

Psychiatric hospitals were scrutinized closely and doubts were raised about the wisdom of hospitalisation. Critics noted that hospitals placed people into a passive patient role, leading many to stop taking responsibility for themselves and becoming fearful of leaving the hospital (Weiten, 1995). Their problems were also aggravated by the fact that state psychiatric hospitals though serving large geographic areas, were placed away from major population centres. Hence, most patients were uprooted from their communities. Thus, being far from their homes, they lost contact with their families, friends and employers. Deprived of their much needed social support, their potential return to the community became even more difficult (Weiten, 1995).

Since the mid-fifties deinstitutionalisation or the discharge of chronic psychiatric patients out of large, public hospitals and back to their communities has been internationally promoted. It was believed that care in the community would lead to better treatment outcomes and a better quality of life for those with mental illness. This shift from in-patient to out-patient care was also made possible by the emergence of effective drug therapies and the establishment of community mental health centres for local care (Weiten, 1995). However, many

communities failed to plan in advance for this trend and thus were unable to provide coordinated and comprehensive services. This resulted in the "revolving door" phenomenon, where mentally ill patients were constantly moving in and out of mental hospitals (Gralnick, 1987; Stanhope & Lancaster, 1988; Weiten, 1995). As a result of scarce or inadequate community services, many patients were left to wander the streets, joining the ranks of the homeless (Weiten, 1995).

According to a study conducted by Seymour and Dawson (1986), families of schizophrenic patients who returned home after deinstitutionalisation experienced a diminished quality of life and had increased concerns about their own physical, social and emotional well being. Threats to personal safety, including freedom from actual or threatened physical, social, or emotional abuse constituted the greatest concern. For these reasons, families needed guidance and support in learning to respond effectively to discharged patients. What was needed in dealing with discharged psychiatric patients was aggressive case management whereby clients are linked with basic resources, provided with support during crises, monitored closely and supervised by someone who can serve as an advocate for the client in his attempts to deal with a complex social and health care system.

2.2.3 The impact of deinstitutionalisation in the United States of America

At first, the United States experienced most, if not all, of the problems mentioned above. The process began in the early 1950s. The shifting of patients from hospitals into the community led to a dramatic drop in bed and inpatient numbers but there was no corresponding increase in community services (Krupinski, 1995). Resources that were allocated for inpatient services did not follow the patients into the community, which resulted in community care facilities and services being under-sourced. The ad hoc manner in which the discharge process was conducted, often without planning or preparation of patients, resulted in homelessness, marginalisation and abuse of patients (Thornicroft &

Bebbington, 1989). It also resulted in the "revolving door" phenomenon, with mentally ill patients constantly moving in and out of hospital as a result of relapse (Weiten, 1995).

It was also assumed that community care would be cost saving, but this was heavily disputed. According to Hafner and van der Heiden (1989), community care was more costly than institutional care, at least in the initial phases when the community services were being set up.

Deinstitutionalisation in the United States is now at an advanced stage both in duration and in the reduction in state hospital beds. The closure of many institutions in the 1970s was undertaken by a coalition of parents, people involved in developing community services and people running the institutions. Local and national laws were used to drive the process. This involved a policy of leading through the development of community services, followed by closure of the institutions rather than announcing closure as the starting point (Mzimela, 2001).

One of the laws that was enacted as a response to the deinstitutionalisation process was **the discharge planning law** which mandated that comprehensive community care tailored to individual needs, including after-care psychiatric service, an adequate living arrangement, adequate economic support, and social and vocational rehabilitation should be arranged before the patients' discharge from hospital (Mzimela, 2001). This was obviously done to guard against homelessness, unemployment, poverty, loneliness and the meaningless existence suffered by deinstitutionalised patients.

2.2.3.1 Lessons on deinstitutionalisation for USA

Mzimela (2001) presents the following as lessons that the Americans have learnt out of their years of experience with deinstitutionalisation:

- Careful planning and setting up of community services must be done before implementation of deinstitutionalisation
- Mental institution services must still be available for those patients who cannot be taken care of in the community such as the chronically and severely mentally ill
- Health professionals must be guided by clinical reality rather than by conceived ideologies if they are to give the best service to the chronically and severely mentally ill. They need to accurately assess the patients' ability to function outside the hospital, their independence and management of freedom as opposed to the cherished beliefs and wishes to discharge patients.
- That all the chemistry in the world cannot replace a human interpersonal relationship. Thus, community care means more than just dispensing medication but involves spending quality time with the patient and the family (Lego, 1993).
- Contrary to the expectations that time limited financing by the federal government would be sufficient to create local and state community mental health systems that would be ongoing, the USA experienced an unwillingness on the part of individual states and many local communities to take financial responsibility as the federal infusion of funds dried up over the decades.

Problems of deinstitutionalisation as compiled in the study by Mzimela, (2001):

(a) Issues relating to the selection of patients

- Chronically ill patients were an undesirable clientele
- Patients were inadequately prepared for life in the community
- Disadvantaged and minority groups, that is, blacks, the poor and rural patients

(b) Issues related to the treatment course of the patient in the community

- Inadequate range of treatment services

- Fragmentation and lack of coordination in community treatment services
- Inaccessibility of treatment services due to distance, cost or working hours
- Questionable quality of care in community services, because of fragmentation inaccessibility or too much reliance on psychotropic drugs

(c) Issues related to the quality of life of patients in the community

- Inadequate community support systems - family, services, accessibility
- Residential facilities

There were other problems that resulted from deinstitutionalisation, such as financial and legal issues.

2.2.4 Deinstitutionalisation in South Africa

Historically, South Africa has been plagued by inequities in all spheres of life. During the apartheid era racially segregated facilities were the order of the day and this promoted separateness and inequities. The mental health system was no different. Vogelman (1986) states that, advances in mental health treatments were confined to white South Africans while services for black South Africans continued to be inaccessible, inadequate and under-funded. While white patients had relatively greater access to formal care, this for black patients was restricted to either profoundly low functioning, disruptive or dangerous patients. The majority of care for patients was managed at home by the family with minimal support from formal mental health services.

During the 1960s psychiatric services were contracted to private organisations. This was done with the aim of providing the much needed psychiatric services but, it served to entrench racial division even more. Mental health services

provided for blacks by private institutions were poor and lacking in rehabilitative approach (Vogelman, 1986).

In the late 1970s to early 1980s primary healthcare and community health centres were established in some parts of the country, mainly in the urban areas. Psychiatric units were established within these community health centres (Dartnall, Lee, Modiba and Porteus, 1999). Even so, the establishment of community psychiatric services has been slow and psychiatric care remains institutionally based (Bhengu, 1989).

According to Desjarlais, Eisenberg, Good and Kleinman (1995) the human rights of the mentally ill should be a significant concern at all levels of policy-making and service provision and should also be reflected in the mental health legislation. In the early 1990s a new movement of human rights for all brought about some changes. Conditions prevailing in psychiatric institutions were scrutinised. In 1995 the National Department of Health formed a committee on mental health and substance abuse to investigate reports of malpractice and patient abuse (Dartnall,et al, 1999). The committee reported gross violations of patient rights in psychiatric institutions. The quality of care at historically black institutions was found to be appallingly poor, without any move toward the development of community services and a continued discrepancy of quality in terms of historical racial privilege (Porteus, Sibeko, Lee, Soderland, Gibson & Peprah, 1998).

In response to these findings, the National Department of Health developed an action plan aimed at improving the conditions of persons with mental illness, in 1997. This was entitled the *Proposed National Health Policy Guidelines for the Improved Mental Health in South Africa*. Emphasis in this document was on priorities for caring for persons with mental illness in their communities (Dartnall, et al, 1999). One of the proposed implementation strategies from the objectives in the document was the policy of deinstitutionalisation. Thus, Tower hospital in

the Eastern Cape and Madadeni hospital in Kwazulu Natal were chosen as sites for pilot projects on deinstitutionalisation of psychiatric patients by the Department of Health. These projects were started in 1998.

2.2.5 Deinstitutionalisation at the Tower Hospital

(a) Historical overview

Tower hospital is situated in Fort Beaufort in the Eastern Cape. It was established in 1894 for Black psychiatric patients. Like all other mental institutions at that time it was oriented towards containment, and patients were locked away from the community. It was characterised by huge wards, a large number of patients and overcrowding (Dartnall & Porteus, 1998).

In the early 1980s, due to its dilapidated state, the hospital was re-built and by 1985 the patients were transferred to the new improved buildings. It was during the course of this process that the hospital population was downsized from over 2000 patients to the current level of fewer than 600. Patients were discharged back to their communities or transferred to hospitals closer to their homes. Those whose families could not be located were kept back. Even though these patients may have been re-admitted, the hospital continued to achieve the downsizing effort to maintain the current bed status of 600 (Dartnall & Porteus, 1998). The remaining "downsizing" was seemingly achieved by a greater rate of discharge of short-term patients (Mzimela, 2001).

Some of the chronic patients could not be discharged because their families could not be found. Those found were located after great efforts to find them and even so, some families were reluctant to take the patients back.

2.3 Concepts of mental health and illness

2.3.1 Mental Health

Definitions of mental health range from the absence of mental disease to the attainment of ones' maximal capabilities. According to Taylor (cited in Stanhope & Lancaster, 1988):

> Several characteristics of mental health are generally accepted: the ability to cope with maturational and situational stressors, to cope with reality, to love and to be loved in return, to accept one'self, and to think independently. (p. 631).

The term mental health is basically an evaluative concept, in other words the standard of mental health depends very much on the personal and social values of the person who defines it. Mental health is usually a synonym for all the positive "good" traits valued by the proponent who is usually a psychologist or psychiatrist of repute. Mental health is contrasted with its opposite, mental ill-health (Vlok, 1984).

2.3.2 Mental ill-health

According to Korchin (cited in Vlok, 1984) lack of voluntary control most clearly describes the mentally abnormal person. Thus, the psychotic may act as if he is possessed by demons, listening and responding to voices that come from within himself and the neurotic cannot get rid of his compulsive behaviour or thoughts, doubts and anxieties, even though he knows them to be irrational. The mentally ill are recognised because their behaviour deviates from the particular cultural norm to which they ascribe. The label "mental illness" carries a social stigma in

Western cultures, probably because the mentally ill person cannot maintain good human relationships or meet the demands of life (Vlok, 1984).

Mental ill-health presents mainly as disordered conduct, anxiety, unhappiness, and personality distortion. It has its roots in disordered human relationships, and sometimes it is preceded by genetic or organic brain pathology. The concept of mental ill-health is based on the level of psychological maturity (DSM-IV Axis II) attained by the individual. Abnormal clinical syndromes (DSM-IV Axis I) for example, functional psychoses, neuroses, and organic brain pathology, complete the picture of mental ill-health in its more florid manifestations (Vlok, 1984).

2.4 Schizophrenia.

According to Carson and Butcher (1992) schizophrenia is defined as:

> "A group of psychotic disorders characterised mainly by gross distortion of reality, withdrawal from social interaction and fragmentation of perception, thought and emotion." (p. 428)

Literally, schizophrenia means "split mind". However, when Dr Eugene Bleuler, a Swiss psychiatrist, coined the term in 1911 he was referring to the fragmentation of thought processes seen in the disorder, not to a split personality. Bleuler thought the condition was characterized primarily by disorganisation of thought processes, a lack of coherence between thought and emotion as well as an inward orientation away from reality (Carson & Butcher, 1992; Weiten, 1995).

Schizophrenic disorders occur in virtually all societies, from aborigines of the Western Australian desert to the remote interior jungles of Malaysia to the most technologically advanced societies. In the United States of America the estimated incidence of schizophrenia is slightly under one percent of the population. Although schizophrenic disorders sometimes occur during childhood

or old age, about three quarters of all first admissions are between the ages of 15 and 45, with a median age of just over 30. The incidence is about the same in both males and females (Carson & Butcher, 1992).

2.4.1 The world of people with schizophrenia

Just as normal people view the world from their own perspective, schizophrenic people, too, have their own perspective of reality. Their view of the world, though, is often strikingly different from the usual reality shared by those around them. Living in a world that can appear distorted, changeable and lacking the reliable landmarks that normal people use to anchor themselves to reality, a person with schizophrenia may feel anxious and confused.

Symptomatically, schizophrenics are recognizable through odd bizarre behaviour apparent in aloofness, suspiciousness, periods of impulsive destructiveness and immature, exaggerated emotionality, often ambivalently directed and considered inappropriate by the observer. The interpersonal perceptions are distorted in the more serious states by delusional and hallucinatory material. Withdrawal into fantasy life may take place and is associated with serious disorder of thought and profound habit deteriorations in which the usual social customs and personal care are disregarded (Carson & Butcher, 1992).

Disturbed, irrational thought processes are the central feature of schizophrenic disorders. Various kinds of delusions are common. For example, a patient may believe that he is an important person, such as the president of South Africa. Also the patient's train of thought deteriorates. Thinking becomes chaotic instead of logical, may jump from one topic to another, unable to connect thoughts into logical sequences. This may contribute to social isolation, as making a conversation with this person becomes difficult (Weiten, 1995). Also a variety of distorted perceptions may occur with the schizophrenia, the most common being auditory hallucinations. The patient may hear voices of non-existent or absent people talking to him.

Schizophrenia usually involves a noticeable deterioration in the quality of the person's routine functioning in work, social relations and personal care. For example, they may fail to get along with others and neglect personal hygiene. In addition to this, people with schizophrenia sometimes exhibit inappropriate affect. They may show emotion that is inconsistent with their speech or thoughts, for example, may laugh when told that someone close to them had died (Weiten, 1995).

2.4.2 Aetiology of Schizophrenia

There is no known single cause of schizophrenia. Carson and Butcher (1992) assert that despite extensive research, the causal factors underlying schizophrenia remain unclear. Primary responsibility has been attributed to a number of factors, namely, biological, psychosocial, and socio-cultural factors. Biological factors, include heredity and various biochemical, neuro-physiological, and neuro-anatomical processes. Psychosocial factors include early psychic trauma, pathogenic interpersonal and family patterns, faulty learning, difficulties in social roles and decompensation under excessive stress. Lastly, socio-cultural factors which influence the types and incidence of schizophrenic reactions. Differences in the content and form of a schizophrenic disorder between cultures and even subcultures have been documented in studies of different African groups. These three sets of factors are not mutually exclusive and it seems likely that each is involved in at least some cases.

2.4.3 Treatment and outcomes of schizophrenia

2.4.3.1 Treatment

Until recently, the prognosis of schizophrenia was generally considered extremely unfavourable. Under routine custodial treatment in large

institutionalised mental hospital settings prior to the 1950's, the rate of discharge was only thirty percent. For most schizophrenic individuals, the outlook today is not nearly so bleak. Improvement in the situation came with dramatic suddenness when the phenothiazine class of drugs were introduced in the mid-1950s. Drug therapy especially when combined with other modern treatment methods such as psychotherapy allowed the majority of cases to be treated as outpatients (Weiten, 1995).

2.4.3.2 Outcomes

According to Carson and Butcher (1992), a schizophrenic individual who entered a psychiatric hospital or clinic as an in-patient for the first time had an eighty to ninety percent chance of being discharged within a matter of weeks or at most months. The rate of readmission, however, remained extremely high although exact numbers were difficult to calculate as patients could not be easily tracked. They also state that at least about one third of schizophrenic patients recovered, which meant that they remained free of symptoms for five years; ten percent showed the classical pattern of deterioration and permanent, profound disability. The remainder of people, about sixty percent of the total, experiencing a first episode showed varying degrees of personality impoverishment and psychotic behaviour. Evidence showed that this group had been seriously neglected resulting in the common "revolving door" pattern of endless cycles of discharge and brief hospitalisation for medication adjustment. Outcome ratios appeared less favourable for those with onset symptoms that occurred at an early point in the life cycle (Carson & Butcher, 1992).

2.5 COMMUNITY PSYCHIATRIC SERVICES

2.5.1 Introduction

Mental handicap is still regarded as a stigma in some societies. Once it becomes public knowledge that a person has spent time in a mental hospital or even that he has in the past or is presently receiving psychiatric treatment, the attitudes of most of the people with whom he is involved are almost always affected, negatively. In the pursuit of friends, a job, a place to live, schooling, or even the maintenance of family relationships, the patient generally finds that his psychiatric problems have created a situation for him which takes precedence over or at least influences nearly everything else that people know about him. He may receive less sympathy, respect or friendliness from other people and this may increase whatever social difficulties culminated in the assignment of a psychiatric diagnosis to begin with. Since low self-esteem is characteristically associated with so many psychiatric conditions, mental patients are particularly vulnerable to the opinions and appraisals of other people. This sensitivity renders the stigma of being labelled mentally ill even harder to bear (Rabkin, 1975).

2.5.2 Move towards community psychiatric care

The worldwide deficiencies in mental hospital treatment of psychiatric patients have given rise to the recent trend, both internationally and in South Africa, to treat these patients within the community. Community Psychiatry is based on Social Psychiatry which sees mental ill-health as a psychosocial disorder and community health services as a mutual support system in which people help and care for one another. The emphasis in Community Psychiatry is on interpersonal, environmental and cultural forces that cause and also can repair maladaptive patterns of behaviour. It highlights continuity between the normal and the abnormal; and it seeks to remove the stigma attached to mental illness (Vlok, 1984).

2.5.3 Aims of Community Psychiatric Services.

The main aim of Community Psychiatric Services is to maintain psychiatric patients in the community and also to involve the community in the care and support of its emotionally disturbed members. This can be accomplished through primary, secondary and tertiary prevention of mental illness (Vlok, 1984).

2.5.3.1 Primary prevention

Primary prevention aims at preventing the occurrence of mental disorders by strengthening individual, family, and group coping abilities. It entails reduction to a minimum or eradication of epidemiological factors, in either the patient or the environment, which predispose to mental breakdown. For example, parenthood is a very exacting vocation and thus promotion of a healthy family life cannot be overemphasised. Also, counselling in human relations is important. Thus the community psychiatric nurse can play a very important role in recognising groups at risk of developing mental ill-health, for example, expectant mothers who do not feel supported, adolescents or the elderly approaching retirement. It is also very important for those who render mental health services to educate the community about mental ill-health so as to help remove the stigma attached to it and help those affected to be understood and accepted (Stanhope & Lancaster, 1988).

2.5.3.2 Secondary prevention

Secondary prevention aims at the early detection of signs of mental health disruption so that prompt counselling, treatment and referral can be provided. For instance, in clinics, schools, home health care and the work place, community health nurses can detect early signs of increased levels of anxiety, decreased ability to cope with stress and failure to perceive the self, the environment and

reality accurately. Early diagnosis and prompt treatment are important secondary preventive measures (Vlok, 1984).

2.5.3.3 Tertiary prevention

Finally, tertiary prevention involves monitoring the progress of discharged patients, especially their medication regimen, coordination of care, use of advocacy and response to referral (Stanhope & Lancaster, 1988). Thus, it involves the whole process of rehabilitation. According to Korchin, cited in Vlok (1984), the goal of tertiary prevention is to limit the after-effects of mental illness and hospitalisation and to restore patients to effective functioning in the community. For example, rehabilitation can include placement of patients in halfway houses where they can be re-trained in a simple household routine and lifestyle that resembles that of people outside institutions. In this way patients learn to fit into the way of life of normal society. This can be followed by vocational rehabilitation, with the aim of job placement and helping the patient to be independent (Vlok, 1984).

In the role of advocacy, the community psychiatric nurse is required to protect, speak for and support the interests of the patient not to be harmed in the process of provision of health care services; for instance, in the referral of patients for social grants. Patients often have difficulty in being sufficiently assertive to get through the red tape of some organisations to secure information or services and so the nurse can help (Stanhope & Lancaster, 1988).

2.5.4 Development of Community Psychiatric Services in South Africa.

Mental Health Services in South Africa have improved since the promulgation of the Mental Health Act of 1973 and the introduction of the tripartite system to coordinate mental health services by universities and provincial and state departments of Health and Welfare. There are seven full time professorships of

psychiatry and consequently increased training facilities for psychiatrists and twenty- three psychiatric hospitals and acute psychiatric units at some of the general hospitals in the Republic of South Africa (Vlok, 1984). Psychiatric outpatient departments are sited at provincial hospitals, even those hospitals that do not have an acute psychiatric ward.

Apart from the in and outpatient services in hospitals, there are Community Psychiatric Services (CPS). CPS play an increasing role in keeping people out of psychiatric hospitals which more often than not are overcrowded and thus can hardly offer patients quality care. Care in the community also helps the patients not to lose contact with "normal life". Long-term hospitalisation places patients in passive roles which lead many of them to stop taking responsibility for themselves (Vlok, 1984).

Each hospital has its own CPS that operates within a defined region or "catchment area," not necessarily situated within the grounds of the hospital. Outlying rural areas falling within a "catchment area" are reached by means of liaison with district surgeons and local authorities. Some CPS centres run a postal medication service (Vlok, 1984). Furthermore, all CPS are multiracial, satellite clinics being run in each area which requires such a service, for example, in Black townships, at old age homes, or at sheltered employment workshops. Many satellite clinics are situated at the health centres of local authorities. There are over 200 satellite clinics run by community psychiatric nurses in the Republic of South Africa. These clinics are visited by psychiatrists from the regional psychiatric service centres. In addition, the public sector is aided by voluntary organisations coordinated by and affiliated to the S.A. National Council for Mental Health. This Council is a welfare organisation with its headquarters in Johannesburg, from where it co-ordinates the work of its sixteen constituent mental health societies with their twenty four mental health clinics situated throughout South Africa. The council is the official public body that makes representation to the government, provincial and local authorities on

mental health matters (Vlok, 1991). Other such organisations include the Smith Mitchell Sanatoria for chronic deteriorated psychiatric patients run by businessmen and private psychiatric institutions, such as Lifecare (Vlok, 1984).

2.5.5 Essential Components of a Comprehensive CPS.

A comprehensive community psychiatric programme includes a twenty-four hour emergency service and a crisis intervention unit attached to a casualty department of a general or provincial hospital. Examples of cases handled at this service include attempted suicide, alcoholic hallucinosis, acute psychosis and medication side effects. Emergency handling may include short-term hospitalisation. For this service a full psychiatric team, that is, a psychiatrist, a clinical psychologist and a psychiatric nurse, is necessary, either on duty or on call. A domiciliary service by community psychiatric nurses is necessary for the patient to be observed and medicated at home. Additionally, there should be long-term drug and psychotherapy services at outpatient clinics through which administration of psychotropic drugs and progress of discharged psychiatric patients are controlled. The supervision of medication is a very important function of the community psychiatric nurse. Finally, rehabilitation units for occupational and recreational therapies where prolonged rehabilitation is carried out on people whose work and social skills have been seriously impaired by their mental illness, should be in place (Vlok, 1984).

In addition to these services the following services are required in order to deliver a comprehensive and co-ordinated service:

- Long stay accommodation with a 24 hour staff in home-like units for people with chronic mental illness who need regular supervision of medication and daily monitoring of their mental state but do not require the continual presence of medical staff
- Day care programmes
- Supported housing

- Concerted outreach efforts and
- Patient and family support services (WHO,1996).

2.5.6 Norms for severe psychiatric conditions

According to the White paper for transformation of the health system in South Africa, a vision for a new mental health system was articulated. The vision advocates for a comprehensive and community-based mental health service that should be planned and co-ordinated at all levels of government, that is, national, provincial district and community levels, and integrated with other health services. These services should be performance driven, affordable and with adequate resources. The quality of care both in hospital and in the community should be monitored with increased concern for the rights and needs of patients. Norms and standards were thus developed to calculate resource needs in line with this vision.

2.5.6.1 Prevalence

Using the National Co-morbidity Survey (NCS) figures in South Africa it has been calculated that in a region/district of 100,000 people, mental health services for severe psychiatric conditions should be available to at least 3004 people (3% of the population) during any given year.

2.5.6.2 Human resource requirement.

According to the Norms Manual for Severe Psychiatric Conditions, a total of 12 ambulatory care staff is required to cover the needs of the 3004 people with severe psychiatric conditions.

Ambulatory care breakdown

- 2.0 psychiatric nurses

- 5.0 general nurses
- 0,5 occupational therapists
- 1.5 occupational therapy assistants
- 1.0 social worker
- 1.0 psychologist
- 0,25 psychiatrists
- 0,75 medical officers

The following are indicators and standards frequently used in mental health care:

- 0,25-1 psychiatrists per 10,000 population
- 0,5-4 psychiatric nurses per 10,000 population (WHO, 1996).

2.5.6.3 Access to Mental Health Care

According to indicators and standards frequently used in mental health care, access to mental health is judged by the travelling distance to the nearest mental health facility and the availability of in-patient treatment facilities. The WHO Public Mental Health recommends that the percentage of population living more than one hour from the nearest mental health facility is less than 20%.

2.5.6 Roles of the various members of the psychiatric team.

Psychiatrists are physicians who specialise in the diagnosis and treatment of psychological disorders. They devote more time to relatively severe psychological disorders such as schizophrenia, mood disorders and such rather than everyday marital, family and school problems. The psychiatrist thus plays an important part in the diagnosis, prescription of medicines and follow-up care of psychiatric patients.

Clinical psychologists also specialise in the diagnosis and treatment of psychological disorders and everyday behavioural problems. They develop and

apply measures to assess the effectiveness of medications. When drugs are used to treat symptoms of psychopathology, the primary criterion for their success is behaviour change in the patient. Psychologists are well qualified to assess such behavioural changes (Hargrove & Spaulding, 1988). Bellack (1986) also states that psychologists influence medication compliance using behaviour management techniques, particularly with discharged patients. They are also involved in psychological testing and psychotherapy of clients.

The Community Psychiatric Nurse (CPN) has a fourfold role, namely, administrative, educational, research and clinical roles. In the administrative role the CPN sees to the efficient running of the service and the provision of good service to the clients. Records are kept up to date, patients are seen by appointment, so that those who miss their appointments can be detected and followed up. A register of patients is kept with details of drug therapy. Medication control is strictly applied. The educational role entails educating the patients, their families and the community about mental health and ill-health. This helps reduce prejudice, which more often than not is a result of ignorance. Also of importance is the education of other professionals. Research is made possible through the keeping of records and through recording of the side effects of psychotropic drugs. The clinical role of the CPN, among other things, involves the dispensing of repeat medication at satellite clinics, screening of new patients, counselling of patients and their families, home visits, crisis intervention, and prevention of medicine defaulting and treatment of defaulters (Vlok, 1984).

Social workers play an important role in coordinating social and welfare services for the patients and their families. They are also part of the family therapy team. They help the families cope with emotional and communication problems. Another role for the social workers in the community is to initiate voluntary support groups and self-help projects (Meacher, 1979).

2.6 Treatment of schizophrenic patients in the community

2.6.1 Introduction

The modern trend in psychiatric hospitals is the early discharge of schizophrenic patients on anti-psychotic drugs to keep the symptoms at bay. The nature of schizophrenia is such that the patient finds it difficult to socialise and to hold down a job. He is dependent on others, yet does not acknowledge this dependency because he withdraws into his own world. He thus is a great concern for his caretakers, namely, community psychiatric service personnel and his family who feel responsible for the regularity with which he takes his medication, his living conditions, his attempts at socialization and his employment. If these skills break down he relapses and has to be readmitted to hospital. This constitutes the "revolving door syndrome", which, if repeated on many occasions suggests that rehabilitation was not complete (Vlok, 1991).

When life loses its meaning, human beings withdraw into themselves and stop communicating. The "burnt out" schizophrenic needs to have a meaningful occupation and also to form relationships. It is therefore important to keep the chronic schizophrenic person out of hospital where he is likely to develop the "hospital dependency syndrome" with complete social breakdown and personality deterioration. This syndrome results from the emotionally deadening effects of the unstimulating, undemanding and dehumanising nature of the mental hospital environment. It therefore is important that these patients be put into rehabilitation programmes even prior to discharge from hospital (Vlok, 1984). The goal of inpatient rehabilitation services should be directed towards returning persons with mental illness to the community by producing measurable gains in functioning that promote increased personal independence, self-direction and care to prepare the patient to live in the least restrictive environment (Gibson, 1999).

2.6.2 Rehabilitation

According to Vlok (1991) rehabilitation can be defined as the restoration of the ability to function in a normal or near normal way following disease or injury. A more comprehensive World Health Organisation (1969) definition is

> 'The combined and co-ordinated use of medical, social, educational and vocational measures for training or re-training the individual to the highest possible level of functional ability' (Vlok, 1991, p. 994).

Rehabilitation of these patients should be started long before they are actually discharged so that the patients are ready for discharge into the community when the time comes. According to a study by Telias, Fronsky and Umansky (2000), preparation for discharge greatly enhanced the ability of the patients to stay in the community, especially those who were referred to halfway houses.

Group counselling for rehabilitation is considered the most suitable measure. In the shared experience of the group, the patient is helped to maintain healthy interpersonal relationships. Group therapy does a lot to help the patients to comply with medication and thus prevents re-hospitalisation after discharge. Group members gradually develop a more positive self-image with enhanced self-worth (Vlok, 1991).

Pre-vocational rehabilitation of the schizophrenic person needs the services of a skilled vocational counsellor. For example, the counsellor helps make patients aware of the requirements for the role of employee, thus helping them to join the world of work. Acceptable and non-acceptable working habits are communicated by the counsellor and solutions to problems found in the work situation are found. Basic requirements of the work role, such as personal care, punctuality, self-discipline, relations with superiors and colleagues, co-operative efforts in the work situation and many more, are taught. The rehabilitation process is

concerned essentially with the building up of a personality structure which is outer directed so that the schizophrenic person no longer withdraws into his own world (Vlok, 1991).

2.6.3 Placement and accommodation in the community

Depending on the motivation of the chronic patient and community resources, rehabilitation also involves placement of these patients. Examples of such places are halfway houses and rehabilitation centres. Psychiatric halfway houses came into being as a result of a need for residential placement for discharged patients. The first one in South Africa was Hillbrow Lodge, in Johannesburg, which was opened in 1975. It catered for discharged long-term white patients from Weskopies Mental Hospital in Pretoria and Sterkfontein Mental Hospital in Krugersdorp. It is, however, no longer in operation (Vlok, 1984).

The responsibility of running halfway houses and rehabilitation centres has been taken over by the South African National Mental Health Society. The Society sees this as its important tertiary prevention function (Vlok, 1984). In 1980 the Witwatersrand Mental Health Society established a halfway house, the Gordonia Residence and Protective Workshop, for discharged psychiatric patients. The patients use this facility to develop their remaining skills, thus increasing their self-esteem and their chances of one day entering the labour market. The Threshold Foundation was founded in 1978. It is a day centre also run by the Witwatersrand Mental Health Society to enable schizophrenic patients to socialize and gain occupational skills for future gainful employment (Vlok, 1984).

According to Vlok (1984) the important task of running halfway houses is the building of bridges between the patient and the community. This is accomplished by involving the families of the patients in the rehabilitation programme, by selecting and training suitable volunteer workers, by contacting prospective

employers for work opportunities for the patients and by arranging for the teaching of skills to the patients.

Chronic patients, some of whom have been institutionalised for more than ten years, are highly unlikely to fit into a society that has been moving forward at a fast pace while life had been almost at a stand still for them inside the walls of mental institutions. They need to be re-educated on commonplace activities such as boarding a bus, going shopping, how to use the library or the phone, housekeeping, budgeting and cooking (Vlok, 1984).

Volunteer workers are used to assist in the rehabilitation of patients who have broken down on the social level. They help re-introduce patients into the community and get them to participate in the daily life of the community. Selection and training of volunteer workers is important, as this will help ensure that they are able to assist the patients without becoming emotionally over-involved. Their task is to help the patients with their social functioning, for instance, they provide social activities for people already in the community. Sports, games, hobbies, outings and discussion groups are examples of such activities. The social groups help the discharged patients to get together and avoid isolation (Vlok, 1984).

In Cape Town, discharged patients are fortunate to have a safety net in the form of a number of rehabilitation-oriented social groups run by the Cape Mental Health Society (CMHS). There are 13 social groups that offer support to about 250 people living with mental illness, most of whom are referred to the society on discharge from a psychiatric hospital. The groups work well together because everyone is in the same position. They help one another to prevent relapse. Social workers visit those who do not show up for group meetings and they help pick up early signs of relapse. Furthermore, the CMHS has set up a project at Fountain House in the Cape Town suburb of Observatory, which helps those who are ready to prepare for the working world. Members have to join one of the three

units, namely, clerical, catering or development and work internally until they are ready for transitional employment. Those who are ready get placed on six-month employment contracts with one of four companies which support the project, Old Mutual, Pick 'n Pay, Baygen and Foschini. Most of the people placed suffer from schizophrenia and bipolar disorders (Cullin, 2000).

In addition, the discharged patient may need help to acquire decent accommodation, as he is socially and vocationally incompetent. Many of them do not have the support of a family and when discharged from hospital, return to a lonely existence or have nowhere to return to. This state of homelessness is likely to lead to a relapse. Therefore, it is of great importance that accommodation is secured for the patient prior to discharge. Placement of patients in suitable accommodation is an important aspect of CPS. The majority of patients discharged cannot be accommodated in halfway houses and rehabilitation centres, as there are only a few of these facilities.

The flat project is another example of alternative accommodation. Lifschitz, cited in Vlok (1984), describes a flat project located near a rehabilitation centre in Johannesburg, whose residents are mostly schizophrenics. The flat project consists of a number of flats accommodating three to four people in each. Interested people and organisations furnish and equip the flats. The proximity of the flats to the rehabilitation centre makes it easy for the residents to participate in the rehabilitation services. Volunteer "flat-friends" are recruited to become active participants in the social rehabilitation as well as becoming friends of the residents. The occupants of the flats support one another, thus facilitating the movement towards independence. They also have to run the flats and pay the running costs. The rehabilitation centre negotiates the leases.

Another type of accommodation facility is the Smith Mitchell Sanatoria. Rehabilitation of chronic deteriorated psychiatric patients with irremediable psychological damage is done at these sanatoria. It is aimed at improving the

quality of life of those patients who are unable to return to the community and to also enable those with sufficient inner resources to return to the community. These Smith Mitchell Sanatoria are run by a private firm of businessmen. State Health hires beds from the organisation and also supplies them with psychiatrists and nursing personnel (Vlok, 1984).

Finally, patients who have families that are able and willing to take care of them are discharged into their care. It is, therefore, important that the family is prepared for receiving and caring for the patient after discharge. The community psychiatric nurses, with the help of social workers, investigate home conditions and also counsel the family to help them accept the patient as having been sick. They encourage them to participate in the rehabilitation programme and accept the patient back into the family.

The CPN is the person who remains in regular contact with the patient after discharge. The role mostly played by the nurse is coordination of care and resources for the patient. The nurse collaborates with the other members of the health team in the care of the patient. Monitoring of the patients' progress, dispensing of repeat medications, prevention of defaulting and education of the patients and their families about mental health and illness are some of the duties performed by the CPN (Stanhope & Lancaster, 1988).

2.6.4 Opportunities for deinstitutionalisation

One of the most compelling opportunities working in favour of a deinstitutionalisation process is the patient's perception of discharge. The patient must want to be discharged. He must also have somewhere to live after discharge and must have a realistic perception of means and skills that would allow him to live outside the hospital environment. He should have, either the job skills, a job plan or any other coping skills, which would help him after discharge. A social grant to support him would also be necessary while the patient is still

without a job. Secondly, proper rehabilitation of the patient prior to discharge also offers an opportunity for a successful discharge plan. This helps the patient to be ready for discharge into a less restrictive environment (Dartnall & Porteus, 1998).

Other opportunities for successful deinstitutionalisation mentioned by staff from a psychiatric hospital in a study by Dartnall and Porteus (1998) are, first, health education focused particularly on mental health, for the family, community leaders such as church leaders, and traditional healers. These institutions, if properly equipped, can be good support systems for the patients in the community. Secondly, the integration of psychiatric health services into Primary Health Care services, would, among other things, help increase access to community services and reduce the stigma associated with mental illness. Availability and easy access to quality community psychiatric services is an important aspect of successful deinstitutionalisation. Thirdly, the involvement and valuing of staff within the mental health care services cannot be overemphasized. The staff members are an invaluable asset in making the deinstitutionalisation process work. They are involved in the care of the patients at all levels, namely, primary, secondary and tertiary levels.

2.6.5 Barriers to deinstutionalisation

Unhealthy family relationships, for example, lack of acceptance by the family or lack of contact, could be barriers to the discharge process. A history of misbehaviour or violence could be the reason for the breakdown in the family relationship. Poor planning, lack of social worker intervention and preparation of the family would be another contributory factor to the lack of acceptance of the patient by the family (Dartnall & Porteus, 1998). Thus, a return of the patient to his family under these circumstances would cause tremendous stress to them. They may feel their personal safety is threatened.

Another barrier stated by Dartnall and Porteus (1998) is lack of community socio-economic development and support services. Poverty, unemployment, lack of accommodation and poor quality of psychiatric services are all cited as barriers to a successful discharge process. When basic needs are not met, people become stressed and some may even break down. They go from poverty into hospital where all their basic needs are provided. Then, on discharge, they are sent back to the same circumstances that may have contributed to their breakdown in the first place. The likelihood is another breakdown. Additionally, the lack of qualified staff and of clinics and transport may result in failure of the process of discharging and keeping the patients in the community. Thus, the lack of an adequate range of treatment services in the community can also serve as a barrier to successful deinstitutionalisation (Bachrach 1976).

According to Weiten (1995) being labelled as psychotic, schizophrenic or mentally ill carries a social stigma that can be difficult to shake off. Even after a full recovery, someone who has been labelled mentally ill, may have difficulty in finding a place to live, getting a job or making friends. Deep-seated prejudice against people who have been labelled mentally ill is commonplace. The stigma of mental illness is not easy to shed and it undoubtedly creates additional difficulties for people who already have their share of problems. It also results in feelings of low self-esteem and thus, having difficulty in being sufficiently assertive to stand up and fend for themselves (Stanhope & Lancaster, 1988). Therefore, to be diagnosed mentally ill opens the door to the loss of personal autonomy and to disempowerment (Shulamil, 1991). Lawson (cited in Shulamil, 1991) gives an example of what it feels like to be a patient, 'to be a mental patient is to wear a label, a label that never goes away, a label that says little about what you are and even less about who you are'.

Finally, substance abuse could also be another problem. The patient is not likely to comply with his health and treatment regime if he is continuing to take alcohol

or dagga. These interfere with successful rehabilitation of the patient (Dartnall & Porteus, 1998).

2.7 Summary

In this chapter the history of the nature and treatment of mental illness was re-visited, from ancient to modern times. Deinstitutionalisation, its progress and problems were discussed. The concepts of mental health and ill-health, and also schizophrenia were explained. Discussion on community services was also included. This chapter serves as a background against which this study is conducted. The next chapter deals with the research methodology.

CHAPTER 3 RESEARCH DESIGN AND METHOD

3.1 Introduction

This chapter presents the research design and method used in the collection and analysis of the data for this study. Also included is the information on the respondents, the research instrument and the procedures followed in the analysis of data.

3.2 The research design

A non - experimental research design, using a questionnaire was used for the study.

3.2.1 Rationale for the research design

The non-experimental research design was used because there were no well-defined independent variables, control factors or causality effects.

3.3 The method

The study was based on a literature study and a survey among health care workers involved in community psychiatric services.

The literature survey was done in order to obtain the theoretical background for the study. The literature included the background on mental illness and changes in perception and treatment over the years, deinstitutionalisation of chronic psychiatric patients and the move towards community psychiatric services.

Questionnaires were used to gather data.

A survey consists of asking questions of a supposedly representative section of the population under study at a single point in time. The questions can be mailed to the respondents, asked by an interviewer in the person's home or elsewhere,

asked over the phone by the interviewer or handed out to the respondents to answer and return (Bailey, 1982).

The participating community clinics were visited by the researcher for the purpose of gathering data from the nurses. Questionnaires were given to the respondents to fill in and then handed back to the researcher. Perusal of records was also done during these visits.

3.3.1 Rationale of the method

The study aimed at evaluating the effects of care for chronic psychiatric patients in the community with regards to its impact on community health services hence the study was done at the community health clinics.

3.4 Scope of the research

The study took place in the Fort Beaufort district in the Eastern Cape. The area that was chosen is serviced by Tower hospital, one of the five psychiatric hospitals in the Eastern Cape that has been involved in a pilot project on deinstitutionalisation.

3.4.1 Rationale of the scope of the research

It was convenient for the researcher to confine this study to the Fort Beaufort area as it was within a manageable distance and allowed for easy contact and increased interaction. Tower hospital is one of the oldest psychiatric hospitals and offers services to quite a large section of the Eastern Cape population.

3.5 Administrative aspects

Permission was sought initially from the superintendent at Tower Hospital to conduct the study at the hospital and the community psychiatric services. This was done both in person and in writing. Permission was granted in October 1999. The clinics were then contacted to seek permission to collect data using questionnaires and the clinic records, which was also granted.

3.6 The respondents

3.6.1 Study population

The population targeted was all the nurses in the community psychiatric and primary health care services involved in the care of chronic psychiatric patients discharged from Tower Hospital who are in the community.

The clinics involved in this study were Tinis, Healdtown, Hillside, Seymour, Balfour and War Memorial clinics and also the community psychiatric unit for Tower Hospital. The furthest clinic is about forty kilometers from Tower Hospital.

3.6.1.1 Rationale for the population

The clinics targeted for this study were those that served the patients discharged from Tower Hospital. The nurses working at these clinics were in a position to provide the information needed by the researcher.

3.6.2 The sample

The sample chosen included all the nurses in the six residential clinics and the community psychiatric unit in Fort Beaufort. Since each clinic had either two or three nurses working in them, the investigator decided to use all those who were

available at the time. The sample consisted of twelve respondents, eleven females and one male in all.

The availability sampling strategy was used. All nurses available were included in the sample.

3.7 The research instrument

The instrument used for data collection was a questionnaire.

3.7.1 Description of the questionnaire

The questionnaire was designed by the investigator to be completed by the respondents (attached as appendix A). Section one consisted of services identified as relevant for each person suffering from psychosis (McCrone, Thornicroft, Phelan, Holloway, Wykes & Johnson (1998). The questionnaire consisted of six sections, namely:

- Available community psychiatric services and general health services
- Utilization of available community services
- Evaluation of the services
- Communication
- Staff support
- Staff attitudes

The questionnaire consisted of 44 items arranged in a series of close-ended questions that needed "Yes" or "No" responses. At the end of each section there was a space provided for comments. The literature survey formed the theoretical background for the questionnaire.

3.7.2 Rationale for using a questionnaire

As a research instrument the questionnaire was used because of the following advantages:

- It is a simple tool that can be utilized in the observation of data beyond physical reach of the observer
- It is a simple method for collecting data, consumes little time and is financially economic to distribute
- Close-ended items, especially, can be easily tabulated
- Questions are standardized making it easier to compare data or opinions of respondents on each item
- It provides data that can be easily quantified

3.7.3 Distribution of questionnaires and response

The questionnaires were distributed to all the participating clinics and handed over to the respondents by the researcher herself. The researcher went from clinic to clinic on different days. Only two clinics were visited per day. The respondents were informed about the reason for collecting the data in order to minimize discomfort and any anxiety they may feel if they were not sure of why this was done. The respondents were also asked not to discuss the questionnaires with one another while filling them. The researcher waited while the respondents filled in the questionnaires. The response was therefore a hundred percent.

3.7.3.1 Confidentiality

The respondents were assured as much as possible about anonymity. To further ensure anonymity, respondents were asked not to identify themselves in any way when filling in the questionnaires. The clinics were also not identified by their names on the questionnaires.

3.7.4 Scoring of the questionnaire

The scoring method for the questionnaire was simple. The questions permitted one possible response, that is, "yes" or "no". Numbers 1 and 0 were assigned to "yes" and "no" respectively.

3.7.5 Pilot study

The research instrument was pilot tested at a nearby clinic, War Memorial Primary Health Care Clinic, for clarity and usability. Limitations identified were rectified accordingly.

3.8 Records

3.8.1 Rationale for using records

Record reviews were done in order to determine the number of clients, frequency of visits, treatment default, the rate of relapse and the rate of re-admissions.

3.8.2 Description of the records

A review of clinic records was done. It covered the statistical report on the patients from September 2000 to August 2001.

3.8.2.1 Information format

The following information was sought:

- Number of patients on roll
- Number of patients admitted in the past 12 months

- Number of patients removed during the past 12 months
- Number of patients relapsed during the past 12 months
- Number of patients re-admitted during the past 12 months
- Number of patients with more than one visit per month
- Total left on roll at the end of 12 months

3.8.2.2 Procedure to access records

As stated before, permission was sought and granted to conduct the survey. The intended use of the records was explained to the relevant heads of the clinics under study and also confidentiality was assured in order to get permission to access the records.

3.8.2.3 Information accessed from records

Period: 01.09.2000- 31.08.2001

Category	Fort Beaufort	Alice	Totals
Number of patients on roll	592	482	1074
Number admitted	29	6	35
Number removed from register	83	10	93
Number relapsed but not admitted	20	6	26
Number re-admitted	102	77	179
TOTAL	**397**	**478**	**875**

3.9 Plan for analysis of data

The data was edited, categorized and coded. Each item of the questionnaire was assigned a number in preparation for computerization. Analysis was done using the SPSS programme available at the Education Policy Unit of the University of Fort Hare. The data was analysed using descriptive statistics, mainly as frequencies of occurrence and percentages.

3.10 Limitations

Close-ended questions forced respondents to choose between "yes" and "no" and no other choice.

3.11 Conclusion

Methodologies used to collect data and how this data was analysed have been explained in this chapter. The following chapter will present detailed results from the data collected.

CHAPTER 4 RESULTS AND DISCUSSION

4.1 Introduction

This chapter deals with the analysis and discussion of the data collected. The data collected by means of questionnaires was analysed and then arranged into tables to clarify the meaning of the information obtained. The results thereof are discussed in this chapter.

4.2 Availability of community psychiatric and general health services.

A comprehensive care programme for patients with psychiatric problems requires a whole range of services that can help support these patients in the community. These services range from medical services to support and social services. For example, the patients would need the services of a psychiatrist to review the patient's condition and adjust medication, community psychiatric nurses to supervise patients and monitor progress, a psychologist and a social worker, to mention a few.

4.2.1 Available community psychiatric services

4.2.1.1 Emergency psychiatric services at the clinics

The respondents were asked whether they rendered any psychiatric emergency services at the clinics in which they worked. The results are shown in Table 4.1 below.

Table 4.1: Emergency clinics

Response	Frequency	Percentage
Yes	3	25
No	9	75
Total	**12**	**100**

The results in Table 4.1 reflect that 25 percent of the respondents offered emergency psychiatric services at their clinics while 75 percent did not. This means that the majority of the patients did not have access to emergency treatment at their clinics and In the event of a relapse the nurses would have to send the patients back to hospital.

4.2.1.2 Services of a psychiatrist at the clinics

A psychiatrist is needed to assess the patients' progress and to evaluate treatment. The respondents were asked whether there was one in their clinics. The results are shown in Table 4.2 below.

Table 4.2: Psychiatrists at the clinics

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

According to Table 4.2 all respondents stated that there were no psychiatrists in their clinics. It is expected that patients discharged from hospital be evaluated by a psychiatrist at least once in six months to assess their progress. According to Vlok (1980) the satellite clinics where follow up for patients takes place should be visited by psychiatrists. From the results reflected in the table above none of the clinics were visited by a psychiatrist.

It is recommended in the *Norms Manual for Severe Psychiatric Conditions* that in a population of 100 000 a minimum of 0,25 psychiatrists is required.

4.2.1.3 Services of a psychologist at the clinics

Psychologists are needed to do psychological evaluations on the patients. The results reflected in the following table show how the respondents answered to the question asked, that is, whether they had the services of a psychologist at their clinics. The results are shown in Table 4.3 below.

Table 4.3: Psychologists at the clinics

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

The results in this table show that all the respondents stated that there were no psychologists in their clinics. This then shows that no psychological evaluations by a psychologist were done.

According to the *Norms Manual for Severe Psychiatric Conditions* the required number for psychologists is 1 in a population of 100 000.

According to Bellack (1986) psychologists play a vital role in influencing medication compliance, using behaviour management techniques, particularly with discharged patients. It would benefit patients treated in the community to have access to a psychologist. In the *Norms Manual for Severe Psychiatric Conditions* it is estimated that one psychologist is needed to serve a population of 100 000.

4.2.1.4 Services of a community psychiatric nurse

The respondents were asked whether they had psychiatric nurses at their clinics. The results are shown in table 4.4.

Table 4.4: Community psychiatric nurses

Response	Frequency	Percentage
Yes	5	42
No	7	58
Total	**12**	**100**

Table 4.4 above reflects that out of 12 respondents, only 42 percent had a community psychiatric nurse in their clinics. The rest of the respondents, 58 percent, stated that they did not have community psychiatric nurses in their clinics.

According to the *Norms Manual for Severe Psychiatric Conditions* the prescribed number of psychiatric nurses required for a population of 100 000 is seven.

There were only two community psychiatric nurses and these two were resident at the two urban clinics. Psychiatric patients in the rural clinics were seen once a month by a visiting community psychiatric nurse. This meant that if the community psychiatric nurse was unable to come or the patient missed her or his appointment for one reason or another, then the patient may be without medication for a month or he or she would have to travel to the community psychiatric unit in town to get that month's supply.

4.2.1.5 Services of a social worker

Social workers are needed to coordinate social welfare services for the patients. The respondents were asked if there were social workers at their clinics. The results appear in Table 4.5 below.

Table 4.5: Social Workers

Response	Frequency	Percentage
Yes	8	67
No	4	33
Total	**12**	**100**

The results in Table 4.5 reflect that 67 percent of the respondents had the services of a social worker at their clinics though not resident while 33 percent did not have any. Patients were referred to social services outside the clinics.

Most patients had access to the services of a social worker. The social worker plays an important role of advocacy in accessing social welfare services needed by the patient.

According to the *Norms Manual Severe Psychiatric Conditions,* the required number is one social worker per 100 000 people.

4.2.1.6 Occupational therapist services

The respondents were asked if they had occupational therapists at their clinics. The results are shown in Table 4.6 below.

Table 4.6: Occupational Therapists

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

According to Table 4.6 none of the respondents had an occupational therapist in their clinics.

Occupational therapy is an important aspect for patient rehabilitation. In this way patients can be exposed to skills that could help them to be meaningfully occupied and at the same time earn money for themselves.

The prescribed norm for occupational therapists according to *the Norms Manual for Severe psychiatric Conditions*, is 0.5 per 100 000 people.

4.2.1.7 Sheltered employment services

This question was asked of the respondents to find out if there was any form of sheltered employment for the patients. The results are reflected in Table 4.7 below.

Table 4.7: Sheltered employment

Response	Frequency	Percentage
Yes	5	42
No	7	58
Total	**12**	**100**

The table above shows that 42 percent of the respondents stated that there was sheltered employment for discharged patients while 58 percent indicated that such services were not available. Sheltered employment affords the patient a chance to work in a non-threatening and non-competitive environment while he

or she re-learns forgotten or new skills. This helps prepare this person for the open labour market eventually.

Disabled persons, both physical and mental, can get employment in the Department of Manpower's sheltered employment 'Service Products' workshops, provided they are 50% productive. Their work is geared towards eventual employment in the open market (Vlok, 1984).

4.2.1.8 Supply of psychiatric medicines

The respondents were asked if they kept medication for psychiatric patients at their clinics. The results thereof are shown in Table 4.8 below.

Table 4.8: Psychiatric medicines

Response	Frequency	Percentage
Yes	8	67
No	4	33
Total	**12**	**100**

The results reflected in Table 4.8 show that 67 percent of the respondents affirmed that they kept medication for psychiatric patients in their clinics and 33 percent did not. The visiting psychiatric nurse brought the medication with her at monthly intervals. This meant that if patients were not able to come on the appointed date they would miss collecting the medication. The implication of this would be that the patient either had to go to the main source of supply or go without treatment for that month. The purpose of having the primary health clinics in the community is to bring the services closer to the people thus increasing accessibility.

4.2.1.9 Health education at the clinics

Respondents were asked whether any form of health education was being given at the clinics. The results are reflected below in Table 4.9.

Table 4.9: Health education

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

Table 4.9 shows that health education was given at all the clinics. As an integral part of a comprehensive health service, health education given to patients, their families and the community in which they live is of great value in empowering them all in dealing with issues pertaining to mental and general illness. This, also, would help minimise or eradicate those factors that predispose to mental breakdown.

4.2.1.10 Home visits for discharged patients

All respondents were asked whether they visited patients at their homes. Table 4.10 below reflects the results.

Table 4.10: Home visits

Response	Frequency	Percentage
Yes	7	58
No	5	42
Total	**12**	**100**

Table 4.10 shows that 58 percent of the respondents were able to visit the patients at their homes while 42 percent were unable to so. Problems cited most were lack of transport and shortage of staff.

Home visits help the staff to know more about the patients' living environment and how they relate with their families. It is also an opportunity for giving both health education and practical help.

4.2.2 General health services

In order to treat these patients in totality other services such as general health services, to cater for their physical health needs, need to be made available and accessible to them. In this section the respondents were asked about the availability of these services.

4.2.2.1 Treatment of minor ailments at the clinics

All the respondents were asked whether they offered treatment for minor ailments at their clinics. Results are shown in Table 4.11 below.

Table 4.11: Minor ailments

Response	Frequency	Percentage
Yes	9	75
No	3	25
Total	**12**	**100**

From the above table it is evident that 75 percent of the respondents offered treatment for minor ailments, 25 percent of them did not. This service was not rendered at the community psychiatric clinic in Fort Beaufort. Patients presenting with minor ailments were referred to the primary health clinics nearby.

Having all these services, that is, psychiatric and general health services under one roof increases access to service and saves the patients from being shunted from one place to another.

4.2.2.2 In-patient beds for overnight cases

Sometimes patients may need to be kept overnight for observation. Respondents were asked if there were overnight services for patients who needed such services. Table 4.12 reflects their responses.

Table 4.12: In-patient bed

Response	Value	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

Table 4.12 shows that 100 percent of respondents stated that there were no in-patient beds in any of the clinics. No services for lying-in patients were available at these clinics. Some patients, after administration of certain drugs, might need to be detained for observation for up to twenty four hours. Thus, in-patient beds need to be made available.

4.2.2.3 Emergency services

The respondents were asked if they had emergency or accident units at their clinics for treatment of general emergencies. The following table reflects the responses to the question.

Table 4.13: Emergency/Accident Unit

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

Table 4.13 shows that all the respondents stated that there were no emergency/accident units at their clinics. Patients were sent straight to hospital if and when such services were required.

4.2.2.4 Dental services at the clinics

The respondents were asked whether they offered dental services at their clinics or not. The response thereto is reflected in Table 4.14.

Table 4.14: Dental services

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

Table 4.14 shows that all the respondents stated that there were no dental services at all the clinics. Patients requiring dental services were referred to the two general hospitals serving the area.

4.2.2.5 Family planning services at the clinics

The respondents were asked if they offered family planning services at their clinics. The results are shown in Table 4.15 below.

Table 4.15: Family planning services

Response	Frequency	Percentage
Yes	9	75
No	3	25
Total	**12**	**100**

According to the above table 75 percent of the respondents stated that there were family planning services in their clinics. For the remaining 25 percent there were none. The patients had to be referred to other clinics for the service.

4.2.3 Accommodation

Accommodation for discharged patients is an important issue to be considered because some of these patients have been away from the community for a long time and on return to the community may not have a place to stay or a home to return to. The family might not want them or may have moved away to a new place. It may therefore be necessary to have supervised interim places of accommodation, for example, halfway houses.

4.2.3.1 Own or family home

The respondents were asked if the patients they took care of stayed in their family homes or their own homes. The results are reflected in Table 4.16 below.

Table 4.16: Own or family

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

The results in the table above show that the patients stayed either in the family homes or in their own homes.

4.2.3.2 Halfway houses for the patients

The respondents were asked whether there were any halfway houses to accommodate the patients after discharge from hospital. The results are shown in Table 4.17 below.

Table 4.17: Halfway houses

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

The table above shows that 100 percent of the respondents said that there were no halfway houses for the discharged patients. Patients went straight from hospital to their homes in the community.

Halfway houses, according to Vlok (1984), form bridges between the patient and the community. It is in such places that patients can be further rehabilitated before turning them loose into the community from which they have long been separated.

4.2.4 Social Services

In this section the respondents were asked if the following social services such as meals-on-wheels and home help were offered to the patients at home.

4.2.4.1 Meals–on-wheels for patients in the community

The respondents were asked whether social services like meals on wheels were offered to the patients in the community or not. The results are reflected in Table 4.18

Table 4.18: Meals on wheels

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

Results in Table 4.18 show that all respondents stated that no such services for patients existed in the community.

4.2.4.2 Home help for patients at home

The respondents were asked if there was any home help offered to the clients and their families from social services. Table 4.19 reflects the results thereof.

Table 4.19: Home help

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

According to Table 4.19 no social services in the form of home help were available to the patients and their families. The patients were dependent mainly on their families.

4.2.5 Employment services

Employment is one of the basic needs of any individual and yet finding a job presents very real problems for the psychiatric patient. Prejudices and fantasies of employers and other employees about the behaviours to be expected from an ex-patient make it even more difficult (Meacher, (1979). Rehabilitation of these patients is understood to include job training and job finding. Special programmes which recognise the schizophrenic client's special vulnerabilities are helpful (Thornton, Seeman and Plummer, (1997).

4.2.5.1 Job centre for psychiatric patients

Respondents were asked if there was a job centre where psychiatric patients could go to when seeking employment. The results on this question are shown in Table 4.20 below.

Table 4.20: Job centre

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

The results in Table 4.20 reflect that there were no job centres for the patients in the community.

4.2.5.2 Job clubs for the patients in the community

The respondents were asked whether any job clubs for psychiatric patients existed in the community. Table 4.21 below reflects the results thereof.

Table 4.21: Job club

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

From the table above it is shown that no job clubs for psychiatric patients existed in their communities. Jobs are scarce enough for the ordinary person. To a person who is either physically or mentally disabled the chances of getting a job become even less.

Job centres or job clubs are of great benefit to those patients who are ready to prepare for work. A project such as the one run at the Fountain House in Observatory in Cape Town helps prepare patients for work in, at least, three fields, namely, clerical, catering and development (Cullin, 2000).

4.2.6 Education

These patients some of whom have been hospitalised for a long time, may have missed getting a basic education or may have left school early without completing their classes. Going back to an ordinary school may not be the best option for them but they may feel more comfortable in adult education classes.

4.2.6.1 Adult education classes for psychiatric patients

The respondents were also asked whether there were any adult education classes for psychiatric patients in their communities. The results thereof are shown in Table 4.22

Table 4.22: Adult education classes

Response	Frequency	Percentage
Yes	2	17
No	10	83
Total	**12**	**100**

Table 4.22 reflects that the 83 percent of the respondents stated that there were no adult education classes for psychiatric patients. The remainder, 17 percent, stated that there were general adult education classes, but not specifically for psychiatric patients. This therefore meant that they had the one option of attending general adult classes since these classes catered for all the adult population and were not catering for a specific group.

4.2.7 Additional services

The study also investigated whether or not other services that were thought to be beneficial in the rehabilitation of chronic psychiatric patients were available.

4.2.7.1 Recreation club for discharged psychiatric patients

The respondents were further asked if there were recreation clubs in the community for psychiatric patients. The results are reflected in Table 4.23 below.

Table 4.23: Recreation club

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

According to Table 4.23 all the respondents stated that there were no recreation clubs for psychiatric patients in their communities.
This means that there was no formal or organised form of recreation for these patients in the community.

4.2.7.2 Business training club for psychiatric patients

Respondents were asked whether business clubs intended for the use psychiatric patients were available. The results thereof are shown in Table 4.24 below.

Table 4.24: Business training club

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

The results in Table 4.24 show that all the respondents stated that there were no business- training clubs for the patients in the community. Business training clubs are useful in empowering patients with business skills so that they could start their own businesses or find gainful employment.

4.2.7.3 Self-help groups for discharged patients

The respondents were also asked if there were any self-help groups in the community that the patients could join and work with. Responses to this are reflected in Table 4.25 below.

Table 4.25: Self-help groups

Response	Frequency	Percentage
Yes	7	58
No	5	42
Total	**12**	**100**

According to Table 4.25 above 58 percent of the respondents indicated that there were self-help groups in operation in their areas while the remaining 42 percent did not have any. Self-help groups and support groups assist in maintaining people in the community and reduce the rate of readmission to hospital, while the sharing aspect of the group serves to enhance coping abilities (Pogenpoel, 1993; Makhale & Uys, 1997).

4.3 UTILISATION OF AVAILABLE SERVICES

In this section of the study the researcher investigated whether the available services were utilised or not.

4.3.1 Patients seen per appointment

The respondents were asked whether all the patients were seen per appointment.

Table 4.26: Seen per appointment

Response	Frequency	Percentage
Yes	10	83
No	2	17
Total	**12**	**100**

According to Table 4.26 above 83 percent of the respondents stated that all patients were seen per appointment while 17 percent said not. This shows that the majority of patients made an effort to keep their appointments. Appointments help to remind the patient to go for check ups as well as enable the care giver to keep track of her/his patients and to be able to easily pick up on those that default on treatment.

4.3.2 'Drop in' visits by patients

The respondents were asked if any of the patients dropped in without any making appointments. The results are reflected in Table 4.27 below.

Table 4.27: 'Drop in' visits

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

The results in the table above show that all the respondents stated that some patients did come in outside the appointment times. This meant that they would miss the visiting community psychiatric nurse on the appointed date or they had concerns that required prompt attention and could therefore not wait for the next appointment.

4.3.3 Treatment defaulters

The respondents were asked if any of the patients failed to turn up for treatment. Table 4.28 reflects the results thereof.

Table 4.28: Defaulters

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

The results in Table 4.28 show that all the respondents stated that there were patients that sometimes did not turn up for their treatment. When out-patients fail to show up for treatment it becomes necessary for the community nurse to follow up on these patients either by visiting their homes or where possible send a village health worker to check on the patients.

4.3.4 Patients accompanied by relatives

The respondents were asked if the patients came to the clinics accompanied by their relatives. Table 4.29 reflects the results thereof.

Table 4.29: Accompany patients

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

According to Table 4.29 all the respondents stated that the patients came in accompanied by relatives. The families do show their concern and support for their own.

PCL XL Error

Error: IllegalTag

Operator: Main

Position: 12080

4.3.5 Patients visiting the clinic by themselves

The respondents were asked if the patients ever came alone to the clinic. The results are reflected in Table 4.30 below.

Table 4.30: Ever come alone

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

The table above shows that all respondents said the patients did come alone sometimes.

4.3.6 Voluntary visits by patients

The respondents were asked if the patients came to the clinics voluntarily. The results are reflected in Table 4.31 below.

Table 4.31: Voluntary visits

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

The results in table 4.31 show that 100percent of the respondents stated that patients did come voluntarily to the clinics. This would not necessarily be the same if the patient had relapsed.

4.3.7 Travelling costs between home and clinic

The respondents were also asked if the patients had to pay any fares in order to get to the clinics where they collect their medication. The results thereof are reflected in the table below.

Table 4.32: Travelling costs

Response	Frequency	Percentage
Yes	7	58
No	5	42
Total	**12**	**100**

Table 4.32 shows that 58 percent of the respondents stated that their patients had to pay fares to travel to their clinics while 42 percent stated that they did not since they walked to the clinics.

4.4 EVALUATION OF SERVICES

This section of the study deals with whether the needs of the patients are adequately covered or not.

4.4.1 Adequate cover of patient needs

The respondents were asked if the services rendered at the clinics adequately covered the needs of the patients. Table 4.33 hereunder reflects the results.

Table 4.33: Client needs covered

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

The responses as shown in the table above reflect that all the respondents felt that the needs of the clients were not adequately covered. Some gaps in the community services available for psychiatric patients have been noted from the previous sections and this was also endorsed through the above responses.

4.5 COMMUNICATION

The respondents were asked about their methods of communication both with their clients and the referral hospitals. The responses are reflected in the five tables below.

Table 4.34: Land phones

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

Table 4.35: Cellular phones

Response	Frequency	Percentage
Yes	2	17
No	9	75
Missing	1	8
Total	**12**	**100**

Table 4.36: "Walkie-talkie"

Response	Frequency	Percentage
Yes	3	25
No	9	75
Total	**12**	**100**

Table 4.37: Written communication

Response	Frequency	Percentage
Yes	11	92
No	1	8
Total	**12**	**100**

Table 4.38: Word of mouth

Response	Frequency	Percentage
Yes	12	100
No	0	0
Total	**12**	**100**

According to Table 4.34 all the respondents stated that there were phones in their clinics that they use to communicate with clients and the hospital.

The results in Table 4.35 show that 75 percent of the respondents did not use their cellular phones to communicate with clients and the hospitals, only 17 percent of the respondents used their cellular phones, this they did only when the clinic phones were not working. The remaining 8 percent did not comment.

Table 4.36 shows that only 25 percent of the respondents had "walkie-talkies" at their clinics that they used to communicate with the hospitals, 75 percent did not have any. Radio communication is a quick method of communication and is very

useful when calling for the ambulance service, especially if the driver is out driving somewhere.

According to Table 4.37 written communication was also made use of by almost all the respondents, that is, 92 percent to send information to clients. This was especially useful where clients did not have phones. The remaining 8 percent stated that they did not communicate by writing.

Table 4.38 shows that all the respondents did use word of mouth to communicate especially with their clients. They did this by sending messages through village health workers or any other relevant persons.

4.6 STAFF SUPPORT

In this part of the questionnaire the respondents were asked whether they got any support from their employers and supervisors in the form of extra remuneration and emotional/psychological support for services rendered. This referred to the special danger allowance and the services of a psychologist for the staff.

These serve as a form motivation and also as means of looking after the welfare of the care givers. The need for counselling and debriefing cannot be overlooked.

4.6.1 Extra remuneration

The respondents were asked if they received any form of extra remuneration such as a danger allowance or a clinic allowance especially so for those in the rural clinics.

Table 4.39: Extra remuneration

Response	Frequency	Percentage
Yes	0	0
No	12	100
Total	**12**	**100**

According to table 4.39 all the respondents stated that they did not receive any extra remuneration such as danger allowance or clinic allowance.

4.6.2 Emotional and/or psychological support for staff

The respondents were also asked if they felt there was some form of emotional or psychological support for them through their supervisors or a psychologist.

Table 4.40: Emotional and/or psychological support

Response	Frequency	Percentage
Yes	2	17
No	10	83
Total	**12**	**100**

In the results reflected in Table 4.40 only 17 percent of the respondents felt that they did receive emotional support from their supervisors through monthly meetings. The rest, 83 percent, stated that they did not receive any support.

4.7 STAFF ATTITUDES

This section seeks to elicit the attitude of the clinic health workers towards caring for the chronic psychiatric patients in the community and whether they felt that it was good for chronic psychiatric patients who had been previously cared for in institutions to be cared for in the community now.

4.7.1 Staff attitudes on caring for the chronic psychiatric patients in the community

The respondents were asked whether they felt positive about this move or not.

Table 4.41: Positive attitude toward care for psychiatric patients in the community

Response	Frequency	Percentage
Yes	9	75
No	3	25
Total	**12**	**100**

From the table above 75% of the respondents felt positive about chronic psychiatric patients being cared for in the community, 25% did not.

The majority of the respondents felt that care for these patients among their own families and the community was good for them and all that was needed for them were improved and better services in the community. Those that felt negative about this move stated that there was nothing for them to come back to but just sitting around doing nothing but drinking and smoking. This could result in the patients neglecting themselves and subsequent relapse and possible re-admission to hospital.

4.8 Conclusion

In this chapter the results were presented and discussed. The information that was sought was presented in frequencies and percentages.
Results, broadly, showed that community psychiatric and support services were inadequate.
The next chapter deals with conclusions, recommendations and limitations.

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

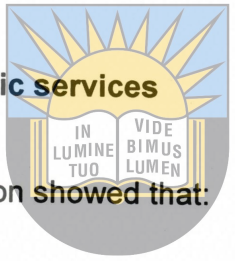
5.1 Introduction

In this chapter the conclusions of the investigation, limitations of and recommendations on community psychiatric services are presented.

5.2 Conclusions

5.2.1 Community psychiatric services

The results of the investigation showed that:



5.2.1.1 The following psychiatric services were not available at the clinics: services of a psychiatrist, services of a psychologist and services of an occupational therapist.

5.2.1.2 Lack of human resources, especially that of specialists, was a problem. This was bound to place a lot of strain on both service providers and patients

5.2.1.3 Services that were available at some of the clinics were emergency psychiatric services, services of resident community psychiatric nurses, services of resident social workers, sheltered employment, psychiatric medication and home visits.

5.2.1.4 None of the clinics had 24hour service, therefore even those clinics that offered emergency psychiatric services only did that during normal working hours on week days. Patients in need of urgent care after hours had to go straight to the hospital.

Community psychiatric services were not well developed and did not adequately cover the patients' needs.

Kaleb (1999) emphasizes the fact that in the reorganization of psychiatric service there should be multidisciplinary teamwork, in which a social worker, nurse, doctor and psychologist actively participate in the care of the patient. Mental problems of patients caused by social, biological and psychological factors could then be handled in a shorter time and with higher quality. He further adds that other professionals such as physiotherapists and occupational therapists could participate in the multidisciplinary team enabling a complete approach to the needs of the patient.

5.2.2 General services including social services, accommodation and employment services

5.2.2.1 The following general services were not available at any of these clinics: in-patient beds for overnight stay, emergency or accident units, dental clinic, halfway houses, meals on wheels, home help from social services, job centers and job clubs, recreation clubs, and business training clubs. The first three were only offered at hospital level.

Lack of the above services can be attributed to the under development of the rural areas of the Eastern Cape and, broadly, to its poor socio-economic state.

5.2.2.1 The following services were available at community level though not all the clinics offered them: minor ailments services, family planning services and self help groups.

All the primary health care clinics offered minor ailments and family planning services. The community psychiatric unit in Fort Beaufort offered only psychiatric services. All patients discharged from the hospital go through this unit and are then referred to their local clinics for follow up care where they are seen once a month by the visiting community psychiatric nurse from the community psychiatric unit. This means that only this health worker is responsible for the psychiatric follow-up care and assessment of these patients. The other general nurses see to the physical problems of the patients.

5.2.3 Utilisation of services

5.2.3.1 Available services were fairly well used by clients. As a result most patients were seen per appointment but there were those that just dropped in any day or time. Both patients and families made use of services available to a large extent. However, there was also a degree of non-compliance in all the clinics. Some patients that did not turn up at all for their monthly check ups and supply of treatment. Non-compliance is one of the causes of relapse in patients in the community setting.

5.2.3.2 Some of the patents had to travel long distances to get to the clinics and as such traveling costs were implicated. This meant that if they did not have fares at some point in time patients and their escorts had to walk long distances to get to the treatment points. These could be some of the reasons why patients failed to turn up for their appointments.

In a study conducted by Solombela and Uys (1994) distance from the clinic was found to be one of the factors influencing the relapse rate of patients treated in the community.

5.2.4 Evaluation of services

On evaluation, the services were found to be inadequate. Not all client needs were covered. According to comments made by some of the respondents, a one-stop centre where all services were offered was a priority need. For example, a primary health clinic that included psychiatric services, social welfare services, dental services, emergency services, minor ailments, family planning services and others under one roof. This would help avoid sending a patient from one clinic or service to another situated elsewhere.

5.2.5 Communication

5.2.5.1 There was a fairly good communication network between clinics and the hospital. Land phones were available at all the clinics. Staff only used their own cellular phones when the clinic phones were not working.

5.2.5.2 Communication with clients was mainly by hand post or by word of mouth sent through relevant persons. This is not a very reliable method of communication.

5.2.6 Staff support

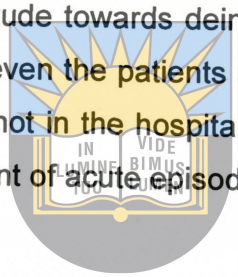
5.2.6.1 The majority of health workers felt that they did not get any emotional or psychological support. Visits by their supervisors were scarce and far apart.

5.2.6.2 None of them received any incentives, such as clinic or danger allowance. It was felt that motivation for staff to work and remain in this kind of service would be enhanced if they were to receive some sort of incentive and psychological support. The clinics were, mainly situated in the rural parts away from the comforts of urban areas.

5.2.7 Staff attitudes towards care of patients in the community

5.2.7.1 It also was established that the majority of the health workers were positive towards the move to keep these patients in the community.

5.2.7.2 Further comments showed that they thought that the living conditions of the patients and also the community health services needed to be improved considerably for the patients to be successfully maintained in the community. In a study conducted by Mzimela (2001, p157) it was found that the attitude towards deinstitutionalisation was almost 100% positive because even the patients and their relatives agreed that, "the patient's home is not in the hospital; the hospital is a temporary home for the management of acute episodes but not a permanent home"



5.3 Limitations

The major limitations of this study have been identified as follows:

5.3.1 The area covered in this study was small and mainly rural and is, basically, in a poorly developed and low economic region. Findings of this study, therefore, cannot be very well generalised to other well-developed regions.

5.3.2 Inaccessibility or scarcity of relevant instruments suitable for the study and previous research reports on similar topics.

5.4 Recommendations

On the basis of the above findings several recommendations are made:

5.4.1 Recommendations on lack of human resources

5.4.1.1 Relevant personnel to overcome shortage of both nurses and doctors. More funding should be made available by the government to run a more comprehensive service for patients in the community. This, though, does not mean that every clinic should have all the members of the multidisciplinary team but that they could be shared between the clinics as visiting specialists

5.4.1.2 General nurses and doctors working in the primary health care clinics should also be given training in psychiatry, through in-service training, so as to help overcome the burden of the shortage in this speciality at community level. This could also prove to be cost effective in the long run.

Freeman (1990) advocates that psychiatric community services would benefit from shifting some responsibility for mental health to general nurses, since this would provide greater availability of care, increase the range of services that could be provided and improve the overall quality of care. He further states that freeing the community psychiatric nurse for other important tasks would benefit the service. Such tasks would be providing continuing education and support to the clinic nurses, manage problem patients, follow up non-attenders and be involved in other community mental health activities such as prevention and promotion

5.4.2 Recommendation on lack of support services in the community

The following are the recommendations made:

5.4.2.1 Special programmes that recognise the schizophrenic client's special vulnerabilities would be helpful.

5.4.2.2 Non-governmental organizations can be involved in the after-care of the patients. These organizations can help with occupational therapy, job training and job finding, shelter and support services. Unused hospital units can be made use of by turning them into day care centres for use by those patients who have homes, occupational therapy centres and also can serve as interim or halfway houses. This allows for supervised transition from hospital to community care.

5.4.2.3 A one-stop center that offers all the necessary services for these patients and their caregivers is also recommended. The clients would then be able to get most, if not all, of the relevant services under one roof. For example, if the patient has been referred to the social worker or physician, both services must be available within the same center in order to enhance continuity and accessibility of the service.

5.4.2.4 Establishment and use of support or self-help groups for both patients and families is another area that needs to be encouraged.

5.4.2.5 In these groups the clients could share their experiences and problems related to mental illness, learn coping strategies in a supportive environment and also support one another. The

community psychiatric nurse would act as the facilitator for these groups.

5.4.3 Recommendations on accessibility of services

The following are the recommendations made:

5.4.3.1 To help meet the patients halfway, regular mobile clinics as well as good roads should be made available. Thus traveling into the far rural areas would be easy especially on the vehicles used to take services closer to the people.

5.4.3.2 Distances from home to clinic for some patients are long and as such traveling costs are involved. Mobile clinics should visit those living far from the clinics

5.4.3.3 24hour emergency services are also recommended. Some of the problems are acute and require immediate attention, so help should be accessible and within reach. In addition, from the lessons learnt from deinstitutionalisation, Stein, Allwood & Emsley (1999) suggest that a highly structured 24-hour service is necessary for the effective treatment of some for these patients.

5.4.3.4 Emergency psychiatric drugs and protocols for use should be made available, too.

5.4.4 Recommendations on staff motivation

The working conditions in rural settings are different from those in an urban set up and not many people show interest in working away from cities and in

isolation. It therefore becomes important that those who have to work under those conditions be given adequate support and incentives.

The following recommendations were made:

5.4.4.1 Incentives, in kind or financial, can be used to motivate staff. These would be useful in helping to reduce or prevent burnout.

5.4.4.2 Living out in a clinic in the rural area, away from one's family where some of the city comforts are non-existent can be de-motivating. A clinic allowance, for instance, can attract staff to commit to serve in these places.

5.4.4.3 Skills development and empowerment for staff is also another powerful motivating instrument. For example, primary health care nurses and doctors can be given sufficient orientation or training that will enable them to provide mental health care at primary level with efficiency.

5.4.4.4 According to Freeman (1990), it is apparent that many general nurses throughout the world are reluctant to take on the mental health function. There is fear of violence from the mentally disturbed patients. However, when the nurses are empowered through training and experience they feel confident of their skill and are more sympathetic to mental health issues and patients than before.

5.4.5 Recommendations for policy makers

The following recommendations were made:

5.4.5.1 Inclusion of service users in the policy making process. This would serve to empower them.

5.4.5.2 People with mental illness are rarely if ever involved in policy-making processes, though these processes impact on them and their quality of life at the end of the day (Tarlton, 1997). The Department of Health should develop links and formalize partnerships with service users so as to make sure that services developed respond well to their needs.

5.4.5.3 Promotion of improved mental health services by service providers, especially NGOs

5.4.5.4 Improved information systems can play an important role in creating equity within mental health care system. Provincial and national information systems must be expanded to ensure that mental health information needs are addressed (Dartnall et al., 1999).

5.5 Conclusion

Findings in the foregoing study have shown that the current community services for discharged psychiatric patients are definitely inadequate. Problems encountered included shortage of human resources, lack of community support services needed for maintaining the psychiatric patients in the community, and even those that were available were fragmented. There was, also, lack of support and motivation for staff. In spite of all those problems, there was a positive

response towards deinstitutionalisation among the staff, especially so if the existing conditions of services were to be improved.

Recommendations made include the establishment of one-stop centers and multidisciplinary teams for comprehensive care of patients in the community. This would be especially convenient for the psychiatric patient who, because of his nature of illness, may not always be able to travel alone to different services at different locations. Motivation and support for staff working under these conditions, some at remotely placed clinics, is essential. Intensive orientation or training, in psychiatric care, of general nurses and doctors working in the primary health care clinics should be done in order to bridge the gap in the delivery of community psychiatric services. NGOs should also be involved in providing community support services such as occupational therapy, sheltered employment and accommodation. This would help improve the life of psychiatric patients in the community and their families.

LIST OF REFERENCES

Bachrach, L. (1976*). Deinstitutionalisation: An analytic review and sociological perspective.* Rockville, Maryland: US Department of Health, Education and Welfare, NIMH.

Bailey, K.D. (1982). *Methods of Social Research.* 2nd Edition. London: Collier Macmillan Publishers

Barham, P. and Hayward, R. (1995). *Rehabilitation madness: From patient to person.* Free books Association, London.

Bellack, A.S. (1986). Schizophrenia: Behaviour therapy's forgotten child. *Behaviour Therapy,* 17, 199-214

Bhengu, L. (1989). Getting Black psychiatric patients to comply with treatment. *Nursing RSA,* August, 4 (8).

Bless, C. and Higson-Smith, C. (1995). Fundamentals of Social Research Methods: An African perspective. 2nd Edition. Juta and Company Ltd.

Carson, L.C. and Butcher, J.N. (1992). *Abnormal psychology and modern life.* New York: HarperCollins.

Cullin, K. (2000,June 05). After living hospital: Safety net for mental patients. *Daily Dispatch.*

Dartnall, E. and Porteus,K. (1998). *Tower Hospital: Thinking about deinstitutionalisation: Context, barriers and opportunities.* Unpublished manuscript. University of Witwatersrand. Centre for Health Policy, Department of Community Health.

Dartnal, E., Lee, T., Modiba, P. and Porteus, K. (1999). *Is deinstitutionalisation appropriate?* Unpublished manuscript. University of Witwatersrand, Centre for Health Policy.

Desjarlais, R., Eisenberg, L., Good, B. and Kleinman, A. (1995). *World Mental Health: Problems and priorities in low-income countries.* New York: Oxford University Press.

Freeman, M. (1990). Decentralized responsibility – A way forward for 'homeland' mental health care? *South African Medical Journal,* 77:478-480

Gibson, D.M. (1999). Reduced re-hospitalisation and reintegration of persons with mental illness into community living: A holistic approach. *Journal of Psychosocial Nursing in Mental Health Services*, Nov: 37(11), 20-25

Government of South Africa (2001) Norms manual for severe psychiatric conditions. Pretoria: Government printers, Department of Health.

Gralnick, A. (1987). *The case against deinstitutionalisation.* The Havard Medical School Mental Health Letter.

Hafner, H. and van Heerden, W. (1989). The evaluation of mental health care systems. *British Journal of Psychiatry*, 155:12-17

Hargrove, D.S. and Spaulding, W.D. (1988). Training psychologists for work with the chronically mentally ill. *Community Mental Health Journal, 24*, 283-295

Kaleb, L. (1999). Professional competency in Community Psychiatry: The role of the psychologist. *Med Arh, 53(3), 151-152*

Krupinski, J. (1995). Progress or abandonment. Editorial. *Social Science medicine,* 40(5), 577-579

Lego, S. (1993). Vincent Foster's Suicide: What can psychiatric nurses learn? *Archives of Psychiatric Nursing,* 7(6), 231

Makhale, M.S. and Uys, L.R. (1997). An analysis of support groups for the mentally ill as a psychiatric intervention. *Curationis: 29*(1) 44-49

McCrone, P., Thornicroft, G., Phelan, M., Holloway, F., Wykes,T. and Johnson, S. (1998). Utilisation and costs of Community Mental Health Services. *British Journal of Psychiatry*, 173, 391-398

Meacher, M. (1979). *New methods of Mental Health Care.* Oxford: Pergamon Press.

Mental Health and Substance Abuse Directorate, (2001). The deinstitutionalisation project. *Quarterly Newsletter 2,5*

Mzimela, D.N (2001). *The deinstitutionalisation of psychiatric patients in South Africa.* Unpublished thesis: University of Natal, Durban.

Pilling, S. (1991*). Rehabilitation and community care.* London: Routledge.

Poggenpoel, G. (1993). Trends in Community Psychiatry. *Nursing RSA, 8*(4), 35-37

Porteus, K., Sibeko, M., Lee, T., Soderland, N., Gibson, L and Peprah, E. (1998). Cost and quality of care: A comparative study of public and privately contracted chronic psychiatric hospitals. Centre for Health Policy. Department of Community Health. Paper 53. ISBN:186838-226-5

Scull, A. (1985). Deinstitutionalisation and Public Policy. *Social Sciences Medicine,* 20, 5, 545-552

Rabkin, J.G. (1975). The role of attitudes towards mental illness in evaluation of Mental Health Programs. *Handbook of Evaluation Research, 2:* SAGE publications, Inc.

Seymour,R.J., and Dawson, N.J. (1986). The schizophrenic at home. *Journal of Psychosocial Nursing 26(1):* 28-30

Shulamil, R. (1991). *Beyond Community Care: normalization and integration.* Macmillan.

Smith, G.B., Scwebel, A.T., Dunn, R.L. and McIver, S.D. (2000). The role of psychologists in the treatment, management and prevention of chronic mental illness. *The International Journal of Psychosocial Rehabilitation*

Solombela, P.W. andUys, L.R. (1994) Factors influencing the relapse of outpatients with schizophrenia in the Kentani area of Transkei. *Curationis, 17(3),* 24-28

Stanhope, M. and Lancaster, J.L. (1998). *Community Health Nursing: Process and Practice for promoting health.* St Lois: Mosby.

Stein, D.J., Allwood, C. and Emsley, R.A. (1999). Community care of psychiatric disorders in South Africa - Lessons from research on deinstitutionalisation. *South African Medical Journal,* September, 89 (9), 942-943

Tarlton, J. (1997). *Views and visions of consumers of Mental Health Care in Gauteng: Results of survey.* Rivonia. Unpublished manuscript.

Telias, D., Fronsky, A. and Umansky, R. (2000). Developments in psychiatric rehabilitation: a therapeutic trip. *International Journal of Psychosocial Rehabilitation, 5,* 53-60

Thornicroft, G. and Bebbington, P. (1989). Deinstitutionalisation: From hospital closure to service development. *British Journal of Psychiatry, 155:* 739-753

Thornton, J.F., Seeman, M.V. and Plummer, E.D. (1997). Schizophrenia: Rehabilitation. *Internet Mental Health.* Reprint. Canada: The Professional Services Department of Merrell Dow Pharmaceuticals Inc.

Torrey, E.F. (1986). Continuous treatment teams in the care of the chronically mentally ill. *Hospital and Community Psychiatry, December,* 37(12), 1243-1247

Torrey, E.F. (1988). *Surviving Schizophrenia: A family manual.* New York: Harper and Row.

Uys, L.R., Dlamini, N.K. and Mabandla, A.P. (1995). A profile of selected psychiatric outpatients in South Africa. *Curationis*, 18(1), 22-25.

Viger, J, (2001). *Community Mental Health* Centres. Conway: The Echo Group.

Vlok, M.E. (1984). *Manual of Community and Psychiatric Nursing.* Cape Town: Juta and Company, Ltd.

Vlok, M.E. (1991). *Manual of Community Nursing and Communicable diseases.* Cape Town: Juta and Co. Ltd.

Vogelman, L. (1986). Apartheid and Mental Health. OASSA Conference, 17-18th May 1986. Witwatersrand.

Weiten, W. (1995). *Themes and Variations.* Pacific Grove: Brookes/Cole Publishing Co.

APPENDIX A

QUESTIONNAIRE

N.B. Please do not identify yourself in any way in this questionnaire

Indicate your response by marking with an X in the appropriate space

SECTION 1: AVAILABLE COMMUNITY SERVICES:

Psychiatric Services.

1. Emergency clinic? yes no
2. Psychiatrist? yes no
3. Psychologist? yes no
4. Comm. psychiatric nurse yes no
5. Social Worker? yes no
6. Occupational therapist? yes no
7. Sheltered employment? yes no
8. Medication? yes no
9. Health Education yes no
10. Home visits yes no

COMMENTS:

General Health Services.

11. Minor Ailments? yes no
12. In-patient bed? yes no
13. Emergency/accident unit? yes no
14. Dental services? yes no
15. Family Planning Services? yes no

COMMENTS:

Accommodation.

16. Own
17. Family homes? yes no
18. Halfway houses? yes no

COMMENTS: yes no

Social Services.

19. Meals on wheels?
20. Home help? yes no

COMMENTS: yes no

Employment services:

21. Job centre?
22. Job club? yes no

COMMENTS: yes no

Education:

23. Adult Education classes

COMMENTS: yes no

Additional Services.

24. Recreation club
25. Business training club yes no
26. Self- help groups yes no

COMMENTS: yes no

SECTION 2

UTILISATION OF AVAILABLE SERVICES.

Patients

27. Seen per appointment yes no
28. 'Drop in' visits yes no
29. Any defaulters yes no

Family

30. Accompany patients yes no
31. Ever come alone yes no
32. Voluntary visits yes no

Accessibility of services to users

33. Hours of service (time) from to
34. Distance (approximate) from to (farthest area served)
35. Travelling costs yes no

COMMENTS:

SECTION 3

EVALUATION SERVICES

36. Do services cover client needs well? Yes no
37. If not, what other services do you think should be included?.....

COMMUNICATION

38. Phone yes no

39. Cellular phones yes no
40. "Walkie-talkie" yes no
41. Written communication yes no
42. Word of mouth yes no

COMMENTS:

SECTION 5

STAFF SUPPORT

43. Financially, extra remuneration such as danger allowance yes no
44. Emotional and/or psychological support yes no

COMMENTS:

SECTION 6

STAFF ATTITUDES

45. Do you feel positive about caring for chronic psychiatric patients in the community? yes no

COMMENTS:

Thank you for your co-operation!!!