CHALLENGES OF INTEGRATING MENTAL HEALTH CARE USERS INTO THE COMMUNITY AFTER DISCHARGE FROM A PSYCHIATRIC INSTITUTION: THE CASE OF FORT BEAUFORT, RAYMOND MHLABA SUB-DISTRICT, SOUTH AFRICA

BY

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DECLARATION

I, the undersigned, declare that this thesis entitled "Challenges of integrating mental health care users in the community after being discharged from a psychiatric institution: the case of Fort Beaufort, Raymond Mhlaba Sub- District, South Africa", submitted to the University of Fort Hare for the degree of Magister Curationis in the Faculty of Health Sciences, and the work contained herein, is my original work and that, where sources have been used, they have been acknowledged with citations, and that this work has not been submitted to any other University in partial or entirely for the award of any degree.

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I, Yvonne Nomamerika Tom, student number: 201415236, hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations.

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CERTIFICATION

This thesis entitled “Challenges of integrating mental health care users in the community after discharge from a psychiatric institution: A case of Fort Beaufort, Raymond Mhlaba Sub-District, South Africa” meets the regulation governing the award of the Degree of Magister Curationis of the University of Fort Hare and is approved for its contribution to scientific knowledge and literary presentation.

Prof DT Goon

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03/04/2018

Supervisor

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DEDICATION

This thesis is dedicated to my late parents, two sisters and my brother; I wish they could see how much I have achieved in my life and I hope they are smiling and rejoicing wherever they are. This is for you guys, I will always be grateful to you.

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ABSTRACT

The purpose of the study was to examine the factors contributing to the inability to integrate discharged mental health care users into the community of Fort Beaufort in the Raymond Mhlaba Sub-District. Mental illness is highly stigmatized and there is low public awareness on the intricacies of mental illness amongst the communities. Mentally ill people are destitute and struggle to find employment and the relations between the users and their families are tense.

A phenomenological approach was used to capture the lived experiences of the study participants. An explorative, descriptive research design was used to explore the challenges encountered by mental health care users with regard to their integration into the community. A qualitative research approach was deemed most appropriate for fostering an in-depth understanding of the challenges faced by mental health care users and the meaning attached to such experiences in relation to the integration in the community. Data was collected using an unstructured interview guide. Interviews were audio-taped and transcribed verbatim. 19 participants participated in the study.

The data base and guidelines on how to analyse data were provided to an independent coder and consensus was reached regarding themes. Four themes emerged from the interviews namely: incongruent mental health services, negative attitudes, non-prioritization of community mental health services and facilitators of integration.

The findings revealed that culturally incongruent mental health care services rendered by mental health care professionals were restrictive as they were based on the Western healing system and did not recognise the indigenous healing system, rituals, customs and spirituality of the users. Relatives and community members stigmatized and violated the rights of the mentally ill, rejected and discriminated against them. Community mental health services were not prioritized and there was a shortage and unequal distribution of material and financial resources, with the bulk allocated to hospitals. Infrastructure in community clinics was of poor quality and there was no multi-disciplinary team at community level.

In conclusion, the study highlighted that mental health care users were not accepted by their own families and the community at large. Mental health care professionals in primary health facilities lacked training and knowledge about mental illness. There seemed to be lack of preparation and readiness of the users and their families for re-integrating the mental health care users into the community of Fort Beaufort in the Raymond Mhlaba Sub- District.

Key words: Mental Health Care Users, Challenges, Community integration.

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CHAPTER ONE

1.1 INTRODUCTION AND BACKGROUND

Mental health care users discharged from mental health institutions are expected to be integrated back into their own communities while recovering from residual symptoms of mental illness and continuing with their rehabilitation programme. Central to the rehabilitation process is the re-integration of the user into the community (Uys & Middleton, 2014:53). Such a move is part of the deinstitutionalisation process by which large numbers of patients are discharged from public psychiatric institutions back into the community to receive outpatient care (Kaplan & Sadock, 2003: 1377).

The rehabilitation programme is preceded by the assessment of the care needs of the users, for example, a proper place to stay, food, accessories for personal hygiene, knowledge of medication administration and management, clothing and activities for socialising. Similarly, Uys and Middleton (2014:300) state that such an initiative boosts the self-esteem of the users and promotes their re-integration back into their communities. Another enhancer of integration is the accessibility of Community Mental Health Services which are provided within a walking distance to a patient's residence and place of work (Caplan, Anderson & Weber, 2004).

The benefit of close proximity is that the illness could be identified early; leading to early diagnosis, treatment and prevention of complications and that brief hospitalization can thus be instituted only when the need arises. Providing stable housing for the users after they have been discharged from hospital is associated with beneficial results related to integration, like reduced instances of substance abuse; lower rates of hospital use; higher quality of life; and several other positive mental health outcomes (Kyle & Dunn, 2008). The author further states that the foundation of discharge planning is a thorough knowledge of the available resources for sustainable care in the community. The knowledge of available resources in the community could be identified as an enhancer of effective integration.

It is stated that, for a successful integration of the discharged users, the community mental health care centre where the discharged users are receiving services and follow up care, should be easily accessible and provide basic psychiatric services such as emergency services for 24 hours (Kaplan & Sadock, 2003:1374). In addition, a community mental health care centre should provide day care services, follow-up after care services for those who had been hospitalized, transitional housing, alcohol and drug abuse services, half-way houses and a broad range of out-patient services (Kaplan & Sadock, 2003:1374). Furthermore, the deinstitutionalisation process assumes that support services for the users, for example, entitlements, material assistance and psychosocial support, are available to enable the users, to function effectively outside the institutional setting (Carrol, 2004:122).

The success of the deinstitutionalisation process is partly dependent on the engagement of the users, family members, and communities, in the discharge planning initiatives. Dolamo, in Mchunu (2009:5), affirms that the achievement of an appropriate health care delivery system requires the involvement of people at grassroots level as part of the process so that the services can be utilised effectively. People at grassroots begin at home with an individual and the immediate family, for example, parents, spouses, siblings or offspring as they are the ones who are always together and see one another more frequently than a psychiatric nurse who is visiting only for help. Helping patients to remain stable and supported in a community to live to their particular abilities and limitations is the central task of the relatives, more so as they operate within their own cultural context.

As a source of psychosocial support, the relatives are a key factor in the recovery and integration of clients with residual psychiatric illnesses (Videbeck, 2013). Parents and relatives are expected to have a positive attitude and positive disposition towards their own user. Of importance to note, is that health care professionals cannot totally replace the relatives of the mental health care user, hence the need for the nurse to encourage relatives to continue providing support to the user in hospital and at home. At times, the lack of relatives' knowledge hampers caring for their loved ones and that exacerbates the stigma and discriminatory practices (Mashau & Davhana-Maselesele, 2009: 40-7). The relatives, therefore, ought to be empowered with knowledge on managing the user at home, on the early signs of relapse and be encouraged to take their family member for help as soon as possible before he or she becomes unmanageable, so as to prevent readmission (Salter & Turner, 2008:153). Such an initiative could serve as a critical factor in enhancing the integration of the discharged user into the community. Uys and Middleton (2014:54) outlined several factors that could enhance integration, namely, the elimination of negative attitudes related to stigma, discrimination and exclusion; 'optimizing symptom control', which is done through medication and psychotherapy. With regard to the role of communities in the integration of discharged users, Kaplan and Sadock (2003: 1375) state that communities should participate in decisions about their mental health care needs and programmes, instead of allowing them to be totally managed by professionals.

Furthermore, mental health services need to be sensitive to the needs of those served, especially where the public is actively involved. In this regard, there is a need for the members of the multi-disciplinary team to be aware of, and develop strategies to, mitigate the challenges to re-integration of the discharged users. The challenges to the integration of users are linked to the stigma attached to mental illness, situations when their rights are violated, some members of the community regard them as insane, not in the right frame of mind to do any meaningful work, and are considered to be dangerous and, when employed, they are underpaid and are continuously at an entry level of employment (Uys & Middleton, 2014).

1.2 PROBLEM STATEMENT

The re-integration of users into the community plays a very significant role in ensuring that mental health care users achieve their purpose in life. Mental health care users develop a sense of belonging and enriching relationships with their families, and are encouraged to participate and contribute to community life (Zhenru & Jern Yi, 2014:228-9). Their re-integration enables them to be accepted members of their various communities (Baumgartner & Herman, 2012:435). However, it is observed that the monthly statistics of the only mental health care hospital in the Raymond Mhlaba Sub-District indicates that the number of readmissions is, at times, higher than the number of newly admitted clients; and this is obtainable from the local psychiatric hospital admission register.

It may appear that the revolving door syndrome is caused by poor preparation of mental health care users and their families for integration into the community. Mental illness is highly stigmatised, and there is low public awareness on mental health among the communities (Dako-Gyeke & Asumang, 2013:1). The community has no activities that keep the users occupied, and there are no skills training or programmes taking place, thus leading to the users roaming the streets of Fort Beaufort and the surrounding communities. People suffering from mental illness are socially segregated, destitute, and struggle to find employment and sometimes have no proper place to stay and end up living in the streets. At times, relations between the mental health users and their families become tense, leading to the families dissociating themselves from the users (Dako-Gyeke & Asumang, 2013:3, 5). The challenges which negatively impact the re-integration of the users who have been discharged from a local hospital back into the community of Raymond Mhlaba Sub-district are unknown and have never been explored. The focus of this study, therefore, was to investigate such challenges as perceived and experienced by the users and their relatives as well as the members of the multi-disciplinary team. The challenges to integration make it difficult for users to return to their prior environment or other suitable community-based setting (Elder, Evans & Nizette, 2009: 213). The identification and prevention of the challenges to the re-integration of the users from the local psychiatric hospital into the Raymond Mhlaba Sub-district has a potential to promote their re-integration. When the users are integrated they will begin to experience and enjoy being mentally healthy, which is, "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2013: 9).The mental health care users will develop a sense of belonging and enriching relationships with their families, will be independent and will be motivated to participate and contribute to community life and, most importantly, will experience decreased episodes of mental illness (Kramers-Olen, 2014:501; Zhenru & Jern Yi, 2014:228-9).

Their re-integration will enable the mental health care users to be accepted members of their various communities (Baumgartner & Herman, 2012:435). With respect to children who are users, emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society (WHO 2013 – 2020 Mental Health Action Plan: 6).

1.3 PURPOSE OF THE STUDY

The purpose of the study was to explore the underlying factors contributing to the inability to integrate discharged mental health care users into the community, in order to inform public health policy based on the findings of the study.

1.4 RESEARCH OBJECTIVES

Research objectives of the study were to:

- Explore the socio-cultural factors contributing to the re-integration of mental health care users into their communities.
- Explore the psychological factors contributing to the re-integration of mental health care users into their communities.
- Explore the institutional structures in terms of administrative and communication strategies in the re-integration of mental health care users into the community.
- Explore the role of stakeholders in the re-integration of health care users into the community.

1.5 RESEARCH QUESTIONS

In order to answer the research objectives, the following research questions were framed:

- What are the socio-cultural factors contributing to the re-integration of mental health care users into their community?
- What are the psychological factors contributing to the re-integration of mental health care users into their community?
- What are the administrative and communication strategies impacting on the re-integration of the users into the community?
- What is the role of stakeholders in integrating mental health care users into the community?

1.6 SIGNIFICANCE OF THE STUDY

The results from this study have a potential to reduce the current burden on psychiatric nurses whose workload is increased by the failure of the re-integration of discharged users into their communities as such users are readmitted into hospital. The promotion of reintegration could have an added advantage of reducing the burden of mental illness to the user, the family, the mental health facilities and the resources of the state.

The users could enjoy a state of complete health, which includes mental health, as cited in the 2013 – 2020 WHO Mental Health Action Plan that ‘there is no Health without Mental Health”.

The findings of the study might potentially promote a dialogue between the Raymond Mhlaba District community, the staff and management of the only local mental health institution together with its surrounding primary health care clinics. The discourses have the potential to improve the lives of the users and their relatives within society. Funds and human resources could be made available to improve services, raise awareness, and help prevent mental illness and place emphasis on effective recovery of the discharged mentally ill individuals. This could also reduce the revolving door syndrome.

1.7 OPERATIONAL DEFINITIONS

1.7.1 Mental Health

The World Health Organisation (WHO: 2013 – 2020 Action Plan) definition of mental health will be adopted in this study as it relates to a discharged mental health care user who enjoys a complete state of well-being, is able to realise his/her potential, to cope with normal stresses of life, is able to work productively and to contribute to his/her community. Mental health is the foundation for effective individual well-being and the effective functioning of a community.

1.7.2 Discharge

The South African Oxford Dictionary (2008) defines discharge as to allow someone to leave. In this study, this term refers to the mental health care user who has stabilised and has been released from the local Mental Health institution to continue with his/her treatment programme from home at the nearest health facility, as a part of the integration process.

1.7.3 A mental health care user

A “mental health care user” refers to a person receiving care, treatment and rehabilitation services or using health services at a health establishment aimed at enhancing the mental health status of a user, state patients and mentally ill prisoners and, where the person concerned is below the age of 18 years or is incapable of taking decisions, and, in certain circumstances, may include: prospective users; the person's next of kin; a person authorised by any other law or court order to act on that person's behalf; an administrator appointed in terms of this Act and an executor of that deceased person's estate. (Government Gazette, 2002:10).

1.7.4 Integration

According to Merriam Webster (2013), integration is the incorporation as equals, into a society or an organisation of individuals of different groups. Integration in this study refers to a discharged mental health care user whose human rights are upheld, who experiences a sense of belonging, self-determination, feels accepted, respected, valued and resourceful as a community member and enjoys freedom of association without discrimination and alienation.

1.7.5 Experience

Merriam Webster (2013) refers to experience as practical knowledge, skill or practice derived from direct observation or participation in events or in a particular activity. In this study, the researcher explored and described the experiences and views of the participants on their own experiences of sensing, interpreting and comprehending the phenomenon of integrating the discharged mental health care users in the community of the Raymond Mhlaba Sub-District.

1.7.6 Community

In this study, community refers to a group of people who are known to each other and reside in the same demarcated area, in the case of this study being the Raymond Mhlaba Sub-District. According to Visser (2012: 5), community refers to people in a specific geographical area and time; it can refer to a social system, to a constructive way of life or a socio-political organisation.

1.8 CHAPTER OUTLINE

The background to the study, problem statement, aim, objectives, and research questions, significance of the study, and the definitions of key operational terms are described and presented in Chapter 1.

Chapter 2 focuses on the literature review. In this chapter, the integration of mental health care users in the community, the benefits of integration, and the roles of the family in the integration of mental care users were described. Also, the dynamics of successful integration and lack of integration, de-institutionalisation of mental health care users, and the impact of deinstitutionalisation programme on families were presented. Finally, the challenges of interaction of mental health care users are described.

Chapter 3 describes the research methodology that is used in this study. Aspects such as the design used for the execution of the study, the settings, population, sampling and sample size, the research instruments, the validity and reliability (trustworthiness) of the data collection and ethical considerations are discussed. This is followed by a description of the methods for gathering data. Finally, the steps involved in qualitative data analysis are described.

Chapter 4 presents and discusses the results of the study.

In Chapter 5, a summary of the pertinent findings, together with the limitations and strengths of the study, is provided. This is followed by the conclusions and recommendations.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents the literature reviewed pertaining to the integration of mental health care users into the community, the benefits of integration, the roles of the family in the integration of mental care users, the dynamics of integration (successful integration and lack of integration), the de-institutionalisation of mental health care users, the impact of deinstitutionalisation programme on families, and the challenges of interaction of mental health care users. The literature reviewed is of a limited scope, as an attempt to ensure that openness to the process of discovery on new information was not inhibited by preconceived ideas (Holloway, 2005:150; Burns & Grove, 2009:91).

2.2 INTEGRATION OF MENTAL HEALTH CARE USERS INTO THE COMMUNITY

Simply stated, integration is the successful rehabilitation of the discharged mental health care user to his or her pre-illness status and role in the community. The user feels accepted, respected, resourceful, enjoys independence as well as a sense of belonging to the family and community. The focus of integration is to ensure that the discharged mental health care user is assisted to cope with the transition from hospital to the community and that his/her needs are met in totality. According to Petersen & Lund (2011), the integration of mental health into the existing services has the potential of lessening the stigma attached to mental illness and the opportunity to provide an all-inclusive care to the mentally ill users. The multi-disciplinary team together with the relatives and the user's community are the active participants in planning for the discharge of the users. Such a process forms the basis for the re-integration of the users into the community.

The integration also contributes towards promoting the rehabilitation of the user as a component of reintegration into the community and prevents readmission (Uys & Middleton, 2014:300). Kaplan and Sadock (2003:1374) state that each community mental health care centre must provide basic psychiatric services such as emergency services for 24 hours, community consultation, day services, follow-up care for those that are in the hospital, temporary halfway-houses for aftercare services and a broad range of outpatient services. It is important that the assessment of the care needs of the mental health care users are carried out, the family is involved and that the community services for follow-up are identified.

With regard to the role of communities in integrating discharged users, Sadock and Kaplan (2003:1375) state that communities should participate in decisions about their mental health care needs and programmes and not rely on health care professionals. Furthermore, mental health services need to be sensitive to the needs of those served, where the public is actively involved. The process of discharging mental health care users back to the community needs communication, interaction, and collaboration between the multi-disciplinary team and the multi-sector team.

2.3 BENEFITS OF INTEGRATION

Rehabilitation programmes are beneficial to discharged mental health care users; as such programmes assist them to meaningfully integrate with the society at large and to lead independent lives amongst their own families and the community (Yanos, Stefanic & Tsemberis, 2012:438; Iancu, Zweekhorst, Veltman, van Balkom & Bunders, 2015). According to Iancu et al. (2015: 175), it is the responsibility of mental health care professionals to engage the communities, and assist in mental health care users' transition into society. Rehabilitation programmes for discharged mental health care users include empowerment with self-reliance and preservation skills for them to enjoy quality health (Whitley, Gingerich, Lutz & Mueser, 2009:202; Kramers-Olen, 2014:498). Kaplan and Sadock (2003) further state that such services should be integrated and balanced, so that the appropriate treatment modalities are available to fit the patients' needs including screening before hospitalization and follow up care for those who have been discharged from hospital. By participating in such programmes, users get a sense of belonging and a chance of choosing their own pathway to better health rather than mental health care professionals choosing on their behalf, which could result in users losing their confidence and self-respect (Kramers-Olen, 2014:499; Pernice-Duca, Biegel, Hess, Chung & Chang, 2015:447).

Whitley et al. (2009:202) maintain that well rehabilitated mental health care users are able to set achievable health outcomes, improve their overall performance, live in acceptable ways, and properly manage their signs of mental illness, which is an indication of being well integrated into their families and communities. According to WHO (2008: 9), integrated individuals need to have unlimited civil, cultural, economic, political and social rights. Discharged users need to be able to earn an income, lift themselves out of poverty, gain access to treatment and support, to reintegrate into their communities and recover from illness.

2.4 THE ROLE OF FAMILIES

The families of mentally health care users shoulder the greatest part of the burden of caring for them, as they are the main resource for the user (Uys & Middleton, 2014:88). The families play a meaningful role in the rehabilitation of discharged mental health care users for successful integration as their involvement leads to decreased episodes of recurrence of mental illness (Kramers-Olen, 2014:501). Continuous, long-term caregiving leads to significant stress, often referred to as the “family burden” or the “care giving burden”, which includes physical burden, social burden, emotional burden and financial burden (Uys & Middleton, 2014:90). It, therefore, behoves of the mental health care professionals to provide continuous support to the families to mitigate the impact of care giving. Oruche et al. (2014: 244) report that it is crucial that caregivers motivate and encourage their mentally ill relatives to take part in programmes that will help them manage their conditions. According to Mokoena-Mvandaba (2013:30), relatives of the mentally ill users are grateful for the opportunity of taking care of their mentally ill relatives. As stated in Pernice-Duca et al. (2015:448-453), meaningful engagements and active involvement of the relatives of the discharged mental health care users in the rehabilitation programmes reduces the workload of looking after their mentally ill relative, improves their relations as the users begin to assume their normal roles, display positive behaviours and a sense of independence.

2.5 MANIFESTATIONS OF SUCCESSFUL INTEGRATION

As much as there are challenges in integrating mental health services into primary health care, there are also positives that could improve the lives of people suffering from mental illness. According to WHO (2008), the integration of mental health into primary health reduces the stigma associated with mental illness as all clients are treated the same and mental illness is treated as any other condition. Primary health facilities are at a walking distance from the users homes and there are no financial implications incurred by their families. Another feature of a successful integration is the reduction of family burden as the relatives no longer need to accompany the users to the health facility, resulting in loss of income. The infringement of the user's rights is less likely to take place as they are managed in their communities where the violation of their human rights is less likely to take place.

Factors associated with successful integration also include the availability of safe houses, sufficient mental health care professionals to take care of mental health care users and to properly manage the three tiers of care, primary, secondary and tertiary (Janse van Rensburg, 2005:103). Integration also fosters relations between people suffering from mental illness, their relatives and peers, and develops a lifelong bond with the services, thus leading to reduced readmission rates (Baumgartner & Herman, 2012:435; Patel, Boyce, Collins, Saxena & Horton, 2011:2).

2.6 MANIFESTATIONS OF LACK OF INTEGRATION

Discharged mental health care users who are not re-integrated into their communities become victims of the revolving door syndrome; as they are repeatedly admitted into mental health institutions, they often become homeless, and others end up being incarcerated (Parker, 2014:76). Manderscheid, Atay and Crider (2009:33), report that the patients end up in the justice system due to the non-availability of assistance from community-based services. Financial, structural challenges and stigma attached to mental illness are also manifestations of lack of integration as they contribute towards the inaccessibility of mental health services to the patients (Mojtabai et al., 2011:1752).

Lack of integration is related to limited knowledge and training of health care workers in primary health care facilities on the conceptualization and intervening in mental illness (Condo et al., 2014; Maritz, 2010:62). Patients in remote rural areas rely mainly on mobile services to gain entry to health care, a factor contributing to the inaccessibility of services (Strumpher et al., 2014:50); and lack of transport and socio-economic circumstances, like poverty, unemployment, are the contributory factors towards the inaccessibility of health care services (Dinwiddie, Gaskin, Chan, Norrington & McClearly, 2013:68). This view is shared by Oruche, Downs, Holloway, Draucker and Aalsma (2014:246) who reported that the families of mentally ill teenagers expressed the need for transport to access mental health services. Lack of transport compromises the accessibility of services as patients fail to honour their scheduled appointments, default in taking medication and lose confidence in the health system (Messidor et al., 2011:290; Syed, Gerber & Sharp, 2013:2; Mendenhall, De Silva, Hanlon, Petersen et al., 2014:34; Schierenbeck, Johansson, Anderson & van Rooyen, 2013:114). Maritz (2010:62) states that socio-economic factors related to poverty and unemployment discouraged families from accessing the much-needed resources. Mavundla, Toth and Melina (2009:362) also allude to the fact that not all people suffering from mental illness had assistance from the government, thus leaving families with a huge responsibility of looking after their mentally ill relatives. According to Mavundla et al. (2009:362), relatives taking care of mentally ill family members were, most of the time, absent from work, a contributory factor to reduction in their earnings. Literature reviewed seems to indicate that the removal of factors associated with lack of integration of the discharged mentally ill patients could promote the re-integration of the users back into their communities.

2.7 DE-INSTITUTIONALISATION OF MENTAL HEALTH CARE USERS

In South Africa, hospital care has always been in the forefront, with all the support and services directed to look after institutionalised mentally ill patients (Petersen & Pillay, 1997:1621). A similar scenario is reported by Abera, Tesfaye, Belachew and Hanlon (2014:2) that in low-and-middle-income countries, mental illness is given less attention than physical ailments and that only limited resources are channelled to address the problem. The institutionalisation of mental health care patients had a negative impact as more changes in social dynamics (aging population, increase in ethnic minority groups, and the growing size of the society) resulted in fewer mentally ill patients discharged back to the community (Manderscheid, Atay & Crider, 2009:30). Patients in the mental institutions were neglected, exploited, and were subjected to varied injustices (Parker, 2014:76). More funds were channelled for physical health care needs with limited allocation of resources for the mentally ill (Abera et al., 2014:2; Ng, Setoya, Koyama & Takeshimae, 2010:59).

According to Lazarus (2005:66), mental health care users were not properly prepared for life in the community and their families received no support on how to manage their mentally ill relatives on discharge in the community. South Africa initiated the move towards limiting dependence on long stay hospitals that meant promoting deinstitutionalisation (Lazarus, 2005: 66). Deinstitutionalisation meant that hospital beds were reduced; mental health care users were removed from psychiatric institutions, integrated back into their communities, and cared for by their family members (Manuel, Hinterland, Conover & Herman et al., 2012:302).

The process of discharging patients back into the community was meant to be preceded by transfer of funds to accelerate service delivery in the community (Lucas & Stevenson, 2005:90). Chakrabarti (2012:19) reported that deinstitutionalisation was negatively impacted by insufficient resources in health care facilities; families had no choice but to become primary caregivers to their mentally ill relatives without any preparation for this role (Manuel et al., 2012:302; Mokoena-Mvandaba, 2013:5). Families and the community started distancing themselves from the mental health care users, others ended up homeless and living in the streets (Manuel et al., 2012:302; Strumpher et al., 2014:52). Manuel et al. (2012:304) further state that mentally ill users felt separated and alone, with their human rights largely ignored by their families and the community.

From the literature reviewed, deinstitutionalisation seems to have failed in integrating users in their families and communities. In Gauteng, South Africa 94 patients who were transferred from Life Esidimeni to various non-profit organisations under unlawful circumstances, and without their relatives being informed, died of hunger, dehydration, negligence and overcrowding. This event was reported on television (Checkpoint, 2016). Strumpher et al. (2014:56) further make reference to the shortage of health centres, hospitals, and facilities for rehabilitation of users, as an indication of failed deinstitutionalisation and failed re-integration of discharged users in their communities. Other contributory factors to lack of integration of the users in the community are related to the stigma attached to mental illness. Users are often marginalised and exposed to malnutrition. The families of the users are equally marginalised and discriminated against by their own relatives and communities, resulting in their withdrawal from all recreational interests (WHO, 2003).

2.8 LACK OF FAMILY SUPPORT

The impact of deinstitutionalisation on mental health care users meant that patients had to be released back into their families and continue receiving care (Manuel et al., 2012:302). Families play a very crucial role in the rehabilitation of their mentally ill relatives; however, the non-existence of support structures and mental health facilities within these communities left families of patients feeling that they would not be able fulfil the role of support (Chakrabarti, 2012:19). The consequences of the lack or insufficient support for mental health care users were detrimental. According to Manuel et al (2012:304), mental health care users expressed feelings of estrangement and loneliness and also that their human rights were being ignored by their families and communities.

Lack of family support has the potential to cause regression in the recovery of mentally ill patients, because family is important in highlighting potentially problematic areas, which could cause relapse, and also help with treatment adherence. However, family members are often overlooked by health professionals (thus never provided with information and knowledge), which makes it difficult for them to understand and support their afflicted family member (Banyani, 2012:32).

Lack of family support is usually triggered by the fact that the family members living with mentally ill family members experience some challenges in everyday life, and how their lives are profoundly influenced by mental illness. These challenges include being ill-equipped to care for their mentally ill relative and also having to sacrifice their way of living (Banyani, 2012:38). Often when there is no resolution, family members withdraw their support in order to avoid burden.

It has also been reported that health care users also verbalized the non-existent support structures as well as acknowledgement by the community (Manuel et al., 2012:303; Maritz et al., 2010:66; Strumpher et al., 2014:51). In addition, these authors reported that relatives were only interested in the social care grant of the users but failed to care and support them.

2.9 IMPACT OF DEINSTITUTIONALISATION PROGRAMME ON FAMILIES

Following the reduction of beds from psychiatric institutions due to the deinstitutionalisation programme, families were obliged to care for their mentally ill relatives in their own homes, irrespective of lack of prior preparation for this role and without any additional physical, material and financial resources (Mavundla, et al., 2009:361); (Pratima, Bhatia & Jena, 2011:211). Such a situation further alienated the families from the users as they experienced the additional responsibility as a huge burden on their physical, emotional and financial health (Pratima, Bhatia & Jena 2011:211). Families were not fully informed and had no knowledge about the de-institutionalization agenda; they were kept in the dark about the profits and services that are in their communities. It became evident that de-institutionalisation will not be able to address the needs of the mental health care users when it comes to housing, employment and the people's wellbeing (WHO, 2014).

According to Saunders (2003: 181-2), families were obliged to take the role of caregivers without proper support and resources in place; this led to their withdrawal from social activities, some suffered from emotional drain, anxiety, fear and depression, as they had to take the responsibility of looking after their mentally ill relatives.

2.10 STIGMA AND DISCRIMINATION

People living with mental illness are ostracized, shamed and exposed to abuse, limiting their chance of receiving the care they deserve as members of society (Overton & Medina, 2008:143). Mental health care professionals go through training, acquire skills to advocate for the needs of people suffering from mental illness, but literature has shown that health professionals fail to advocate for mental health care users. The negative attitude of professionals towards mentally ill people perpetuates the scourge of stigma and discrimination against people suffering from mental disorders (Kapungwe et al., 2011:290).

Furthermore, mental health care professionals verbalized their discomfort in dealing with mental health care users, who they view as ruthless, dangerous and associate with acts of brutality (Ross & Goldner, 2009:561; Ghai, Sharma, Sharma & Kaur, 2013:294). Thornicroft, Rose and Kassam (2007:118) indicated that intern doctors displayed an uncaring attitude, based on their experience and anxiety of dealing with mental health care users. They disregarded the users' opinions and excluded them in the decision-making about their care. Studies confirm stigma as a barrier to mental health and primary health care integration, treatment of mental illness, and recovery from mental illness (Kapungwe et al., 2011:296).

2.11 STIGMA BY THE COMMUNITY

Communities also tend to reject the mentally ill, even when they do not display any symptoms of mental illness, as they believe that their conduct is a sign of relapse, this is an unacceptable form of stereotype (Thornicroft et al., 2007:113; Overton & Medina, 2008:143). Similarly, other researchers shared the same view point by stating that the society felt that looking after a mentally ill person would constitute a huge challenge because of the stereotype conceptions held by the society that the mentally ill persons are unstable, ruthless, and unsafe to accommodate (Ghai et al., 2013:294; Kapungwe et al., 2011; 291). Ghai et al. (2013:294) further noted that people in the community were unwilling to work or live with them, an indication of lack of integration of the users. Thornicroft et al. (2007:114) and Overton and Medina (2008:145) reported that employers were prejudiced against people suffering from mental illness, as they denied them opportunities to work.

2.12 CONCLUSION

In this chapter, a brief overview of the literature review in relation to the conceptualisation of integration of discharged mental health care users in their families and communities has been presented. The conceptualisation has highlighted the benefits of integration, the manifestations of successful integration, the manifestations of lack of Integration, issues related to the deinstitutionalisation programme in South Africa and elsewhere. The conceptualization of integration has been identified from literature in other countries, with limited studies conducted in this subject in the Eastern Cape Province. This study was conducted to obtain the perspective of the Eastern Cape Province, particularly in Fort Beaufort in the Raymond Mhlaba Sub-District, on the issue of re-integrating the discharged mental health care users into their communities. An in-depth literature review was conducted to support the discussion of findings of the study. Chapter 3 provides a detailed description of the methods and the design chosen for this study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides an overview of the research design and methodology used in exploring and describing the experiences and practices of the members of the mental health multi-disciplinary team, mental health care users and their relatives in relation to the integration of discharged mental health care users into the community. This section describes the research design, setting, population, sampling and sample size of the study, the research instrument, the validity and reliability, data collection procedure, ethical issues and data analysis techniques employed.

3.2 RESEARCH APPROACH

In this study, a phenomenological approach has been used to capture and describe the lived experiences of study participants (Burns & Grove, 2009:54). The researcher attempted to understand the experiences within the context of the members of the mental health multi-disciplinary team, mental health care users and their relatives.

3.3 RESEARCH DESIGN

An explorative, descriptive research design was used to explore the challenges encountered by mental health care users with regard to their integration into the community. The opinions of the discharged mental health care users, their families, and community psychiatric nurses, psychologist, psychiatrist, social workers, and occupational therapists were sought. A qualitative research approach was deemed most appropriate for fostering an in-depth understanding of the challenges faced by mental health care users, as well as the meaning and the significance attached to such experiences in relation to the integration of the discharged mental health care users in the community of the Raymond Mhlaba Sub-District.

3.4 RESEARCH SETTING

The study was conducted at a local psychiatric hospital, local clinics where the mental health care users go for follow-up care, and in the homes in the Fort Beaufort community area.

3.5 POPULATION

According to Burns and Grove (2009:491), population is defined as the elements that meet the sample criteria for inclusion in a study. The population for this study were mental health care users discharged from a local psychiatric mental health institution; the relatives of discharged users and the members of the mental health multi-disciplinary team (psychiatrist, psychologist, social worker, occupational therapist and psychiatric nurses) involved in planning the discharge and the care of the mental health care users in the Raymond Mhlaba Sub-District.

3.5.1 Inclusion criteria

Participants were included in the study if they are mental health care users between 18-59 years, asymptomatic and in touch with reality at the time of data collection and had been discharged from a psychiatric hospital. Additionally, those currently diagnosed with residual mental illness, were on anti-psychotic medication, compliant with treatment and had not relapsed in the last six months before commencing the study; and the users who were functional members of the community were also included.

3.5.2 Exclusion criteria

Mental health care users who were admitted in hospital and those who had been discharged but had relapsed within the past six months prior to conducting the study were excluded from the study.

3.6 SAMPLING METHOD

A purposive sampling method was used to select the research sample of participants. The following participants were purposively selected, as they had vast knowledge about the phenomena under study due to their involvement in the planning and rehabilitation of the discharged mental health care users, namely:

- Members of the mental health multi-disciplinary team;
- Mental health care users who had been discharged from a psychiatric institution and were currently residing in the community, were in touch with reality and were orientated to time, place and person; and
- The relatives of the discharged users.

The sample size was determined when there was no new emerging information from the interviews (saturation of data).

3.7 GAINING ACCESS TO THE STUDY PARTICIPANTS AND SETTINGS

The researcher spent two weeks involved in the process of selecting the sample for this study. The mental health care professionals were selected by seeking permission from the management of a local psychiatric hospital and the manager for the primary health care facilities. Appointment dates and times for the interviews were then set. The discharged mental health care users and their relatives were identified from the hospital register and with the assistance of the clinic professional nurse where the discharged users were collecting their medication. Ethical considerations were observed.

3.8 SAMPLE SIZE

Speziale and Carpenter (2007:460) state that in qualitative research, data generation or collection continues until the researcher believes saturation has been achieved, that is, when no new themes or essences were emerging from the participants and the data is repeated. In this study, the researcher considered the purpose of the study as well as the depth of the information generated. Thus, the researcher interviewed as many participants as possible until she reached the saturation stage. The saturation was reached after interviewing 19 members of the multi-disciplinary team, namely; 2 Social Workers, 2 Occupational Therapists, 2 Psychiatric nurses, 1 Psychologist, 1 Psychiatrist, 6 discharged mental health care users and 5 relatives.

3.9 DATA COLLECTION

The researcher used the following data collection instruments, namely; the researcher as an instrument and an unstructured interview guide.

3.9.1 The researcher as an instrument

The first data collection instrument was the researcher herself. The researcher as a person was totally involved in perceiving, reacting, interacting, reflecting, attaching meaning and recording, as it is a standard practice in a phenomenological study. Data collection issues related to the relationship between the researcher and participants were addressed. Personal characteristics, such as the manner of speaking, gender, age and other personality traits were recognised to ensure that they did not interfere with data collection (Speziale & Carpenter, 2007:110). The researcher spoke clearly, audibly and was careful not to use other non-verbal messages that would disrupt data generation. Unstructured interviews were conducted with the individual participants through a face-to-face interaction and using the language preferred by the participants.

3.9.2 Unstructured interview guide

The second data collection instrument was the unstructured interview guide through which the researcher sought to gather insight on how participants made sense of their experiences (Burns & Grove, 2009:103). Open-ended questions were used in order to elicit a description of participants' experiences, perceptions and insights about the lack of or promotion of re-integration within the community of the user who is discharged from a mental health institution.

3.9.3 Data collection process

During the interview process, participants were encouraged to talk about their life experiences with regard to the phenomenon of integration of discharged mental health care users (Silverman, 2006). Since interviewing is a special skill, the researcher practised this skill amongst her colleagues before initiating the interviews. Proficiency in conducting the interviews enabled the researcher to use effective communication skills, like minimal verbal responses, clarification, probing, reflection and observation of the non-verbal behaviour for quality data gathering processes.

The broad questions that guided the interview process were as follows:

"As a member of the mental health multi-disciplinary team in this hospital, what are your experiences and views with regard to the re-integration back into the community of the mental health care users who are discharged from a psychiatric hospital?

As a mental health care user, what are your experiences with regard to being re-integrated back into your own community after you have been discharged from a psychiatric hospital?

As a relative of the mental health care user who has been discharged from a psychiatric hospital, what are your experiences and views with regard to his/her re-integration back into the community where he/she lived before admission?

Probing focused mainly on the following questions:

What do you, as mental health care professionals and/or relatives of the users, do to ensure that the user is welcomed back, accepted, respected and valued within his/her community?

What do you as a mental health care user do to ensure that you are welcomed back, accepted, respected and valued within your community?'

A question that applied to all participants was, 'What do you suggest needs to be done to promote the re-integration of the discharged mental health care user back into the community?'

Probing for more information was done in order to clarify issues that sounded vague from the participants. Field notes were taken in order to capture the intended messages and observe both verbal and non-verbal messages. Non-verbal messages such as nodding the head and minimal verbal responses that indicated interest were used to facilitate interactions. Participants were allowed to talk freely about their lived experiences. The participants that gave short answers were then encouraged to further elaborate. Any other questions posed to the participants were explained for clarification and to keep the interview process on track. The researcher tried to "bracket" her presuppositions about the phenomena of integration (Speziale & Carpenter, 2007:467; Burns & Grove, 2009:690; Polit & Beck, 2008:748).

Questions to which the participants would answer 'yes' or 'no', were avoided because these would not offer much information during data analysis. The language used for the interviews was English for the mental health professionals. For the benefit of the non-English speaking, that is, Xhosa speaking participants, the mental health care users and some of their relatives, interviews were conducted in either Xhosa or English by the researcher. The length of the interview varied for each participant, because each interaction between the interviewer and the interviewee was unique. Each interview took on average 30 to 45 minutes.

A tape recorder was used throughout the interview process after seeking permission from the participants. Interviews were audio recorded for verbatim transcription (Polgar &Thomas, 2008). The environment for the interview was quiet to avoid the sensitive microphone from picking up even faint distorted voices, thereby increasing inability to make accurate transcriptions later during analysis (Burns & Grove, 2009; 695).

Enough batteries were organised to last for the entire interview so as to avoid embarrassment and loss of a trusting relationship between the researcher and the participants. Interviews continued until saturation was reached. Saturation was reached after interviewing nineteen (19) participants. The interview ended when the same statements or concepts were heard over and over again. Field notes were taken based on the observed body language of the participants during the interviews. Interviews were conducted during the months of February, March and April 2017.

3.10 PILOT STUDY

The pilot study was conducted using two participants who were not part of the actual study. The aim was to identify any problems, ambiguous, vague and unreliable statements that could interfere with the trustworthiness of the actual data collection and analysis processes. In addition, the pilot study was conducted to find out if the instruments were able to elicit the necessary responses from the participants before the actual data collection for the main study. The pilot study helped to ensure that the researcher was proficient and efficient in conducting interviews. The research design and methods proved to be appropriate except for the participants' responses to the question which did not elicit the required data and was ambiguous to the participants (Polit & Beck, 2008:761).

A quiet venue was identified and used for data collection process. Data was analysed and submitted for co-coding to an expert in qualitative research who is also a subject specialist. The co-coder recommended the researcher to proceed with the actual data collection for the main study.

3.11 ETHICAL CONSIDERATIONS

A good research problem often conforms to moral, ethical and legal standards of scientific inquiry. Ethical consideration must ensure that the rights of the individuals are protected and any research study, which directly involves studies on humans, calls for ethical consideration on the part of the researcher (Brink et al, 2012:32-45). During the course of this study, the following ethical principles were adhered to, namely, autonomy, beneficence and justice in order to protect and uphold the rights of the participants. Ethical considerations for the study participants were applied as follows.

Prior to conducting the study, an Ethical Clearance Certificate was obtained from the University of Fort Hare's Research Ethics Committee. Permission to conduct the study was obtained from the Epidemiology Section of the Eastern Cape Department of Health, and the Director of the District Health Services in the Raymond Mhlaba Sub-District and from the Chief Executive Officer of the local psychiatric hospital. This was done because research is an ethically significant activity and any research must be done in an ethically reflective manner to prevent the violation of the rights of the participants, protect human life and privacy (See Annexure A, B, D, and C).

3.11.1 No harm to participants

Nursing research should never injure the people being studied, regardless of whether they volunteered for the study or not (Polit & Beck, 2008:170). Participants who were included in the study were the ones who were in a position to comprehend what was happening. They were informed that they had the right to self-determination and the freedom to participate or not to participate in the study. The researcher adhered to the ethical principle of beneficence, by ensuring safety and no harm to the participant either physically, emotionally, economically or socially. The interviews lasted for an average of 30-45 minutes, thus ensuring that the participants were not exhausted by being detained for a lengthy period of time. To prevent harming the participants economically, interviews were conducted at the hospital where the participant professionals work and in the clinics where participant users go for their medication and follow up care.

Interviews were also conducted in the communities where the mental health care users and their relatives lived. This was done to economise on travelling expenses and time. A one-on-one researcher participant relationship was developed to establish rapport and to allay any anxiety.

3.11.2 Voluntary participation

Voluntary consent was obtained after the prospective participants had been given essential information about the study and had shown comprehension of the information. The purpose and scope of the study were explained to the participants. They were also informed about the benefits and potential risks of the study. Explanation to the relatives of the patients was provided in their predominant home language, Xhosa. English was used for the mental health care professionals and some of the relatives. Participants were given sufficient information to help them decide whether they wanted to be research participants or not. Apart from explaining to the participants about the study, they were also given a copy of the information sheet. (See annexure E).

The contents of the information sheet were: An introduction of who the researcher was, the purpose of the research and the participants in the study, the duration of the interview and assurances of anonymity and confidentiality. A statement was made that participation was voluntary and any refusal to participate would not involve any penalty or loss of benefits to which the participants were entitled. The information sheet also indicated that participants were free to withdraw at any stage of the interview, should they feel uncomfortable. After going through the information sheet, each participant was also given a written consent form to read and sign if they were in agreement with the contents of both the information sheet and the consent form (See annexure E).

All the participants signed the consent forms which indicated that they were ready to participate in the study. The participants were told in advance to feel free not to answer questions which they feel uncomfortable with. The rationale for using the audio tape was explained and permission to use the audio tape during the interviews was obtained from each participant (See annexure F).

Brief field notes which were taken during the course of the interviews were later used to deepen the meaning-seeking attributes of the data analysis and data interpretation.

3.11.3 Confidentiality and anonymity

Participants were assured that confidentiality and anonymity would be upheld and were also assured that they would be treated with respect and dignity. Burns and Grove (2009: 694) state that anonymity exists if the participant's identity cannot be linked, even by the researcher, with his or her individual responses. According to Burns and Grove (2009:694), a breach of confidentiality can occur when a researcher, by accident or direct action, allows an unauthorized person to gain access to the raw study data. Breach of confidentiality can occur by accidentally revealing the participant's identity during reporting or publication of a study (Burns & Grove, 2009:694). Such violation of confidentiality and anonymity has a potential to harm the participants psychologically and socially, as well as destroy the trust participants would have had in the researcher.

Participants were assured that their names and addresses will not appear anywhere in the study or publication of the study. The names and contact details of the participants were not necessary for the study, as the researcher was only interested to find out about the participant's experiences and views about the phenomena of re-integration of discharged mental health care users in the community. Confidentiality and privacy was assured by conducting the interviews in a quiet closed room away from possible disturbances and interference by other people. The information (transcripts and the tapes) were only made available to the researcher's co-coder and the supervisor. The transcripts are currently kept in a safe place and will be destroyed two years after the publication of the research.

3.12 AUTHENTICITY AND TRUSTWORTHINESS OF THE DATA

The goal of rigour in this study was observed by accurately representing the study participants' experiences, by demonstrating that attention and confirmation of information discovered was accurate.

Speziale and Carpenter (2007:48-52); Lincoln and Guba (1985) state that credibility; dependability; confirmability and transferability are terms used to describe the operational techniques that contribute to rigour in qualitative research. In this study, the criteria, as described by Lincoln and Guba (1985), were applied.

3.12.1 Credibility/Truth value

Credibility refers to whether the inquiry was conducted in such a manner so as to ensure that data gathered and emerging themes were accurately identified and described (Speziale & Carpenter, 2007:458). To achieve credibility, the data collected and the conclusions drawn from the information collected during interviews were verified with the participants to ensure that the interpretations made were correct. Speziale and Carpenter (2007:458), Polit and Beck (2008:751), refer to this activity as "member checks". The interviews were tape recorded to capture the accurate responses of the participants. The transcribed data was checked with the audio tapes from time to time for accuracy and against field notes.

The participants were given in-depth explanations regarding the study in question to enable them to answer appropriately when responding to the questions that were asked. Member checking with participants was carried out on an ongoing basis during data collection (through deliberate probing), to check the accuracy of both data and the interpretation and thus to ensure that the interviewer had understood participants' meanings (Babbie & Mouton, 2009:277).

3.12.2 Dependability

Dependability criterion is met once the researchers have determined the credibility of the findings. Polit and Beck (2008:536-537) state that dependability refers to the stability (reliability) of data over time and over conditions; whereas Babbie and Mouton (2009:277) describe dependability as "the extent to which the findings of the study would be consistent if the enquiry were replicated with the same participants in a similar context." Engagement with the participants was prolonged to increase the dependability of the results.

The dependability question affirms if the findings of an enquiry be repeated if it was replicated with the same participants in the same context. Credibility cannot be attained in the absence of dependability just as validity in quantitative research cannot be achieved in the absence of reliability. The transcribed data recorded during the interviews were verified with the participants for authenticity and accuracy, as recorded during the interviews. The analysis of the data was further verified by an expert in qualitative research. In essence, the researcher coded, audited and archived the raw data.

3.12. 3 Confirmability

Confirmability was assured by documenting clearly all the steps involved in the study, for purposes of an audit trail (Brink, van de Walt & van Rensburg, 2012:173). The sequence of activities over time was recorded to enable the replication of the study by any other person, a process known as fiscal audit (Speziale & Carpenter, 2007:97). Confirmability was observed by giving an accurate interpretation of data which reflected that the data had been obtained from the respondents during data collection (Brink, et al 2012:173). The objective was to illustrate as clearly as possible the evidence and thought processes that led to the conclusions drawn. The initial coding of the data was conducted. The data, the identified themes, categories and sub-categories were then submitted to the expert of qualitative data analysis for validation. A meeting was held with the co-coder to compare and verify the findings.

3.12.4 Transferability

Transferability refers to the probability that the applicability of the study has to others in similar situations and is labelled as "fittingness" (Speziale & Carpenter, 2007:98). The research method used in this research responded to the principles of transferability and audit trail as the researcher had detailed all the processes followed in conducting the study up to the results stage, the discussion of results, the recommendations made and the presentation of the limitations. Sufficient information had been given about the characteristics of the sample for judgements to be made about the extent to which findings could be expected to apply more widely.

3.13 DATA ANALYSIS

Data was systematically organised, synthesized and manipulated for the purpose of categorising, ordering, and describing it in meaningful terms (Brink, et al 2012:177). As it is standard practice in qualitative research, data analysis was concerned with the analysis of written words, and audiotapes (Brink, et al 2012: 193). Data analysis involved reading through the data repeatedly and engaging in activities of breaking down the data into categories and to identify possible themes. The audiotape was listened to several times as the data was transcribed. The process of data analysis was initiated by transcribing the data verbatim from the audio tapes within 24 hours of data collection. Data analysis was conducted according to the steps as described in Creswell (2014:198) as follows:

Table 3.1: Summary of the systematic application of the stages of data analysis

Stage	Process Analysis
Transcription and familiarisation	Transcriptions and descriptions read by the researcher
Content analysis (a process of immersion)	In-depth understanding of the content by the researcher
Inducing themes and categories	Grouping significant words phrases and statements into columns of themes, categories and sub-categories
Coding	Meanings formulated from significant statements and phrases
Elaboration & clustering	Related meanings and phrases clustered into themes, categories and sub-categories
Interpretation and checking	Results integrated into thorough description of phenomena

The data analysis process was guided by Tech's steps, as cited in Creswell, (2014:198).

Creswell (2014:198) outlines Tech's steps as follows: Getting a sense of the whole by reading through all the transcriptions carefully and jotting down ideas.

- Picking the most interesting interview and considering its content.
- Categorising topics as major, unique and "leftovers" abbreviating the topics as codes next to the appropriate segments of the text, and then trying out this preliminary organising schemes to see whether new categories and codes emerge. Finding the most descriptive wording for the topics and turning them into categories and groupings that relate to each other in order to reduce the total list of categories.
- Make a final decision on the abbreviation of each category and placing codes in alphabetic manner.
- Assembling the data belonging to each category in one place and performing preliminary analysis.

3.13.1 Transcription of data

Transcription and familiarisation were the first steps used to analyse the data. The interviews were transcribed from the audio tape recordings immediately after completion of data collection so as to facilitate the process of data analysis. Most of the transcriptions were done on the same day of the interview (Burns & Grove, 2011:94-97). In cases where this was not possible, it was done within 24 hours of recording. In this manner, the researcher became familiar with the data as it was gathered.

3.13.2 Familiarization and immersion

The verbatim transcriptions or written responses were read and re-read, word for word, sentence by sentence, in order to search for recurring statements or phrases and to identify what general ideas or impressions were actually coming out in each transcript. This was done to ensure that the data had been interpreted correctly. While reading through the data and field notes many times, the researcher began to write notes on the transcript margins, drew up diagrams and brainstormed about emerging themes as the collected data began to shape up. This process continued until the researcher was convinced that the data was interpreted correctly. This activity in phenomenological study is termed "dwelling" with the data (Burns & Grove, 2011:695). The transcriptions were compared with the audio-tapes and with field notes for accuracy. The transcripts were then read carefully in their entirety and then compared to the tapes for accuracy. All responses were read repeatedly in order to get a sense of their meaning. A list of topics was made for each transcript. These topics were then clustered according to similarities.

The process of conscious interpretation was used to understand the phenomenon re-integration of discharged mental health care users into their communities in relation to its challenges and the strategies to mitigate the challenges. The most descriptive words for each topic were found and the process of coding was then undertaken by grouping significant statements and phrases into columns of themes, categories and sub-categories. The researcher used the process of bracketing and remained neutral by holding in abeyance preconceived beliefs and opinions about the phenomena of re-integration (Brink, et al 2012:122). Field notes were checked for correctness and completeness on the day of data collection. The field notes were then analysed together with the transcribed interviews to obtain a deeper insight into the descriptions made by the participants. Field notes taken were important in capturing the context of observations made during the interview sessions and were used to enhance the recorded data gathered and recorded. Body language and tone of voice expressing any feelings or observations are examples of information included in the field notes.

3.13.3 Content analysis

Content analysis was performed in order to achieve an in-depth understanding of the meaning of the primary data content. During the process, the principle of discrimination of meaning of units was applied. This phase involved refining the contextual understanding achieved in the previous step by focussing on discrete changes of meaning within the larger context of each individual transcript. The microscopic search for discrete changes in meaning was reached through a series of data analysis synthesis, scrutinising each term and marking the occurring change in meaning with reference to the phenomenon of re-integration of the discharged mental health care user into the community.

This meticulous attention to detail was done to ensure that all relevant nuances and details were accounted for in further analysis. This was an indication that a considerate amount of time had been spent, considering all meanings when moving to a greater degree of abstract meaning as opposed to descriptive meaning (Speziale & Carpenter, 2007:86).

3.13.4 Coding and clustering

Coding is a word or short phrase that symbolically assigns summative, salient, essence-capturing and/ or evocative attribute for a portion of language, based on visual data. It is the transitional process between data collection and extensive data analysis (Saldana, 2009:3). However, Terre Blanche, Durkheim and Painter (2006:323) define coding as breaking up of data in analytically relevant ways. In this study, the individual participants were coded numerically and data was coded according to themes that emerged.

3.13.5 Elaboration

Elaboration was done for further exploration of themes in order to capture the finer nuances of the meaning not captured by the original coding system. Themes and coding system were brought together to compare the sections that appear to belong together. Coding, elaboration, and recording continued until no new insights appeared or emerged (Terre Blanche et al., 2006:324).

3.13.6 Interpretation and checking

Interpretations were checked by discussing with other people who are familiar with the topic, as well as with people to whom the topic is unknown, as the latter may be able to lend a fresh perspective. The linear approach of data analysis as presented above is for clarity on the activities and thought processes that occurred. The processes were done simultaneously and interchangeably.

In summary, data was analysed manually, the researcher first read through the transcripts and then encoded the units by underlining all the relevant statements or words that gave them a code name. Then all similar codes were grouped and linked together as themes. The themes emerged from the participants' description of what they had observed and experienced as challenges to re-integration as well as strategies to promote re-integration of the discharged users. The process continued until the final themes were identified together with the relationships or links between them, which were used to enrich the description of the themes.

The utilized data analysis method comes under the umbrella of interpretive analysis, wherein the researcher safeguarded the uniqueness of each participant's lived experiences, whilst ensuring that there is an understanding of the phenomenon under investigation (Terre Blanche et al., 2006: 332-336). The data base and guidelines on how to analyse the data were provided to an independent coder, a professional who is a subject specialist with knowledge and skills in qualitative research. Afterwards, the researcher and the expert met and discussed the results until a consensus was reached regarding the themes.

The data analysis method applied, gave the researcher a full emerging story from the data collected from individual interviews, the final emerging picture became evident to answer the research questions (Burns & Grove, 2009:170).

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 INTRODUCTION

In chapter three the research methodology that informs the study was explored and described in detail. The findings of the study are presented and discussed in this chapter. The discussion of the findings covers the responses emanating from the interviews. The discussion also covers the summary of themes that emerged from the data on the challenges of re-integrating mental health care users in the community after being discharged from a psychiatric institution and the role of stake holders in promoting the re-integration of users into the community of Raymond Mhlaba Sub-District of the Eastern Cape Province.

The data is being presented into two sections:

4.2 Demographic data of participants

Shown in Table 4.1 is the profile of the participants involved in the study. The participants were all adults between the ages of 18-59 years. Participants were mental health care users who had been discharged from psychiatric hospitals, their relatives, community psychiatric nurses as well as members of the multi-disciplinary team of a local psychiatric hospital.

Table 4.1: Participants involved in the study

Type of participant	Number
Social workers	2
Occupational therapists	2
Community Psychiatric nurses	2
Psychiatrist	1
Psychologist	1
Mental health care users	6
Relatives of mental health care users	5
Total	19

4.3 FINDINGS OF THE STUDY

Themes emerged from the interviews with the participants who were grouped according to the objectives of the study. These are presented in chapter 1 as challenges to the re-integration of discharged mental health care users into the community, and the role of stake holders on re-integrating discharged mental health care users into the community. The grouping of themes is according to the identified challenges, namely; socio-cultural, psychological, administrative and communication challenges. Strategies to mitigate these challenges were also identified. The findings of this study revealed that participants viewed the following as themes on challenges to the re-integration of the discharged mental health care users into the community of the Raymond Mhlaba sub-district, namely:

- from a socio-cultural perspective - **“incongruent mental health care services”;**
- from a psychological perspective - **“negative attitudes”;**
- from the perspective of the administrative and communication strategies is **“non-prioritization of community mental health care services**”;
- On the role of stakeholders on re-integration, the main theme is, **Facilitators of re-integration”.**

The stake holders were mental health care professionals who were members of the mental health multi-disciplinary team, mental health care users and their relatives. Table 4.2 displays the main themes, categories and subcategories derived from the data. The findings of the study are presented according to the main themes and initial categories. In the presentation of findings, participants’ verbatim statements that support the findings are also used.

Table 4.2: Main themes, categories and subcategories generated from the data on challenges and facilitators of re-integration of discharged users

Objective	Theme	Category	Sub-Category
Socio-cultural challenges	Culturally incongruent mental health care services	• Indigenous health care system • Customs and rituals • Spirituality of users	Consultation of traditional healers; Spirituality of users not addressed in community mental health services rendered
Psychological challenges	Negative attitudes	• Stigma • Violation of rights • Discrimination • Rejection by families/communities	Rejection Exclusion from society, community cultural events; physical and/or sexual abuse; denying the users employment rights and opportunities, non-acceptance, undermined & alienated,
Challenges on Administrative and communication strategies	Non-prioritization of community mental health care services	• Lack of advocacy • Lack of consultation and communication of information amongst the role players • Shortage of resources • Mental health care professionals, users and their relatives not capacitated with knowledge • Inequities • Inadequate governance structures	No representation of discharged mental health care users at management level Lack of material, financial and human resources; No community mental health care workers; Lack of transport for home visits and shortage of medications; No in-service training programmes for latest developments; lack of psycho-education; No budget allocations for community mental health services; Poor infrastructure Poor monitoring and evaluation of services.
Strategies to mitigate the challenges	"Facilitators of integration"	• Consultation • Resourcing and capacitating users; community mental health care services and facilities, mental health care professionals, communities; • Promoting accessibility of mental health services to the community; • Uphold rights of mental health care users; • Deliver culturally sensitive services or congruent services; • Establish and develop a therapeutic infrastructure and facilities in the community; • Establish a functional multi-disciplinary team in the community. • Set up governance structures for mental health care rehabilitation in the community	Participation in decision making Train users in life skills and psycho-education; Up-skilling mental health care professionals Assessment for resourcefulness and readiness of communities; Creation of employment opportunities for users Promote inclusion, Eradicate stigma

4.3.1 CULTURALLY INCONGRUENT MENTAL HEALTH SERVICES

Participants revealed that the culturally incongruent mental health services rendered by mental health care professionals to the users were a deterrent to the re-integration of the discharged users back into their communities. The services are regarded as restrictive, as they are based mainly on the Western Healing systems and do not recognise the indigenous healing systems in relation to rituals, customs and the spirituality of the users. The discharged users and their relatives revealed that, as soon as they are back home from hospital, they abandon the western healing systems and revert to their own indigenous health care systems, as it is customary to consult traditional healers for diagnosis, treatment and management of mental health related problems.

The following are some of the responses from the participants:

“*My son has started using drugs when the drugs have a negative effect on him I don’t see that as the cause of drugs, I quickly take him to “egqirheni” and say that he is bewitched then the “igqirha” (meaning the witchdoctor) will tell me to slaughter a goat for him and I do all the things I was told to do but if we had vast knowledge and be taught about early signs of mental illness, if we can know those signs that would help a lot instead of taking him to “egqirheni”.*”

“*We do not believe in going to the doctor we first think about Xhosa medicine or to perform a ritual for that person that’s part of our culture once one is mentally disturbed we only think that the person is bewitched or he or she has what we call “Amafufunyane” okanye we did not perform a ritual for him.”*

4.3.2 NEGATIVE ATTITUDES

Participants revealed that the negative attitudes of some relatives and community members were a deterrent to the re-integration of the discharged mental health care users into their communities. Such relatives and community members displayed their negative attitudes by stigmatising and violating the rights of the users, discriminating, ridiculing and even rejecting the mental health care users. In addition, they show their negative attitude by abusing the users either physically or sexually and also by denying the users employment opportunities.

The following are some of the responses from the participants:

"I would say when we sit drinking beers and stuff sitting there, people are still unsure, afraid pending to how one went to the hospital then, because if it was said he or she is violent whatever there's still that thing, as a result of that culturally we kind of get one container of beer to share among ourselves you find them given their own separately, that simply stigmatise them because they kind of being alienated or treated aside, hence I'm saying even in terms of culture we need to understand if there's one big dish we have to kind of share all of us."

"You know when you come from Tower it's kind of becoming difficult or impossible to get a partner, I'm being honest because once you approach a lady being a man coming from Tower everyone doesn't want to be associated with one coming from there even if for whatever reason one is normal then, because there is that stigma attached to that hence I'm saying there is stigma around if we can remove the issue of stigma because the stigma issue whether you go cultural or otherwise that stigma thing play a very big role in terms of bringing the negativity around those who are coming out of the hospital."

Rejection by relatives*:*

"Ndihlala ndodwa endlini kuba bendihlala nenkosikazi kodwa ke inkosikazi yandishiya" (meaning he is living alone at home because his wife left him).

Denied employment opportunities:

"Ugqhira kaloku wandixelela ukubana ndiphazamisekile ngokwase ngqondweni so kengoku andisafuni lamsebenzi we social worker but ndiyawufuna nje noba ngowomabhalana ndibe yi clerical for ba ndibene cent noko ezizakuncedisa lemali yepay" (Meaning that the Doctor told him that he is mentally disturbed therefore he no longer wants to be a social worker, however, he wants a job even if it is a clerical one to supplement his disability grant).

On violation of rights by being undermined, insulted and ridiculed:

"Abanye ke ade athi omnye uba akuthuke, athi ufundile kodwa uhleli uyayibona lonto" (Meaning that others would say defamatory statements that he is educated yet he is not working).

"Kunentetho ezithi njengoba sigula ngengqondo nje kuthiwa ezazibhanxa kuthi ecaweni ndikuxelele so kengoku xa umtu esithi usisibhanxa apha kwa Thixo that means into bana uyakuhleka kulanto bana wagula wena" (Meaning that in church members refer to them as stupid because of their mental illness and are therefore ridiculed).

Response from a mental health care professional:

"At times others in their homes once they kind of query or fight for their rights by the way, it gets said no let's take him back because he is not right all that stuff but when you kind of listen you find, it's money related, family problem this and that, so there are plenty challenges around that."

The family members stigmatised their own relatives, as the data revealed that some families do not welcome their discharged relatives. The users are found wondering in the streets, homeless, looking for something to eat, hungry, dirty and unkempt, with no one to care for them. One participant revealed that the rejection happens even as the relatives benefit from the social grants that are meant for the users:

"The families of people suffering from mental illness do not take good care of them, you see them roaming in the streets, dirty and begging for money."

Another feature of exploitation and abuse against the users, as revealed by another participant, is that:

"Even though he knows that he is receiving the grant he has never seen his card and he does not know what it looks like, the problem is the disability grant cards; their relatives neglect them instead of taking care of their needs."

Here is a response from a mental health care professional*:*

"At times, even some families they don't welcome their people and that is very strange."

"You will find these families misusing the money that is meant for these people and they begin not to care at all."

4.3.3 NON-PRIORITIZATION OF COMMUNITY MENTAL HEALTH SERVICES

Participants revealed that the lack of re-integration of discharged users into their communities was related to the non-prioritization of community mental health care services by management structures. There is no representation at policy making level, an indication that there is no one to advocate for the interests of the users. There is lack of consultation and communication with stakeholders, there is shortage and unequal distribution of financial, material and human resources for quality care for discharged users in the community. Outreach programmes for follow up care and home visits for the discharged users are not conducted. There are no initiatives to empower the users and their relatives with mental health related knowledge.

The infrastructure in mental health care clinics is of poor quality. In addition, there is no multi-disciplinary team at community level and at the clinics. Participants revealed that the failure by governance and management structures to prioritise mental health care programmes and services is further evidenced by the failure of management to make provisions for step down facilities in the community, for care giver training, for continuity at community level of the programmes and services offered in hospital, including the presence of a multi-disciplinary team.

The non-prioritization of community mental health care services seems to be a feature of inadequate governance structures.

The following is one of the responses from mental health care professionals on non-prioritization of services:

“*Because it’s an issue these people go out there come back go out there and come back clearly there’s something that needs to be done and there’s something that’s missing, because in cities because that’s where I did my degree in practicals we would see these facilities available in communities it’s not available in the city only but in the township, it’s available, so they do have services and when you come this side there’s nothing.”*

The following statement is from a participant mental health care professional:

“*I think what’s lacking is family education as well that needs to be included in the education as well in terms of what they can do to carry on so there’s no carry on, so what happens here, happens here and that’s it so there is no follow through and there’s no step down facilities anyways this side of town so that’s also what’s lacking and missing, in terms of making sure really that they are ready for outside, so they* *participate in therapy, they go straight home there is no step down facilities as well, there's no caregiver training as well so it's stops here and that's it."*

4.3.4 FACILITATORS OF THE RE-INTEGRATION OF USERS

Themes, categories, and subcategories on the role of stakeholders in promoting the re-integration of mental health care users into the community refer to what the participants, as stakeholders, do and what they suggested needs to be done to promote the re-integration of users and to militate against the identified challenges.

The results revealed that stakeholders facilitate the re-integration of users by using strategies that mitigate the challenges to re-integration, namely, consultation, providing resources for community mental health care facilities and services; assessment for resourcefulness and readiness of communities; the creation of employment opportunities for users; promoting accessibility of mental health services in the community; the eradication of stigma against mental health care users and upholding their rights; rendering culturally sensitive or congruent services; empowering the users and their relatives and community members with knowledge on psycho-education and life skills as well as job creation skills; up-skilling mental health care professionals; establishing and developing a therapeutic infrastructure and facilities in the community, e.g. Half-way homes and shelters for the displaced users; establishing functional multi-disciplinary team in the community and setting up functional governance structures for the rehabilitation of discharged mental health care users in the community and promoting advocacy for the users.

The results revealed that establishing management and governance structures for community mental health services to advocate for the discharged mental health care users has a potential to promote re-integration, as based on the following response from a participant:

"I think there is a huge role the government can play in that regard especially offering services, outpatient services for mental care I think that would be very, I think that's where they need to play a role as well."

Participants revealed that advocating for mental health care users as a strategy for promoting re-integration could be done by having a representative at policy making level and mobilising themselves as users and communities to assume the role of being activists, as reflected in the following statement from a participant user:

"…like uyabona kunoba sihlale nje sibe inactive we want to be activists sibe ngama 'activist' ale mental health, like nakwi Aids mos HIV babakhona abantu ufumanise uba bathetha ngokuphandle ngesigulo sabo bane programmes zabo nendawo abahamba kuzo banengqungquthela banentoni but kuthi kwelicala lethu kuthe cwaka yabona" (Meaning *that instead of doing nothing they want to be activists of mental health, like people living with AIDS/ HIV has people who are outspoken about their illness, they have their programmes and visit places, they have conferences but on the mental health side it is quiet).*

In addition, the policy makers and management need to prioritise community mental health services in order to facilitate the integration of users, as one participant responded:

"*If we want to reduce this illness during the time the 80's there was an ambulance in Tower we knew that when we see the ambulance driven by 'amateyndara" we knew they were coming to fetch a mentally ill person and they would take him to hospital instead of what is happening now, there is no ambulance, there is nothing but these people are roaming the streets. I think that would help us and the community would also assist and that would curb the mentally ill people walking up and down the streets."*

Promote inclusion and eradicate stigma

The eradication of the stigma about mental illness, as a strategy to promote re-integration of users, could be done by giving support and encouragement to the users and their relatives*; as* a participant mental health care user said,

"Mna sisi ndifuna umtu ofana nawe yabona wena uyandincedisa kulento bandagula akundihleki ubungenakuthatha le session ingaka nam kanti uyandihleka" (Meaning *that he wants a person like me (the researcher) who is not going to laugh at him but takes a long session assisting him since he is ill).*

Establish and develop a therapeutic infrastructure and facilities in the community

Results show that stakeholders, especially government or policy makers, can promote integration by establishing and resourcing community based mental health facilities to be used by support groups of discharged mental health care. There is a need to establish half-way homes and shelters for the displaced users in the community. Users are able to use such facilities to network and support each other within their own support groups in the community. The following responses emerged from the participants:

“*Phaya bake bayizama o sister phe town i support group sethu sabantu ke abagula ngengqondo nomnye umfana lo ndithi ke ndandim identifayile kodwa ke zange ibeyinto ehambela phambili” (*Meaning the *sisters and a guy I identified tried to put together a support group for people suffering from mental illness but it never progressed).”*

“*Yabona kengoku imele ibekhona i outpatient lantuka facility whereby lendawo izaba mhlawumbi yindawo yethu apho kengoku sinothi nathi i support group apha ibe nothi ivele because i support group yake yakhona apha kodwa yajema.” (*Meaning, *you see, there is supposed to be an outpatient facility that maybe will be our place so that we can have a support group but there was a support group, but it did not advance further).*

“…b*endifuna mna indawo ebu mental facility yaqonda indawo enkulu enokwakhiwa then kengoku kulondawo kuyazi kengoku kuza specialayizwa ezizinto mhlawumbi kuvele i maunufacturing uba zikhona, kuvele i poultry”*. (Meaning, *he wanted a big place like a mental facility that will be built for specializing in things like manufacturing and poultry).*

An example of a statement by a participant mental health care professional:

“…the games because then fortunately I was born around this community we used to have games playing with patients and staff, I’m kind of saying to reconnect those people to the community they kind of need to make sure that awareness campaigns, games and everything so that they feel and become part of the community.”

Capacity building and empowerment

Results revealed that capacity building and the empowerment of users, their families and community members need to be implemented by informing them of the availability of resources, like specific budget allocations, the availability of technical support, transport for outreach programmes, facilities in the community to meet their basic needs, human resource development and management for community mental health services, including up-skilling mental health care professionals and capacitating users, families or relatives, community members with psycho-education, job seeking and life skills. Conducting campaigns to create an awareness of the importance of providing support for the discharged mental health care users is advocated as a remedy to this situation.

The following are some of the responses from the participants:

"*…is awareness that will teach the families of the mentally ill people on how to treat them, it must not be only their families it must also be extended to the community the problem with us is the lack of knowledge if we can be educated on how to treat them, take them as you would take yourself…training of community on managing and supporting discharged users.*"

"We *basically engage patients in activities, for example like simple thing as taking care of yourself, it's a problem with psych patients so what we do, we do have self-care groups where we educate and we practise how to take care of our self; we take care of our hair, our faces, dressing up appropriately which makes it more socially acceptable."*

"We *currently have fourteen projects and groups in the wards okay, projects here we have sewing we have baking, gardening, taking care of pigs, sport, and we have events so the list is quite extensive."*

Establish a functional multi-disciplinary team at community level:

One of the responsibilities of the stakeholders in promoting integration is related to discussing and determining the readiness of the user to be discharged as well as the readiness of the family and community to receive the discharged user. Here is an example of a statement made by a participant:

"Okay, what we do we write reports and the MDT also comes together and also discuss a patient, the social worker does say okay this person has been doing well, he's engaged in therapy doing this and this and that so the family also knows what kind of activities the patient is engaged in to prepare for discharge."

4.4 DISCUSSION OF FINDINGS

In this section, the main themes on the challenges to the reintegration of discharged mental health care users are discussed. The challenges that emerged from the interaction were: culturally incongruent mental health care services; negative attitudes towards mental health care users and non-prioritization of mental health services by management and governance structures. The findings are also discussed in relation to the strategies to facilitate and promote the re-integration of users as well as militating against the identified challenges to re-integration. Literature to substantiate the results is also presented.

4.4.1 Culturally incongruent mental health care services

Culturally incongruent mental health care services rendered by mental health care professionals contribute to the non-integration of users in the community. These services are solely based on the western healing systems and seemingly ignore the traditional healing systems of the Xhosa people of the Raymond Mhlaba Sub-district. The health workers ignore the indigenous healing systems of the users. A similar view is shared in Leininger (2006:78) wherein it is suggested that culturally incongruent care demonstrates the inability to provide, accept and comply with individual's beliefs, as well as the inability to plan, negotiate and restructure care based on the knowledge about one's culture. Culturally incongruent services are bound to be ineffective as they are based on inappropriate treatment modalities which do not fit patients' culturally based needs (Kaplan & Sadock, 2003:1374).

4.4.2 Negative attitudes as challenges to lack of re-integration

Some family members of users, and members of the community, have a negative attitude towards the users. In relation to negative attitudes, Marais and Pietersen, (2015:7) state that with regards to challenges related to the implementation and operationalization of the Mental Health Care Policy Framework of South Africa, negative attitudes and lack of experience or training in mental health by primary health care nurses, in particular, was identified as a major barrier to the responsiveness to integrated mental health care, with the integrated model not being fully embraced by all health workers. Health care professionals are reported to be having a negative attitude towards the users; as noted by several studies affirming that mental health professionals were intolerant and pessimistic about health care outcomes of people suffering from mental illness (Ross et al., 2009:559; Kakuma et al., 2010:117; Kapungwe et al., 2011:291).

A study by Ghai et al. (2013:298) to evaluate the opinions of mental health care professionals, reported that psychiatrists expressed a desire to distance themselves from people suffering from mental illness. Happell et al. (2012:250) confirmed that mental health users gave up on the opportunity to utilize the mental health facilities due to the negative attitudes of health care professionals. A similar view is shared in a study conducted in the Eastern Cape by Strumpher et al. (2014:53) which revealed that the shame of suffering from mental illness was a stumbling block to seeking help, and resulted in mental health care users discontinuing their therapy sessions (Happell et al., 2012:251). In an earlier study by Gary (2005:986), the mentally ill were blamed for their own illness, condemned, and the society distanced themselves from them. Similar sentiments are shared by Overton and Medina (2008:144), who reaffirm the fact that the community rejected and disputed the integrity of the users, and took decisions on their behalf.

According to Thornicroft, Rose and Kassam (2007:114), disclosing mental illness was forbidden and led to avoidance, as the community remain hidden. MacCabe and Macnee (2002:263-278) share a similar view, stating that users avoid being seen going into identified mental illness treatment centres, and, instead, preferred to present their concerns to primary care providers or work with faith-based or natural community helper sources, who are less clearly identified as mental health providers. Strumpher et al. (2014:53) state that mental illness tarnished the social standing of the mentally ill users in the society. As reported in Thornicroft, Rose and Kassam (2007:119), mental health care users were disgruntled about how the mental health system managed their care. Negative attitudes such as stigma, discrimination, the violation of the rights of the users, alienation and rejection, are an obstacle to the promotion of the re-integration of users into their communities.

The findings of the current research study revealed that care givers of users were also victims of negative attitudes, a finding previously reported in Perlick, Link, Miklowitz and Struening (2007:535-536) study, where 43% to 90% of carers of users with bipolar disorder experienced depressive symptoms and low morale. Such a situation further contributes to non-integration. Similarly, Strumpher et al. (2014:53) reported that families of people suffering from mental illness were labelled as outcasts due to their connection with their mentally ill relatives. Family members stated that having a mentally ill relative would lead to devastation and humiliation and, in some instance, caused hostility between the mentally ill, their families, and close associates (Gary, 2005:987; Ghai et al., 2013:294). Gary (2005:987); Pratima, Bhatia and Jena (2011:214) reported that even the users' families and peers were shunned and isolated by the society.

Overton and Medina (2008:147) indicated that the public assumed that people suffering from mental illness were unable to take charge of their own lives. Their families shielded them and expressed their discomfort talking about mental illness (Thornicroft, Rose & Kassam 2007:114). Negative attitudes are often exhibited towards the users, as reported in Overton and Medina (2008:147) and Ghai et al. (2013:294), that news broadcasters planted a bleak picture in the minds of the public, reinforcing the idea that people suffering from mental illness were a menace, inhumane, unreliable and not worthy of the trust of the society. Negative attitudes impact negatively on the wellbeing of the mental health care users who often experience reduced levels of self-respect, pride, and confidence (Rusch et al., 2010:150; Watson et al., 2007:1312; Overton & Medina, 2008:143; Lucksted & Drapalski, 2015:99; Gary, 2005:989).

Gary (2005:989) reported that the users were belittled, discredited, and their importance, as credible members of the society, frowned upon. Rusch et al. (2010:150) further revealed that their wellbeing was severely affected, and the effect of condemnation left them with little possibility of getting better. The findings of this study showed that the environment where human rights of users are violated was the home and family settings, general community settings, the workplaces or potential workplace, psychiatric institutions, social gatherings like cultural events, health care settings like clinics.

A negative attitude leads to family disintegration. According to Bauer et al. (2011:145), some marriages do not survive mental illness; partners become overwhelmed by the process of taking care of their loved ones. A negative attitude could be attributed to non-compliance to medication as it causes a barrier between carers and mental health care users (Bauer et al., 2011:144). Mavundla, Toth and Melina (2009:361) reported that families disengaged from all social activities to offer support to their mentally ill relatives.

4.4.3 Non-prioritization of mental health services by management and governance structures

Findings on the non-prioritization of services revealed that, in some instances, there was an absence of representation of the community mental health services at management and policy making levels. In instances where there were management and governance structures, these were non-functional, as they failed to prioritize community mental health services. Non-prioritization was demonstrated through failure to advocate for the needs of discharged mental health care users, failure to ensure that there was constant consultation and communication between and amongst the stakeholders for active participation in the decision making processes regarding mental health related issues. The findings further revealed that management had failed to promote the accessibility of services to the users as there was only one hospital servicing a wide rural area. In addition, the therapeutic infrastructures for community mental health clinics are inadequate, outdated and unsuitable for mental health care users.

Furthermore, management did not make provision for human resource development and management as there was a shortage of human resources for community mental health services, and this was linked to the lack of capacity development for mental health care personnel and community members as well as the users about psycho-education.

The discharged users and their relatives revealed that they had never been capacitated with knowledge on the diagnosis of their illness, how to supervise and monitor medication and side effects. One participant succinctly put it as follows:

"I think it is awareness, it's awareness."

Participants revealed that the shortage of human resources was evidenced by the allocation of one (1) community psychiatric nurse to run a clinic alone and by the absence of a multi-disciplinary team at community level. The results further revealed that the services, programmes and training programmes offered at hospital level are not available at the clinics, resulting in a lack of continuity of services at community level. The failure of management to provide resources was also revealed to be related to the unequal distribution and shortage of material resources, especially medication and transport, to access far off rural areas for outreach services and follow-up care. Participants revealed that the shortage of medication meant that there was a shortage of supply of prescribed medications, and this shortage caused users to default on treatment.

Medication was often out of stock in the government central medical stores which supply medication to all government hospitals; as a result, nurses prescribed what was available and not what is appropriate for the patient. Management had also failed to facilitate the establishment of a functional multi-disciplinary team in community mental health clinics. Results also revealed that monitoring and evaluation was not done to determine the effectiveness and impact of services rendered. Overall, the participants revealed that the governance structures for community mental health services were non-functional.

Since mental health services are not regarded as a priority service, findings have revealed that participants, who are professional mental health care practitioners, indicated that they were suffering as a result of the effects of the neglected services as they felt demotivated and demoralised since they were not exposed to further training or given any other incentives such as being sent for a workshop by management.

Literature is abounds with views on similar findings with regard to the non-prioritization of mental health services. As stated in Booyens (2008:56), psychiatry faces vast problems with regards to implementing programmes for the chronic mentally ill and to apply principles of differential therapeutics. A similar view is presented in a study by Marais and Petersen (2015), who identified intrinsic factors within institutional and policy contexts that were likely to facilitate or hinder the implementation of integrated mental health care in South Africa. These authors identified obstacles to integration as follows: mental illness was less prioritised and was stigmatised; there were poor administrative and organisational capabilities in terms of establishing and implementing mental health care plans at provincial and district level; those with general training were not in-serviced in mental health care and were not familiarised with integrated care; there was also a high rate of service termination by employees; weak organization between different sectors; infrastructural limitations and no budget for mental health.

Policy makers seem to neglect the mental health care systems as can be seen from a lack of resources for effective service delivery. For example, as reported in Strumpher et al. (2014: 56) and Schierenbeck et al. (2013:113), the difficulty in maintaining privacy in facilities was due to limited rooms available for proper consultation. In other facilities, poorly implemented procurement processes led to the keeping of invalid treatment in health care facilities (Oppong et al., 2016). According to Sullivan and Decker (2005:22-25), nurses are obligated by the professional body to be advocates for their patients, as stated in one of the codes of ethics for nurses. Nurses are, therefore, expected to promote, advocate for, and strive for the health, safety, and rights of the patients. Both authors further state that nurses can be held liable for acts and omissions or commissions and that inadequate staff is not an excuse for negligent acts. Findings seem to reflect that the lack of prioritization of mental health care services by management at policy making levels is central to the lack of re-integration of users into the community, as the rest of the identified themes on challenges allude to the non-prioritization of services as the root cause.

Communication problems between different health care providers, particularly between hospitals, clinics and pharmacies, pose a challenge to the re-integration of users (Marais & Pietersen, 2015:10). In some instances, the breakdown in communication, between the mental health community facility and the hospital which down-refers patients, results in incorrect medication being issued or medication not being packed on time to be available during the next visit of the user.

On the lack of prioritization of community mental health services by management, Ng et al. (2010:59) revealed that in Japan there was a lack of assistance in looking after mentally ill patients in the community, lack of community services and insufficient preparation by health care professionals to deliver expected health care services.

Such a situation is reported as factor in the denial of mental health, low perceived need to access services, and lack of motivation to take treatment (Sorsdahl, Stein & Lund, 2012:169; Mojtabai et al., 2011:1757).

4.4.3.1 Governance structures

A study conducted by Azermai et al. (2014:351) maintained that the deterioration in health, undesired complications and signs of addiction on the elderly, were due to the failure in reviewing treatment, yet another indication of lack of supervision by management with a negative attitude on the quality of care provided. A similar view by Oppong et al. (2016) stated that in other facilities, poorly implemented procurement processes led to the keeping of invalid treatment in health care facilities. The Gater et al. (2005: 530,534) study indicated that general practitioners in other facilities were only allowed to issue sedatives and antipsychotics on the recommendation of a psychiatrist, and this led to limited antipsychotic drugs being kept in health care facilities. Management has also failed to advocate for job creation opportunities for the mental health care users. The failure of management to advocate for job creation opportunities for mental health care users was reported in a study conducted in the Eastern Cape by Strumpher et al. (2014:53-54), which clearly indicated that the Department of Health and its partners failed to assist in improving services in the mental health sector.

4. 4.3.2 Shortage of Resources

Shortage of resources refers to the lack of provision of working tools like personnel, budget and material resources. Results revealed that management did not facilitate the process of allocating a budget for community psychiatric services and did not provide for training and employment of community mental health care workers. As part of limited resources, transport for home visits was lacking and there was also a shortage of medication. Staff shortages and a poor organization in some facilities delayed the provision of services by health care professionals (Mesidor et al., 2011:286; Strumpher et al., 2014:55).

Lack of training, supervision and information utilization in primary health care facilities were seen as major concerns that could hamper the provision of quality care in health care facilities (Condo et al., 2014; Maritz, 2010:62; Petersen & Lund, 2011:752; Mendenhall et al., 2014:37). Personnel in the 72-hour emergency and observation unit had no advanced knowledge in psychiatry and doctors complained of poor knowledge in diagnosing mental illness (Petersen & Lund, 2011:752). Another feature related to the shortage of resources due to poor management is reported in the Schierenbeck et al. (2013:117) study which points out that, in primary health care facilities, doctors with no psychiatry qualification were left to handle people suffering from mental disorders, resulting in the possibility of misdiagnosis and improper admission of patients as well as a negative financial impact for the admitting hospitals.

According to Ashton and Jarvis (2011), when one talks about the shortage of resources, one refers to either one of these two things, or to both supply and/or demand. In this case, it really seems to be an issue of supply. The study further reports that the shortage of human resources available for mental healthcare in most low-income and middle-income countries is likely to persist, as affirmed by Maritz (2010:62).

It has been reported that in low and middle-income countries, there is lack of physicians, psychiatrists, nurses and multidisciplinary teams, these include psychologists, occupational therapists and social workers, with the public sector hardest hit by gross shortage of health care professionals who are better qualified to manage mental disorders (Schierenbeck et al., 2013:13; Lehmann, 2008:166). Not only are the resources for mental health care scarce, they are also inequitably distributed between countries, between regions and within communities. The shortage of resources is also related to the shortage of housing and accommodation for the users (Manderscheid, Atay & Crider, 2009: 29). According to Mkhize and Komatsu (2008:108) and Parker (2014:76), although community-based facilities are operational, institutions still experience an overflow and the recurrence of mental health symptoms; meanwhile mentally ill patients in the community become homeless, and others end up being incarcerated. On lack of resources, literature cites the lack of integration to be related to the non-availability of community-based services; inadequate preparation of the users for life in the community; users' non-compliance with medication due to financial and structural challenges, stigma attached to mental illness, as well as lack of support to their families (Lazarus, 2005:66; Manderscheid, Atay, & Crider, 2009:33; Oruche et al., 2014:245).

As a result, a lot of programmes were slashed because of a country budget crisis. A lot of patients without access to care went into psychiatric crisis and became a danger to themselves or others and that had a devastating impact to the community. Ashton and Jarvis (2010) state that the unavailability of essential medicine also hampers effective mental health treatment. About a quarter of low income countries do not provide even basic anti-depressant medication in primary care settings. In many countries, the supply does not extend to all regions of a country or is irregular, despite the fact that effective pharmacological treatment for many disorders depends on continuous access to medication for extended periods. This indicates that users are not followed up when they are discharged back into their communities and are caught in a vicious cycle, leading to a major feature of lack of integration of discharged users, which is the revolving door syndrome.

4.4.3.3 Inaccessibility

Another challenge to re-integration relates to the underperforming management structures. Accessibility remains a complex concept. It is used in relation to geographical distances or to travel times from the patients' homes to health centre sites and also to delays in how long it takes for patients to be assessed (Kaplan & Sadock, 2003:1382). In rural America, it was found that the absence of providers and services clearly correlated with decreased access to services and diminished treatment for patients (McCabe & Macnee, 2002:263-278).

4.4.3.4 Inequities, a problem related to underperforming management structures

A study by Bredlar, Lindquist and Norredam (2014:4) observed that there was no equity in health facilities for asylum seekers in Sweden. They received fewer antipsychotics than people who were born there. Mkhize and Komatsu (2008:109) reported that South Africa lacked equity in the sharing of assets amongst the provinces, especially in remote areas, and was also experiencing a poor state of community-based services. Crotty, Henderson and Fuller (2012:216) reported that health care professionals encounter a lot of challenges in providing services, especially in rural areas, like in the present setting of the study (Raymond Mhlaba Sub-district), and this problem is compounded by the mass exodus of experienced professionals. Oruche et al. (2014:246) reported that mental health care users and their custodians felt that the exodus of health care professionals influenced their withdrawal from treatment.

Lehmann (2008:166, 169) states that, regardless of the incentives offered, doctors and nurses declined offers to work in remote areas, citing a disconnection between theory and practice. The problem with mental health care is the inability to segment and individualize the treatment so that the correct treatment is provided to each mentally ill person.

Practice procedures and laws need to be changed so that each individual receives the services he or she needs, in the most optimal setting (Talbott, 2004: 1136-1140). The author continues to state that, despite years of vowing to provide continuity of care, there is no such a thing in most communities.

4.4.3.5 Lack of training, supervision and information utilization

The results of this study on the non-prioritization of mental health care services by management structures is mostly manifested through the shortage of, or lack of financial, human and material resource allocation. Lack of resources negatively impacts the accessibility and quality of services provided and received by mental health care users after they have been discharged from hospital. Lack of training, supervision and information utilization in primary health care facilities was seen as a major concern that could hamper the provision of quality care in health care facilities (Condo et al., 2014; Maritz, 2010:62). Petersen and Lund (2011:752) and Mendenhall et al. (2014:37) reported that personnel in the 72-hour emergency, management, and observation had no advanced knowledge in psychiatry, and doctors complained of poor knowledge in diagnosing mental illness. Staff shortages and a poor organization in some facilities delayed the provision of services by health care professionals (Mesidor et al., 2011:286; Strumpher et al., 2014:55).

4.5 THE ROLE OF STAKEHOLDERS TO PROMOTE INTEGRATION

Findings in this study on the role of stakeholders in the re-integration of users who had been discharged from hospital within the community of Raymond Mhlaba sub-district revealed that stakeholders use and suggest a number of strategies to facilitate re-integration and to mitigate the challenges of re-integration. Strategies for the re-integration identified in this study were based on what the participants are currently doing as well as their suggestions of what needs to be done to militate against the challenges to re-integration.

4.5.1 Establishing functional management/governance structures

In a study by Pilkola, Sund, Sillen and Wallpeck (2009:147-153), the well-developed community mental health services with representation at management level were associated with low suicide rates. Booyens (2008:56) states that in order to promote functional management structures, an unbroken chain of authority and communication should extend from the highest to the lowest level. If the public mental health system is to survive, it must shift the balance of resources and services from institutional to community-based services (Talbott, 2004:1136-1140).

4.5.2 Consultation

The participants further indicated the need for the users to remain at the centre of decision making on issues that affect them to ensure that the services rendered remain culturally sensitive. Consultation plays a major role in militating against culturally incongruent services, as the participants suggested that members of the community and mental health care users should be consulted on policy decision initiatives in the development and implementation of plans of action and strategies to address their mental health care needs and challenges.

4.5.3 Adopt a positive attitude and uphold the rights of users

On militating against the negative attitudes, the participants suggested that the constant violation of human rights of mental health care users requires a range of strong, inclusive, and integrated strategies to be adopted to uphold the rights of the users. This is against the back drop of understanding that upholding the human rights of users means that the users will be included in the general mainstream of society, as they will enjoy unrestricted civil, cultural, economic, political and social rights. Furthermore, it confers on the user a full recognition of a sense of being human and respected, with a potential of being integrated into the family and community.

The results revealed that the participants were of the view that mental health care professionals, the community and the relatives of mental health care users should promote the re-integration by demonstrating behaviour and actions which are indicative of upholding the rights of the discharged users. Promoting the rights of users has a potential to eradicate the stigma against the users and thus promote their inclusion into the mainstream of society. The stakeholders need to conduct campaigns on eradicating the stigma and advocating for the welfare of mental health care users. Relatives need to provide the users with the basic needs of living, like health, food, shelter, and safety, protection against severe weather, cleanliness, rest and sleep.

Such basic needs will have to be streamlined with the social, cognitive, interpersonal relationships and emotional needs. Job opportunities need to be created for the users for them to lead an independent satisfying life using the remaining potentials of their mental health. This finding talks to the declaration in the National Mental Health Policy Framework and Strategic Plan (2013 – 2020:51) of South Africa, which states that the stigma and discrimination against people with mental disorders should be eliminated as a realisation of the United Nations Convention on the Rights of Persons with Disabilities.

As stated in WHO (2010), discharged users need to be able to earn an income, lift themselves out of poverty, gain access to treatment and support that will help them to be reintegrated into their communities and to recover from their illness. In addition, campaigns to create awareness about the rights of mental health care users need to focus on their competences and capacity to function as community members who have recovered from mental illness, for example, through testimonies by rehabilitated patients. Testimonies by discharged mental health care users who have been re-integrated with their communities potentially reduce the stigma against mental illness (Kakuma et al., 2010: 122).

The finding of this study revealed that non-integration related to negative attitudes needs to be addressed through the specific training and education of people acting on behalf of the state or with other social authority so that all sections of society are aware of the rights of mental health care users. The training of relatives and community members as a strategy to eradicate the stigma against mental illness has a potential to promote integration of discharged users into the community (Drew et al., 2011). The findings of this study have indicated that it is the role of the stakeholders, including the mental health care professionals who are members of the multi-disciplinary team, to advocate for the admission and discharge of mental health care users from hospital, as prescribed in the Mental Health Care Act, (Act No.17 of 2002).

Birkmann, Sperdip and Smith (2006:157-165) stated that the integration of the discharged mental health users in the community requires healthcare workers to be at the forefront of fighting the stigma and discrimination against the mental health care users as fighting stigma and discrimination is fighting for mental health. It is important to be mindful that the strategies to promote the human rights of users, as presented in this section, should not exist in isolation from each other, but should be co-ordinated, multi-faceted and be culturally congruent for the better integration of users. This means that there should be collaboration between various community stakeholders for an integrated multi-sectoral approach.

4.5.4 Resource allocation

On the resourcing and capacitating of communities, results revealed that a thorough assessment of communities for resourcefulness and readiness should be done as part of the discharge planning of the users. The results revealed that the assessment needs to include the availability, accessibility and location of facilities to provide follow up care to the users. Such facilities should include the availability and the need for half-way homes and shelters for the displaced users. Also, the availability and readiness of relatives or carers to provide care and support to the user on discharge needs to be assessed. The assessment process should inform the process of developing a costed programme plan for the user. The programme ought to be specific on deliverables, outcomes, time frames, evaluation and monitoring systems. The buy-in of the governance structures for mental health care rehabilitation in the community is the key element in the effective implementation and sustainability of such a programme. The suggestions from the participants seem to be highlighting the need for a policy framework to promote the re-integration of users in their communities. Furthermore, participants suggested that the integration of the mental health care user into the community through resource allocation is a role of policy makers and management. Policy makers need to ensure the transfer of budget and resources currently earmarked for hospital as well as clinical and material resources to community mental health services, as recommended in the de-institutionalisation programme.

Such an initiative has a potential of ensuring that quality, effective and efficient community mental health care services are rendered with improved outcomes for the optimum health of the users. Participants suggested that personnel employed should include community mental health care workers. The establishment of functional well-equipped clinics, specifically earmarked to address the needs of the discharged mental health care users, should be part of resource allocation. Attention needs to be paid to the setting up of a clinic infrastructure that promotes a therapeutic environment for the users and their carer's. Repeat medication should be available at the clinics for sustained recovery from mental illness. In addition, before the users are discharged, the community should be assessed for readiness to receive the users and also capacitated in areas where there is a shortfall. On resource allocation, participants revealed that the current good practice of social grant allocation is meant to provide support to the users and their carer's.

The challenge, as pointed out by the participants, is the prevention of abuse of the social grant by carers who neglect the users. The situation seems to point to the need for a consultation with local community structures, e.g. Councillors and traditional leaders, to play a role in monitoring the situation and setting up control measures. This finding responds to the declaration in the National Mental Health Policy Framework and Strategic Plan (2013 – 2020:50) of South Africa, which states that there should be physical infrastructure that is conducive to the needs and human rights of people with mental disorders.

4.5.5 Empowerment and capacity building

Findings have revealed that health care professionals have a responsibility to empower the users and their relatives with knowledge and skills to manage the patients at home while giving adequate consideration and respect to their background, which includes cultural beliefs, norms and values, the language, and the availability of needed resources. The focus of empowerment should be on psycho-education. The role of management is also linked to up-skilling mental health care professionals and capacitating users, families or relatives and community members with psycho-education; and the establishment of a functional multi-disciplinary team in the community. Empowerment means finding ways for people in a community or population to acquire skills and knowledge so that they can participate in the decision making about their health (Carroll, 2004: 2).

4.5.6 Psycho-education

Findings have revealed that psycho-education is used as a strategy to facilitate integration. According to Thornicroft and Szmukler (2001:51), psycho-education is beneficial to patients on long term treatment as well as their families, as they are equipped with skills that aid in dealing with mental illness. Valencia, Rascon, Juarez and Escamilla et al. (2010) stated that patients actively participate in their care and receive first-hand information about their illness, thus resulting in taking full initiative regarding their mental condition. Family psycho-education is an evidence based practice that has been shown to reduce relapse rates and facilitate recovery of persons with mental illness (Dixon et al., 2001:903-910).

As reported in Gilbert, Plant and Nigel (2008:85-96), mental health care users who are in the community need to be supervised on what and how to take medications and identify side effects. These authors further state that the main supervisors are the relatives. However, it should be borne in mind that supervising a user is not easy as it needs a lot of dedication and patience.

Findings further reveal that, to promote integration, families and communities should be empowered with knowledge on the importance of creating jobs for users, engaging them in sport and, ultimately, the acceptance of the user as a member of the community. In addition, empowerment relates to the empowerment of users and their relatives about the importance of compliance with the treatment regimen, managing the side effects of medication, the location of the nearest clinic for follow up care; the dangers of alcohol and drug abuse while on treatment, as well as self-reliance. Furthermore, the patient should be given an opportunity to participate in community events and rituals, for example, celebrations of the rites of passage, weddings, funerals, church events.

The patient feels empowered and self-reliant when empowered with work related skills; given opportunities to participate in sporting activities; when opportunities for employment are made available; when trained in skills for self-employment; when accepted and respected by the community. The sense of empowerment and self-reliance is further enhanced when the patient is a recipient of the social security grant from government.

4.5.7 Provision of community-based mental health facilities and services in the community:

Findings reveal that simply providing mental health services in the community is not sufficient, a broad set of services or programmes are needed to enable people to attain and maintain maximum independence and full inclusion in society. Marais and Petersen (2015:8) report that establishing community-based services motivates communities to play a greater role in caring for patients at a community level. The authors further state that user organisations should be enlisted to provide support and to work with families, thus going beyond what government can do.

Community health-workers, NGOs and the Department of Social Development social workers could be capacitated to deliver community-based psychosocial services (Marais & Petersen, 2015:6). The findings reveal that users, who are exposed to employment opportunities and are engaged in employment schemes that enable them to undertake paid work with ongoing support and training, are likely to demonstrate independence, an important factor in promoting integration into the community.

According to Marais and Petersen (2015:10), such services should include habitation and rehabilitation services, vocational and life-skills development but also in-home, residential, personal assistance and other community-support services are vital to achieving independence and inclusion. The authors further state that the issue of communication needs to be rectified with respect to drug prescriptions and delivery systems (Marais & Petersen, 2015:10). The participants from the current study expressed the need for a broad set of services or programme to enable people to attain and maintain maximum independence and full inclusion in society. Social and health-care services need to adopt a holistic approach to meet the multiple needs of users. Strong links are needed with other sectors to ensure that people have access to housing, education, and employment. The National Mental Health Policy Framework and Strategic Plan (2013 – 2020: 43- 47) of South Africa specifies the various inter-sectoral roles and responsibilities in the collaboration initiatives.

4.5.8 Multi-disciplinary Team

The participants revealed that the Multi-Disciplinary Team (MDT) is supposed to play a major role in promoting integration, and engage in determining the readiness of the user to be discharged. This will ensure that their rights are upheld when they go back to their respective communities.

4.6 CONCLUSION

This chapter has presented the data analysis processes used. The findings of the study in the form of themes have also been presented. During data analysis, the researcher interpreted what each theme signified. Direct quotations from the interviews of the participants, were also included. A discussion of the findings of the study and consolidation with relevant literature is also provided.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents the summary, limitations, conclusions as well as recommendations to mitigate the challenges to the re-integration of discharged mental health care users in the community of Raymond Mhlaba Sub-District.

5.2 SUMMARY

Mental health care users that are discharged from mental health institutions are expected to be integrated back into their own communities while recovering from residual symptoms of mental illness and continuing with their rehabilitation programme. For a successful integration of the discharged users, the community mental health care centre, where the discharged users are receiving services and follow up care, should be easily accessible and provide basic psychiatric services such as emergency services for 24 hours (Kaplan & Sadock, 2003:1374).

The re-integration of users into the community plays a very significant role in ensuring that mental health care users achieve their purpose in life. Mental health care users develop a sense of belonging and enriching relationships with their families, and are encouraged to participate and contribute to community life (Zhenru & Jern Yi, 2014:228-9). Their re-integration enables them to be accepted members of their various communities (Baumgartner & Herman, 2012:435). However, it is observed that the monthly statistics of the only mental health care hospital in the Raymond Mhlaba Sub-District indicates that the number of readmissions is at times greater than the number of newly admitted clients; and this is clearly obtainable from the local psychiatric hospital admission register. The challenges which negatively impact the re-integration of the users who have been discharged from the local psychiatric hospital back into the community of Raymond Mhlaba Sub-district are unknown and have never been explored. The focus of this study, therefore, was to investigate such challenges as perceived and experienced by the users and their relatives as well as the members of the multi-disciplinary team. Their re-integration will enable them to be accepted members of their various communities (Baumgartner & Herman, 2012:435). The purpose of the study was to explore the underlying factors contributing to the inability to integrate discharged mental health care users into the community.

The research objectives of the study were to:

- Explore the socio-cultural factors contributing to the re-integration of mental health care users into their communities.
- Explore the psychological factors contributing to the re-integration of mental health care users into their communities.
- Explore the institutional structures in terms of administrative and communication strategies in the re-integration of mental health care users into the community.
- Explore the role of stakeholders in the re-integration of health care users into the community.

The following research questions were framed:

- What are the socio-cultural factors contributing to the re-integration of mental health care users into their community?
- What are the psychological factors contributing to the re-integration of mental health care users into their community?
- What are the administrative and communication strategies impacting on the re-integration of the users into the community?
- What is the role of stakeholders in integrating mental health care users into the community?

A phenomenological approach was used to capture and describe the lived experiences of study participants. An explorative, descriptive research design was used to explore the challenges encountered by mental health care users with regard to their integration into the community. The opinions of discharged mental health care users, their families, and community psychiatric nurses, psychologist, psychiatrist, social workers, and occupational therapists were sought.

The study was conducted at a local psychiatric hospital, local clinics where the mental health care users go for follow-up care, and in homes in the Fort Beaufort community setting. The population includes mental health care users discharged from local psychiatric Mental Health institution; the relatives of discharged users and the members of the mental health multi-disciplinary team (psychiatrist, psychologist, social worker, occupational therapist and psychiatric nurses) involved in planning the discharge and the care of the mental health care users in the Raymond Mhlaba Sub-District.

A purposive sampling method was used to select 19 participants. The sample size was determined when there was no new emerging information from the interviews (saturation of data). Open-ended questions were used in order to elicit a description of participants' experiences, perceptions and insights about the lack of or promotion of re-integration within the community of the user who is discharged from a mental health institution. In order to clarify issues that sounded vague from the participants, the researcher probed further. Field notes were taken in order to capture the intended messages and observe both verbal and non-verbal messages. A tape recorder was used throughout the interview process after seeking permission from the participants.

An Ethical Clearance Certificate was obtained from the University of Fort Hare's Research Ethics Committee. Permission to conduct the study was obtained from the Epidemiology Section of the Eastern Cape Department of Health, the Director District Health Services of the Raymond Mhlaba Sub-District and from the Chief Executive Officer of the local psychiatric hospital. Trustworthiness (credibility, dependability, conformability and transferability) was observed by applying the principles of Lincoln and Guba (1985). Data was analysed using thematic content analysis by Tech's steps as described in Creswell (2014:198).

5.3 MAJOR FINDINGS OF THE STUDY

The major findings of the study were:

i. The present study indicated that culturally incongruent mental health care services rendered by mental health care professionals contribute to the non-integration of users in the community; as these services were based on the western healing systems, seemingly the mental health care professionals have a tendency to ignore the traditional healing systems of the Xhosa people.

ii. Some family members of users and members of the community have a negative attitude (stigma, discrimination, violation of the rights of the users, alienation and rejection) towards the users.

iii. Findings on the non-prioritization of services revealed that, in some instances, there was an absence of representation of community mental health services at management and policy making levels. However, where there is evidence of management and governance structures, these were non-functional as they failed to prioritize community mental health services.

iv. The findings further revealed that the management failed to promote the accessibility of services for the users as there was only one hospital servicing a wide rural area. Additionally, the therapeutic infrastructures for community mental health clinics are inadequate, outdated and unsuitable for mental health care users.

v. Furthermore, there is shortage of human resources for community mental health services, which is associated with a lack of capacity development of mental health care personnel and community members as well as the users.

vi. The discharged users and their relatives revealed that they had never been capacitated with knowledge on the diagnosis of their illness, how to supervise and monitor medication and side effects.

vii. The results further revealed that the services, training programmes offered at hospital level are not available at the clinics, resulting in a lack of continuity of services at community level.

viii. Participants revealed that the shortage of medication meant that there was a shortage of the supply of prescribed medications, and this shortage caused users to default treatment. Medication was often out of stock in the government central medical stores which supply medication to all government hospitals; as a result, nurses prescribe what is available and not what is appropriate for the patient.

ix. The study also demonstrated that there is a lack of a functional multi-disciplinary team in community mental health clinics.

x. Results also revealed that monitoring and evaluation was not done to determine the effectiveness and impact of services rendered. Overall, the participants revealed that the governance structures for community mental health services were non-functional.

xi. Findings have revealed that the professional mental health care practitioners indicated that they were suffering the effects of the neglected services as they felt demotivated and demoralised because they were not exposed to further training or given any other incentives such as being sent for a workshop by management.

xii. Communication problems between different health care providers, particularly between hospitals, clinics and pharmacies, pose a challenge to the re-integration of users.

xiii. Results revealed that management did not facilitate the process of allocating budget for community psychiatric services and did not provide for the training and employment of community mental health care workers.

xiv. The participants further indicated the need for the users to remain at the centre of decision making on issues that affect them to ensure that the services rendered remain culturally sensitive. Consultation plays a major role in militating against culturally incongruent services. Against this background, the participants suggested that members of the community and mental health care users should be consulted on policy decision initiatives in the development and implementation of plans of action and strategies to address their mental health care needs and challenges.

xv. The participants suggested that the constant violation of human rights of mental health care users requires a range of strong, inclusive, and integrated strategies to be adopted to uphold the rights of the users.

xvi. The results revealed that the participants were of the view that mental health care professionals, the community and the relatives of mental health care users should promote the re-integration by demonstrating behaviour and actions which are indicative of the upholding of the rights of the discharged users. Promoting the rights of users has a potential to eradicate the stigma against the users and thus promote their inclusion into the mainstream of society.

xvii. The finding of this study revealed that non-integration as related to negative attitudes needs to be addressed through the specific training and education of people acting on behalf of the state or with other social authority so that all sections of society are aware of the rights of mental health care users.

xviii. Findings have revealed that health care professionals have a responsibility to empower the users and their relatives with knowledge and skills to manage the patient at home, while giving adequate consideration and respect to their background, which includes cultural beliefs, norms and values, the language, and the availability of needed resources.

xix. Findings have also revealed that psycho-education is used as a strategy to facilitate integration.

xx. Findings further reveal that, to promote integration, families and communities should be empowered with knowledge on the importance of creating jobs for users, engaging them in sport and the acceptance of the user as a member of the community.

xxi. Findings reveal that simply providing mental health services in the community is not sufficient, a broad set of services or programmes are needed to enable people to attain and maintain maximum independence and full inclusion in society.

xxii. The participants revealed that the Multi-Disciplinary Team is supposed to play a major role in promoting integration, and engage in determining the readiness of the user to be discharged. This will ensure that their rights are upheld when they go back to their respective communities.

5.4. LIMITATIONS

Due to the nature and design of the study, the small sample size of the study cannot be generalised to other settings in the Eastern Cape. However, the purpose of the study was to gain an understanding and information concerning the underlying factors contributing to the inability to integrate discharged mental health care users into the community, as opposed to relying on a generalisation of the findings.

5.5. CONCLUSION

The re-integration of mental health care users back into the communities is a process facing multiple challenges which trigger their relapse, leading to a revolving door syndrome. An important aspect of re-integration is the collective support of mental health care professionals, relatives and the community at large; however, negative attitudes inhibit the effective re-integration of mental health care users. The lack of infrastructure and mental health care services in communities is often caused by the non-prioritisation of mental health care at policy making level. It is, therefore, important that there is constant consultation between mental health care users and stakeholders in order to foster a community environment that is conducive to the recovery of the mentally ill users.

The aforementioned challenges of non- integration of discharged mental health care users into the community can be eradicated. It will, however, take a combined effort on the part of management at policy making level, the private sector and in consultation with the communities at local government level. This collaboration enables the users' relatives and the community at large to be involved in the users' recovery from mental illness.

5.6 RECOMMENDATIONS

Based on the findings and the conclusions from the study, the following recommendations are made:

- The recognition of the indigenous and religious healing systems of the Xhosa people has a potential to promote a sense of ownership of the mental health care systems. Such an approach will ensure that they benefit from both the Western healing systems as well as their own indigenous healing systems, resulting in the re-integration of the users with limited chances of relapsing.
- Members of the community from a Xhosa cultural background should be involved in the decision making process for the development of a strategic plan which focuses on culture sensitive mental health rehabilitation processes.
- Strategies to mitigate the challenge of negative attitudes towards the mental health care users who have been discharged from a psychiatric hospital, should be captured in the proposed strategic plan to promote a positive attitude towards the users. The inherent benefit of positive attitudes is that the users will feel accepted, respected, valued, as well as have their self-esteem boosted and will experience a sense of belonging into their own community, with these all being features of successful re-integration
- At management and policy making level, mental health rehabilitation programmes in the community should be represented to promote advocacy for the needs of the discharged users with special focus on providing

resources. There should be a broad representation in the community of mental health management and governance structure.

- The representation needs to comprise of the hospital mental health care professionals, the traditional leadership and traditional healers' structures, the local municipality at local government level, the relatives of discharged mental health care users as well as the rehabilitated mental health care users.
- The suggestions and views of the management structure should be captured in the framework for the strategic plan. The findings of this current study on factors negatively impacting integration of users in the community, as well as facilitators of integration, should be used partly to evaluate the extent of the implementation of the National Mental Health Policy Framework and Strategic Plan (2013 – 2020) of South Africa.
- There should be an effective re-integration informed by an assessment of the family and community for readiness to receive and provide the required support to the discharged user.
- Communities are at Local Government level, thus consultation should be inclusive of Local Government structures and people at grassroots level.
- The community will have to work as a collective in establishing their own non-governmental organisations to serve the socio-culturally related needs of the discharged users and their relatives or care givers.
- The users themselves need to establish their own organisations as a consultative forum to provide peer support, to share ideas and learn from one another.
- Community members and users should be consulted on their mental health care needs and what they require.
- A platform has to be established to train, educate and empower mental health care users, their relatives and communities with information on psycho-education as a tool to conceptualise the diagnosis, treatment and management, psychotropic medication and management of their side effects, early identification and management of the relapse. During the campaigns, the users who are well integrated into the community may give testimonies of their capabilities and what has sustained them in the community.

- Users are to be assisted with resources and community mental health care facilities to establish their own network forums for support and the sharing of coping mechanisms.
- Inclusion into the mainstream of society to include liaising with the private sector for employment opportunities and also the establishing of workshops for occupational therapies and activities. Communities should develop and set up sporting facilities for the users.
- The focus of the awareness campaigns should be on correcting the misconceptions about people with mental illness, and for the community members to demonstrate a positive attitude towards the discharged users, thus facilitating their re-integration back into their communities
- Budget allocation should accommodate the following: human resource management and development, the creation of more posts to employ qualified mental health care specialists, provision of technical and material resources, e.g. medication supplies, training and empowerment of mental health care professionals, communities and mental health care users.
- Resource allocation should also cater for the establishment of mental health facilities like half-way houses and community mental health care centres. Resource allocation should also take into consideration the need for financial and material support, like food parcels for the caregivers of the discharged users, who, in the midst of the prevailing vulnerabilities like poverty, lack of housing and high unemployment rate, are obligated to carry the additional burden of providing support and care to their sick relatives. Saxena & Skeen (2012:399) suggested that South Africa should strive to fulfil the maxim “No Health without Mental Health”.
- Mental health care clinics should be established nearer the communities which are being served. The infrastructure of the clinics and the community mental health facilities, more especially in the rural areas, should be structured to be of the same standard as that of the hospital and clinics in urban areas. The infrastructure should be improved through a co-ordinated interdisciplinary initiative involving housing, roads and transport and community mental health centres for the day-care of users. The infrastructure must reflect the features of a therapeutic aesthetic environment.

- In prioritizing the community mental health systems, management has to facilitate the establishment of monitoring and evaluation systems, impact analysis and quality assurance systems for effective implementation of the prescripts of the Mental Health Care Act, (Act No. 17 of 2002), especially in relation to the promotion of rights of the mental health care users.
- In providing resources for community mental health care facilities, management should ensure that there is budget allocated for the delivery of quality community mental health services to ensure an effective rehabilitation of a discharged user. Community mental health governance and management structures should be established. Such structures will help to ensure that community mental health care services for discharged users are prioritised and also address the advocacy needs of the users and serve as their voice. Community forums; Non-Governmental Organisations; Civil Society Organisations and other societal structures, have to lobby for and motivate for the establishment of community mental health governance and management structures.

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ANNEXURE A: CERTIFICATE OF APPROVAL FROM THE UNIVERSITY OF FORT HARE ETHICS COMMITTEE

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	GOO131STOM01
Project title:	**Challenges of integrating mental health care users in the community after discharge from psychiatric institution: A case of Fort Beautfort Community, Nkonkobe Sub-District, South Africa.**
Nature of Project:	Masters in Health Science
Principal Researcher:	Nomamerika Tom
Supervisor:	Prof D.T Goon
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
    - Any unethical principal or practices are revealed or suspected
    - Relevant information has been withheld or misrepresented
    - Regulatory changes of whatsoever nature so require
    - The conditions contained in the Certificate have not been adhered to

- Request access to any information or data at any time during the course or after completion of the project.

- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Wilson Akpan
Acting Dean of Research

23 November 2016

ANNEXURE B: LETTER OF APPROVAL FROM THE EASTERN CAPE DEPARTMENT OF HEALTH

Eastern Cape Department of Health

Enquiries: Madoda Xokwe
Tel No: 040 608 0856
Date: 14 December 2016
Fax No: 043 642 1409
e-mail address: madoda.xokwe@echealth.gov.za

Dear Mrs. Y.N. Tom

Re: Challenges Of Integrating Mental Health Care Users in the Community after Discharge from Psychiatric Institution: A Case of Fort Beaufort Community, Nkonkobe Sub-District, South Africa (EC_2016RP6_921)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

ANNEXURE C: LETTER OF APPROVAL FROM TOWER HOSPITAL

Province of the
EASTERN CAPE
HEALTH

TOWER HOSPITAL
Private Bag X228, Fort Beaufort, 5720,
Tel 046 6455003, Fax 046 645 2623
Email hendrik.potgieter@echealth.gov.za Website www.ecdoh.gov.za

Date: 10.01.2017

Ms. Y N Tom
Tower Hospital
Private Bag X 228
Fort Beaufort
5720

RE: PERMISSION TO ENTER PREMISES TO DO DATA COLLECTION FOR STUDY PURPOSES.

With reference to the above.

Hospital Management have no objection in you entering the Hospital premises and doing your data collection as per your letter dated 23 December 2016 and Department of Health Research Committee letter dated 14 December 2016.

You are again reminded and referred to paragraph 2 of the letter issued by the Eastern Cape Health Research Committee and you need to adhere to this.

Your compliance in this regard will be highly appreciated.

Yours sincerely.

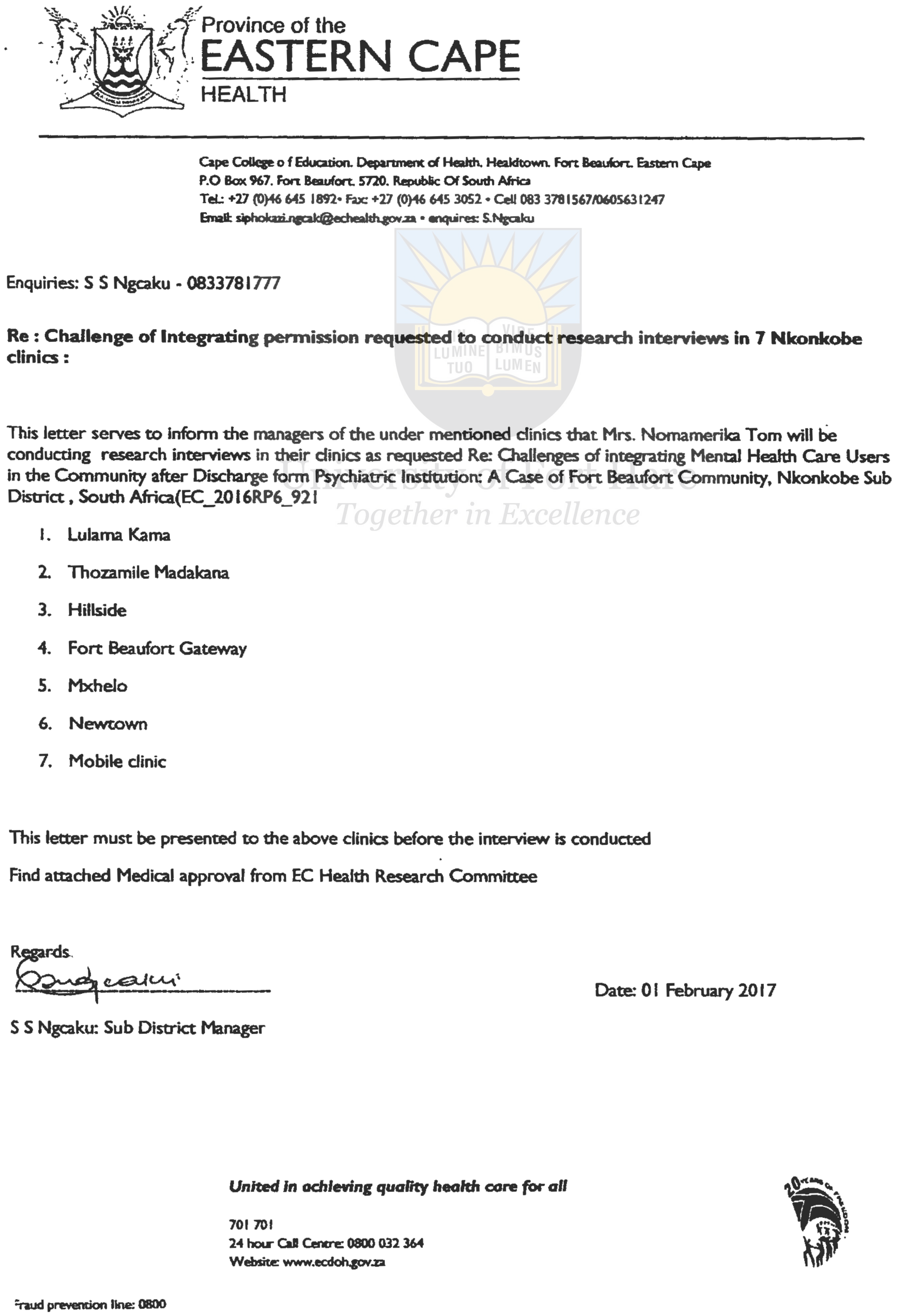
Ms.N E Ngcume
Chief Executive Officer.

Together, moving the health system forward

Fraud prevention line: 0800 701 701
24 hour Call Centre: 0800 032 364
Website: www.echealth.gov.za

20 YEARS OF FREEDOM

ANNEXURE D: LETTER OF APPROVAL FROM THE SUB-DISTRICT MANAGER RAYMOND MHLABA SUBDISTRICT



Province of the
EASTERN CAPE
HEALTH

Cape College o f Education. Department of Health. Healdtown. Fort Beaufort. Eastern Cape
P.O Box 967. Fort Beaufort. 5720. Republic Of South Africa
Tel.: +27 (0)46 645 1892• Fax: +27 (0)46 645 3052 • Cell 083 3781567/0605631247
Email: siphokazi.ngcaku@echealth.gov.za • enquires: S.Ngcaku

Enquiries: S S Ngcaku - 0833781777

Re : Challenge of Integrating permission requested to conduct research interviews in 7 Nkonkobe clinics :

This letter serves to inform the managers of the under mentioned clinics that Mrs. Nomamerika Tom will be conducting research interviews in their clinics as requested Re: Challenges of integrating Mental Health Care Users in the Community after Discharge form Psychiatric Institution: A Case of Fort Beaufort Community, Nkonkobe Sub District , South Africa(EC_2016RP6_921

1. Lulama Kama
2. Thozamile Madakana
3. Hillside
4. Fort Beaufort Gateway
5. Mxhelo
6. Newtown
7. Mobile clinic

This letter must be presented to the above clinics before the interview is conducted

Find attached Medical approval from EC Health Research Committee

Regards.
Sngcaku

S S Ngcaku: Sub District Manager

Date: 01 February 2017

United in achieving quality health care for all

701 701
24 hour Call Centre: 0800 032 364
Website: www.ecdoh.gov.za

Fraud prevention line: 0800

ANNEXURE E: ETHICS RESEARCH CONFIDENTIALITY AND INFORMED CONSENT

NAME OF APPLICANT4 Ethics Human 2015

<< >>

OFFICE USE ONLY

Ref	Date

University of Fort Hare
Together in Excellence

Ethics Research Confidentiality and Informed Consent Form

I, Nomamerika Yvonne Tom, is conducting research on the challenges of integrating mental health care users after they are discharged from psychiatric institution in Fort Beaufort Nkonkobe Sub-District. The study aims to investigate the challenges of re-integrating users in the community.

Please understand that you are not being forced to take part in this study and the decision on whether to participate or not is entirely yours. However, it will be really appreciated if you do share your thoughts with anyone. If you choose not to participate in this study, you will not be affected in any way. If you agree to participate in the study please understand that there will be no monetary benefits, however you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around (45) minutes. I will be asking you questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before, and which also involve thinking about the past or the future. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers. When we ask questions about the future we are not interested in what you think the best thing would be to do, but what you think would actually happen.

If possible, our organisation would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for people in this area.

ANNEXURE E: (XHOSA VERSION)

UPHANDONZULU OLUYIMFIHLO NESIVUMELWANO SOKUTHABATHA INXAXHEBA KUPHANDO

Mna Nomamerika Tom ndenza uphando ngemingeni ethi ifunyanwe ngabantu abagula ngengqondo xabekhululwe kwizibhedlele zengqondo bebuyela ekuhlaleni e Bhofolo. Ndinqwenela wazi ukuba akunyanzelekanga ukuba uthathe inxaxheba koluphando, kukuwe ukuba uqhubekeke okanye urhoxe. Kodwa kungumqweno into yokuba izimvo zakho wabelane nabanye abantu ngazo. Ukuba ukhetha ukungathabathi nxaxheba koluphando akukhonto imbi apho. Ukubangaba uyavuma ukuthabatha inxaxheba yazi ukuba akuzobakho mrhumo, kodwa uvumelekile ukuba ungacela ukuyeka ukuthabatha inxaxheba. Ukubangaba uthabatha isigqibo sokuyeka ukuthabatha inxaxheba lonto ayizokwenza ukuba ubenetyala okanye ujongeke kakubi.

Kushicelelo lemibuzo igama lakho alizokuvela okanye loyanyaniswe nempendulo ozinikileyo. Ngabaphandonzulu kuphela abazakwazi ukufikelela kwinkcukacha ezingoyanyaniswanga negama lakho. Iinkcukacha azizoba namivuka kwimpendulo ozinikileyo.

Olu dliwanondlebe lizokuthabatha imizuzu emalunga namashumi amane anesihlanu. Ndizakubuza imibuzo yaye ndicela unike impendulo ezinyanisekileyo kangangoko unako. Eminye imibuzo ingayimibuzo echukumisayo okanye ethe ngqo kuwe. Ndizakubuza imibuzo esenokuthi kanti khange ucinge ngayo okanye imibuzo ezakuvuselela izinto ezadlulayo okanye ezakuthetha ngekamva lakho. Siyazi ukuba ungangazichani ngqo impendulo zalemibuzo kodwa siyacela ukuba uzame kangangoko ukuyiphendula. Kwimpendulo ozazinika zalemibuza akukhonto izakuthi yinyani okanye ayiyonyani. Xasikubuza imibuzo ngekamva lakho asizokuba sinomdla wokwazi ukuba ucinge ukuba yintoni ekufaneleyo, koko sifuna ukwazi ukuba ucinge kuzakube kusenzeka ntoni ebomini bakho.

Ukuba izinto zihambe ngendlela uno College wase Fort Hare uzakunqwenela ukubuya azokunika ingxelo ngphando kuwe nakusebantwini basekuhlaleni senze ingxoxo ngesikufumeneyo neziphakamiso malunga nophando nokuba zithetha ntoni iziphumo.

ANNEXURE F: INFORMED CONSENT

I hereby agree to participate in research regarding the challenges of integrating the mental health care users into the community after discharge from psychiatric institution: the case of Fort Beaufort community.

I understand that I am participating freely, and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively. I understand this is a research project whose purpose is not necessarily to benefit me personally. I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential. I understand that, if at all possible, feedback will be given to my community on the results of the completed study.

Signature…………………………………………… Date

I hereby agree to the tape recording of my participation in the study

Signature…………………………………………….Date

ANNEXURE F: INKCAZELO ENGESIVUMELWANO (XHOSA VERSION)

Ndiyavuma ukuthabatha inxaxheba kuphandonzulu ngemingeni ejongene nabantu abagula ngengqondo xabekhululwe ezibhedlele bebuyela ekuhlaleni e Bhofolo.

Ndiyazi ndithabatha inxaxheba ngokuzithandela, nangaphandle kokunyanzelwa. Ndiyazi kananjalo ukuba ndinako ukucela ukuyeka kolodliwano ndlebe nangeliphina ixesha endithanda ukuyeka ngalo, yaye lonto esosigqibo azizoba namiphumela mibi kum. Ndiyazi ukuba olu luphandonzulu elinjongo zalo ingekokwenza ukuba mna njengesiqu ndibenenzuzo. Ndiyazi ukuba esisivumelwano asizokuyanyaniswa noludwe lemibuzo, yaye impendulo zam ziyokuhlala ziyimfihlo. Ndiyazi ukuba xa izinto zinokuhamba ngendlela uno College uzakubuya azokunika ingxelo ngeziphumo zophando ezipheleleyo.

Signature……………………………………………………Date……………………….

Ndiyavuma ukuba olu dliwanondlebe lunga shicelelwa.

Signature……………………………………………………Date…………………….

ANNEXURE G: INTERVIEW GUIDE

INDIVIDUAL INTERVIEW GUIDE

- Greetings and introductions were done;
- Rapport established;
- Purpose of the session was explained by the researcher;
- Topic of the research was read and confirmation that the participant understands;
- Consent signed by participant, and explanation given for using the audiotape and approval given;
- Explanation that participant was free to express herself as much as possible;
- The researcher will ask questions as clearly as possible and the participant was free to respond as freely as possible;
- It was explained that during the interview, the researcher will use many communication skills to obtain as much information, e.g. listening, nodding, probing, paraphrasing, clarifying and reflecting;
- Rules of engagement were laid down e.g. switch off all cell phones to prevent any disturbance. The participant should talk as freely as possible as there is no right or wrong answer.

The broad questions that guided the interview were as follows:

As a mental health care professional, what are your experiences with regard to the re-integration back into the community of the mental health care users who are discharged from a psychiatric hospital?

As a mental health care user, what are your experiences with regard to being re-integrated back into your community after you have been discharged from a psychiatric hospital?

As a relative of the mental health care user who has been discharged from a psychiatric hospital, what are your experiences and views with regard to her/his re-integration back into the community where he/she lived before admission?

Probing focused mainly on the following questions:

What do you, as a mental health care professionals and/ or relatives of the users, do to ensure that the user is welcomed back, accepted, respected and valued within his/her community?

What do you, as a mental health care user, do to ensure that you are welcomed back, accepted, respected and valued within your community?

A question that applied to all participants was 'What do you suggest needs to be done to promote the re-integration of the discharged mental health care user back into the community?

ANNEXURE H: SAMPLE TRANSCRIPT FOR INDIVIDUAL INTERVIEW

INTERVIEW 1 MP (SW) – 06. 02. 2017

R: Good afternoon

P: Good afternoon

R: How are u?

P: I'm fine thanks, how are u?

R: I'm also fine

My name is Ricka Tom, working in Tower Hospital as an Operational Manager presently I'm studying with Fort Hare University, Masters in Psychiatry. I am conducting a research on the challenges that are faced by mental health care users when they are discharged from the psychiatric institution back into their communities, my focus will be in Fort Beaufort. Can you introduce yourself?

P: My name is Mydarly Petshwa, I'm working as a Social Worker here at Tower Hospital, and I am originally from East London.

P: Thank you.

R: Miss Petshwa I've got two forms that I need you to look at and if you are happy with them to sign them. The first one is the Ethics Research Confidentiality and Informed Consent Form. I would like you to read it on your own then we will talk about it. Another one is the Informed Consent that you will also have to read and sign.

P: Should I read it quietly or aloud?

R: You can read it aloud it doesn't matter.

Participant reading the Ethics Research Form and the Informed Consent Form and agrees on the tape recording of the interview. Consent signed.

R: Are you ready for us to start?

P: Yes I am.

R: Another thing I will be taking notes. Don't be offended by that because there are issues that you are going to say that I will need to make follow up on.

P: Maybe I will also write something but I'm trying to think.

R: The questions are structured like this, I've got one broad question for you to answer and two follow up questions. Ok can we start?

R: As a member of the Multi-Disciplinary Team in this hospital what do you do or what is your role to make the discharged users feel welcomed, accepted, useful and valued by his community?

P: Okay (adjust her seat) First of all neh my role is to educate the patient based on what were the reasons for the patient to come to hospital which means the rehabilitation programme. After I have done all of that I prepare the family because most of our patients they have done things that are not easily acceptable by their community or by their families, so I also prepare the community, educate them about the condition of the patient and how they can help, assist or support the patient when he has been discharged. I also intervene in the community resources available that helps the patient to know the resources around his community that he can use when he is out in the community so as to prevent him or her from relapsing again.

R: Okay, you say you educate the community and the family, what type of education are you giving to the family or the community about the patient?

P: As I have said before that I educate the family or community first of all about the condition of the patient which means the diagnosis that has been given to the patient and also how to assist the patient to cope at home things like the importance of treatment, the avoidance of stigmatizing the patient and how to treat the patient like things like dignity that the patient has to retain or restore his dignity.

Those are the kinds of things that I educate the community and the family and also the patient and the family need to know the resources that he can use when the patient need those resources, for an example the police if the patient is aggressive they need to go to the police, if the patient needs treatment they need to go to the clinic and if the patient needs occupation during the day they need to know the centres in the community that the patient can go to so as to occupy him during the day.

R: Mmh

R: Okay, you mention the occupation of patients when they are in the community, do you know of any resources that will cater for that in the community?

P: Not in the community of Fort Beaufort but in other communities there are resources like that but they are so scarce.

R: What are those resources in those areas?

P: Okay, there are sheltered employment where the patient can go during the day and do some work like for an example make handwork things that they can sell, like cutting sponges to make continental pillows, doing wood work, sewing, doing gardening and those kind of things or sometimes they do covering chairs, table chairs or car seats all of that. Also patients can also occupy themselves by going to, taking part in the saloons where they assist in cutting hair sometimes making shoes those kinds of things there are resources like those in the community but as I have said before they are very scarce because people they fear people with mental disabilities.

R: Nods head

R: So I believe as part of the multi-disciplinary team you are involved in the discharge process of these patients when he is going to go home. So what preparations are there to these patients? How do u prepare him?

P: (Quiet for a moment) Most of our patient's mental disability is caused by substance abuse first of all, so we try and educate them about the dangers of using substances and also most patients engage in substance abuse because they have nothing to do when they are at home or they are exposed in so many things like they have access to money that they do not know how to use it, so we educate them that i grant is not for them to buy substances, i grant is there to assist them to look after himself, so that's how we prepare them.

R: And the family? Do you prepare the family when this person is going to go home?

P: Yes we do prepare the family by educating them about the condition of the patient, sometimes we also go to, because sometimes the victim that the patient had injured or something is not in the family, so sometimes we go to the community to make restorative justice, that is to make peace between two families that were affected by the patients behaviour before he or she was admitted in hospital, so that we make sure that when the patient goes out she is accepted by the community, there are they are not stigmatized or is not blamed or they do not refer to what he had done before. So we go to the communities and families to prepare them for that and tell them about how the patient is supposed to take his treatment and all of that.

R: When you try and bring peace between these two families have you ever encountered where the family of the patient or the victim's family not wanting to have the person back to the community?

P: (fiddles with her hands) Yes we experience that a lot, these patients are not accepted by i relatives and the victim's family, they don't want to accept them, they do not understand their illness, they don't want to understand that they committed whatever crime or act because they were ill, they most of the time they reject them.

R: So….

P: And they even chase us as social workers away

R: Okay, because they don't want to listen

P: To us ewe

R: Then in that case how do you approach the patient, how do you give feedback to the patient of what happened at home?

P: Yha (looks sad) it becomes very difficult but as counsellors *ke* we need to tell them what like(pause) we need to tell them to help them face the reality in fact we start preparing the patient even before going to the family because when we are treating the patient *mos* we need to make the patient understand what had happened and that if he is remorseful about had happened or not, so we first prepare the patient and after we had prepared the patient and we are comfortable that the patient understands, then we make them understand that he might or he might not be accepted by the family. So when we go to the family the patient already know that they are expecting two answers and then as difficult as it is we need to give them true feedback of what has going on in the family

R: Do you have a lot of patients in your hospital from Fort Beaufort?

P: Not many from Fort Beaufort, most of our patients are from Port Elizabeth area, there are very few from Fort Beaufort. Like I would say if I can just estimate about 15% come from Fort Beaufort otherwise most of them are not coming from Fort Beaufort hence we are not admitting straight from the community, we are admitting *mos* referrals from other hospitals so mostly are getting referrals from P.E. area.

R: Is there anything you want to add to this, anything that you are thinking about?

P: Except that really *ke* integration is something that is important that we really need to do but it still needs lot of work especially because of stigmatization because people still feel that the people with mental disabilities cannot stay with other people or that they belong to the Government that's how thy refer to them that they are government people they need to be institutionalized right through whereas they want to use their grant money at home whilst the patient is here in hospital, so it's very challenging to de-institutionalise patients.

R: How do you handle the grant money when the person is here, what happens, how do you ensure that this person benefits from his grant?

P: Okay, first of all its very difficult for us to find out if the patient is getting grant or not, because the families they don't tell us if the patient is getting grant because they know it needs to be cancelled when he is here in hospital, but once we have found out we are supposed to cancel it immediately but we try to be fair we consider the conditions, like if the patient is going out on Loa's more often we rather not cancel that grant because it's gonna take time for the patient to get the grant when he is discharged or as I've said most of these patients come from very far and the families need that money, so they use that money to travel so that they can come visit the patient buy few things for the patient and to buy even some things like at home for an example a bed, if the patient is gonna be discharged most of them usually they burn their beds before coming to hospital, so the family needs to buy a bed for the patient when he is going to be discharged, so that is one of the reasons why we don't cancel the grant immediately. But if the family is rejecting the patient totally we cancel the grant because *ke* he can't get the grant whilst he is in hospital, and also *ke* we assist them although that is also difficult, we assist them, the families in administering the grant when they are at home and we also educate the patients on how to use their grant at home.

R: What if the patient is here in Tower and is going to be discharged and he didn't receive the disability grant what happens to that patient? When he is going to go home and does not have grant?

P: (sighs) Okay, first of all most of the patients that we are discharging we make sure that they do have a grant. If the patient does not have a grant we educate them on how to go about applying for i grant depending on the reason why that patient is discharged without grant, otherwise these things have been made easy I don't want to lie u Sassa is assisting people to apply for their grant, so they don't struggle that much and if they need medical report from us we do send them i medical report and even from their local clinics the Doctors there, they help them to when apply for their grant when they are at home.

R: Okay, let's go to the second question. How do you ensure the smooth transition of the user from the hospital to the community? Or how do you ensure that the process of releasing the user from the hospital to the community will be successfully implemented?

P: It's very difficult because the (pause) what can I say the stakeholders or the, let me just say the components involved when discharging the patient are not the same in the hospital, the hospital setting is not the same as the community setting, so it's very difficult especially now that we are dealing with areas that are very far because for an example here in hospital things are done procedurally, they are having beds, they wake up, they know they must make their beds and they know it's time for treatment this and that. In the community settings are not like that, first of all they do not sleep maybe in one room, the patient sleeps maybe in an outside room, so maybe by the time the parent or whoever is the custodian wakes up the patient is already gone already or maybe the custodian is going to wake up before the patient wakes up and the patient would not want to be woken up if he is not going anywhere and the custodian maybe needs to go to work and the patient is left alone during the day, so the circumstances here in hospital are very different they not the same as the situations at home so it's very difficult to balance or to make sure that the integration is smooth, that is why we need to go and assess the home conditions and the environmental conditions so as to try and balance and try and design i education of the patient according to the circumstances at home so that if you know that in this area for an example here in hospital there no shebeens there are no selling substances but will tell them that i substances are not good for you when he goes out to the community the first thing he sees is a shebeen or a drug dealer or what, so will always have to balance the two but it's very difficult but we have to prepare them so that they know that the circumstances out there are not gonna be the same as in the hospital.

R: Do you liaise with the community social workers? What is their role? When you have prepared this person from inside then you are taking him now to the community, do you have a relationship with them?

P: Yes, we do have a relationship with them but *ke* I won't lie because of i lack of resources even in our institution we don't do as much work as we would like to do. We are supposed to liase with all the community structures not necessarily the community social workers you see. We are supposed even the councillors and every stakeholder in the community, we supposed to liase with them like sometimes we need to go because some of the patients are rejected by the (pause) like one will tell you that *yhoo* even the councillor here is the one that we are reporting this case to he does not want him we I signed with the councillor that so and so won't come back to this community, so we go there and speak to the councillors tell them that we need to bring back the patient, it's not an easy job but we try and work with them. Social workers, community nurses you name them all of those people and even business people because we do mos give them a little bit of skills here, so we try and talk to business people so that they can employ them in their car washes and all of that but because we don't have phones, we don't have transport to do this we don't do it more often but when we get a chance to do it we do it.

R: So you mean the social workers in the community have got nothing to do with the patients that are coming out or is there something they do? Is there anything that they do for them? Because I believe you finish your job when you were preparing this person now there is this social worker now in the community what...

P: I think there is still a problem there, there is a gap that needs to be breached, because social workers in the community are the ones I would say who stigmatize or discriminate against people with mental disability, they will say no we don't have services for people with mental disabilities whereas people with mental disabilities they are like just the rest of the people in the community.

I think it depends on that office how those people are like, *indlela aba educathwe ngayo nabo* because if at least they have an open mind and insight they do accept patients and then we refer to them whatever that we would like them to do but most of them are even scared, they say they are scared of mentally ill patients so they don't want anything to do with them, so it becomes very difficult.

It depends otherwise they are supposed to be serviced by community social workers as like every other person in the community. Sometimes they will tell you *hayi thina* we are not trained to look after people with mental disability and you would wonder where does that comes from. We were also not trained to deal with people with mental disabilities but we use the skills that we have to deal with those but it's a challenge, so the social workers in the community play a very minimal role.

R: Is there anything you would like to add?

P: No

R: What would you recommend to promote the acceptance and integration of mental health care users back into the community?

P: Mna I would recommend that the work that is being done inside the institution should be taken out to the community as an outreach programme, because I think we focus a lot, i mental illness is mostly behavioural more than otherwise. The doctors can play their part by giving the patient the correct treatment but most of the work that needs to be done is practical there in the community, so if what is being done in the institution can be taken out to the community and be tailor made for that community because the communities are not the same, they differ there are those who have high rate of substance abuse, there are those which are still doing things the traditional way all of that. All communities are dynamic in their own way so if the work being done in the institutions can be transformed to i communities through outreach programmes and there are social workers, say whatever staff members employed by the Department of Health but working in the community, just like the clinics you see because *mos* the patient is taken to the clinic and then the clinic refers to the hospital that's what is supposed to happen even with other disciplines.

There should be professionals employed by the Department of Health that's start the work there in the ground level there in the community. I think that would help

R: You talking about outreach programmes, what could they be? What are you thinking about? What can be done?

P: All the services that are done, let us say for an example we've got OT's who train patients on certain skills and all of that but you see when I used to work in another rehabilitation centre what was done there I think it was working. If a patient is given i skill for example for shoe repair or something that patient would be given capital some money so that when he goes out we make sure that he starts the business of making shoes, not just give skill and then you discharge a patient and it end there, you should follow, you should make follow-up even if the patient has been discharged and see to it that he establishes her business and then *kengoku* maybe supervise him for a few months and then after few months when we see that the business is stable we let them continue with whatever, and even ke with us social workers we visit and hear how are the attitudes in the community so that we can see that the person has really adjusted in the community, because sometimes patients would be scared to come back and say social worker *mna* I haven't adjusted well into the community, maybe the people in the communities are saying this to me then he would feel weak to report that. So at least if we were doing follow-up it would be much better, we need to do aftercare services.

R: And something like sheltered employment in the community for them, because they have got the skill but now they don't know where to use it. Is there anything else that you would like them to do whilst they are in the community or your vision?

P: You know what I've learnt about people with mental disabilities we know that they have lot of energy, there's a lot that they can do, really as I'm saying if we can have outreach programmes that are structured it would be like for an example brick laying, if we can teach them how to make bricks and how to do brick laying we know *mo*s they are abused in the communities doing these things without being trained but I we can structure it, train them and then make sure there is someone who is going to supervise them, who's going to ensure that they do all these things in a proper way it would be fine.

R: I understand what you are saying because I remember seeing community members doing gardening in the clinics, I was thinking to myself those people can do that because if they can be taught how to do gardening or they have got that skill of doing gardening they can help doing the gardening but they are not utilized in the community

P: For an example *apha* e Tower last year we were I'm sure we are gonna start that project this year, thinking of those gardening services like cutting grass and growing flowers so that we have our patients, like the patients that are here in Tower Hospital those that are not wanted by their families to have their own sort of project or company and then they advertise themselves around Fort Beaufort and then they cut grass and charge people and then keep the money for themselves.

R: That would be a very good idea, thank you very much social worker your input was very helpful for me and it's going to help these patients fortunately maybe this study will be considered to implement the recommendations that I got from you. Thank you very much.

P: You welcome. (Hugging each other)

ANNEXURE I: LETTER REQUESTING CODING DURING DATA ANALYSIS

TO WHOM IT MAY CONCERN

I, Nomamerika Tom, hereby request your assistance to become an independent coder during data analysis for my dissertation (Student number: 201415236) entitled: "Challenges of integrating the mental health care users into the community after discharge from a psychiatric institution", submitted in fulfilment of the degree Masters in Psychiatric Nursing (MCUR) in the Faculty of Health Sciences at the University of Fort Hare.

I have conducted nineteen individual interviews using an unstructured interview guide using the attached interview guide and schedule. Also attached is a sample of the transcription of one of the interviews conducted. Any queries can be directed to me at (082 738 7596)

Thank you

Y. N. Tom (Student)

ANNEXURE J: LETTER REQUESTING EDITING OF THE STUDY

TO WHOM IT MAY CONCERN

I, Nomamerika Tom hereby request your assistance in assessing and editing my dissertation (Student Number: 201413652) entitled: “Challenges of integrating the mental health care users into the community after discharge from a psychiatric institution” submitted in fulfilment of the degree in the Faculty of Health Sciences at the University of Fort Hare. Any queries related to the editing of this dissertation can be directed to me at

(082 738 7596)

Thank you

Y.N Tom

ANNEXTURE K: EDITING/PROOF READING CERTIFICATE

EDITING/PROOFREADING CERTIFICATE

To whom it may concern

This serves to certify that I, Jabulani Mkhize, have proofread and/or edited Mrs Y. N. Tom's Masters' thesis to ensure that the language, grammar, punctuation and spelling are academically sound and appropriate, by rectifying errors, wherever these have been identified, and rephrasing sentences that would possibly make one lose sight of the flow of the argument.

Thesis Title: "Challenges of Integrating Mental Health Care Users into the Community after Discharge from a psychiatric institution: the case of Fort Beaufort, Raymond Mhlaba Sub-district, South Africa."

Editor's Name: Jabulani Mkhize

Signature

Date : 19 November 2017

Contact Details: jmkhize@ ufh.acza

Qualifications: PhD (English)