REASONS ASSOCIATED WITH RELAPSE IN PATIENTS WITH SCHIZOPHRENIA

BY

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MASTER OF CURATIONIS

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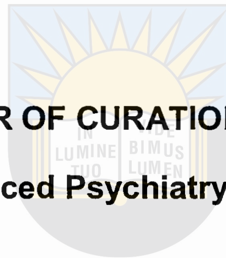

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In the Faculty of Science and Agriculture

At the

UNIVERSITY OF FORT HARE

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30 November 2012

DECLARATION

I, Babalwa Christina Mtana, student no. 200041266, declare that this study is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. This study has been prepared only for the University of Fort Hare, and has not been submitted for any other degree at any other institution.

The study was done under the supervision of Mrs N.I.N. Magadla and Dr. N. Tshotsho at the University of Fort Hare.

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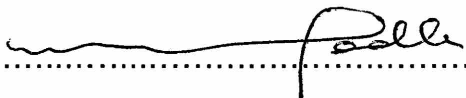
In my capacity as supervisor of the student's thesis, I certify that the above statements are true to the best of my knowledge:



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Mrs N.I.N. Magadla   Dr. N. Tshotsho

ABSTRACT

Introduction: The high number of relapse in patients with schizophrenia has prompted the researcher to conduct the study and this result in these patients having to be admitted in hospital for a longer period.

Problem: The researcher is concerned about the high rate of re-admission of patients with schizophrenia at Fort England Hospital. During the month of June 2011, from the twenty users who were admitted with schizophrenia 70% of these patients were relapsed cases. The problem is the movement of users in and out of the institution. When these users are discharged they are sent home in the care of their families. The patients diagnosed with schizophrenia require a lot of support from their families. It is questionable if the families are offering enough support to the user. Therefore, based on the stated problems, the researcher wanted to establish the factors that cause relapse (Almond et al, 2004:2).

Purpose: The purpose of the study was to explore and describe the reason for relapse in patients with schizophrenia who are admitted to Fort England Hospital and recommend strategies to reduce relapse.

Method: The research design was quantitative and descriptive. The population comprised patients with relapse schizophrenia admitted at Fort England Hospital. The sample was collected conveniently. The designed tool was a questionnaire and the tool was administered by the researcher. Data were analysed, tables and graphs are shown in the results.

Conclusion and Recommendations: The study revealed that medication was equally monitored by the patients (50%) and the care givers (50%). Results showed that about 68.75% of the patients claimed that they did not use their medications regularly, and 31.25% agreed that they used their medications regularly.

The recommendations included the prevention of relapse in patients suffering from schizophrenia should take priority in the programs of Department of Health just like other chronic conditions. Home visits are essential in tracing non compliant cases.

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Directly observed therapy is only used in TB management, it can also be introduced in the management of these patients.

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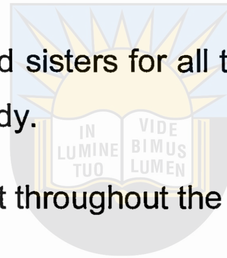

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1. Introduction

The admission, treatment and discharge of Mental Health Care Users (MHCUs) is controlled by the Mental Health Care Act, 2002 (Act 17 of 2002). The Act advocates for the integration of MHCUs into the community, following discharge from the mental institution. The focus of the Mental Health Care Act, 2002 (Act 17 of 2002) is care, treatment and rehabilitation. Rehabilitation ensures preparedness of the MHCUs to sustain in the community. However, relapse of MHCUs has been observed to occur

The study looked into the reasons for relapse of MHCUs who have a diagnosis of schizophrenia. The desire to conduct the study was triggered by a constant observation in the street, of people who displayed the characteristics of mental illness namely unkempt appearance, eating from the rubbish bins and mattering incoherently to name some (Kneisl and Trigoboff, 2009:21). Schizophrenia is the commonest disorder that affects the mentally ill. In one of the male wards of the mental institution in which the study was conducted, out of twenty MHCUs, 17 had a diagnosis of schizophrenia (Hospital records). The researcher decided to conduct the study on this group (Schizophrenia) as they showed a high relapse rate. During the month of June 2011, from the twenty users who were admitted with schizophrenia, 70% of these were relapsed cases (Hospital records). Discussions surrounding the circumstances under which schizophrenia sustain in the community is discussed as the background of the study.

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1.2. Background of the study

Schizophrenia is a chronic disorder usually characterized by relapses alternating with periods of full or partial remission (Hertz, Lamberti, Mintz, Scott, O'Dell, McCartaan, Nix, 2000). Hetz et al (2000) argue that schizophrenia is a chronic, lifetime mental disorder that cannot be cured, but can be effectively treated and

managed. The authors argue that although antipsychotic medications are effective in reducing relapse rates, patients still relapse. The same authors still maintain that relapse may result in hospitalization, treatment resistance, and cognitive impairment owing to progressive structural brain damage. Relapse consequently which yields chronicity puts economic strain on the healthcare system of the country because it becomes expensive to manage these patients when they get admitted (Almond, Knapp, Francois, Toumi, Brugha, 2004:346). Relapse in patients with schizophrenia causes personal distress as it interferes with their daily living thus requiring some adaptation. Relapse is one of the most costly aspects in schizophrenia due to the medication used, the strain to the patient, burden to the family and the load to the hospital staff. It can devastate the lives, not only of the users, but also of their families, hospital staff as well as the community (Almond et al 2004:2).

Like the health care providers, families of relapsed users get frustrated, as the researcher has observed. The source of frustration for the family comes from the feelings of helplessness, as they do not always have skills to handle the user. Health care providers get frustrated because they do not have community support for the users and their families. Studies have shown that the burden which is created by staying with a mentally ill person is significant (Uys and Middleton, 2004:77). The authors contend that families of mentally ill people usually shoulder the greatest part of the burden of caring for the users.

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The researcher has often asked herself a question "what could be the possible reason for mental health care users not to sustain in the community?" the response to this question should be a comprehensive community care which embraces integration and equal citizenship (Newell and Gournay, 2000:23). As a healthcare provider the researcher believes that lack of comprehensive community support programmes decreases stability of the mental health care users.

The researcher also observed an increase in the number of schizophrenic patients who are seen by psychiatrists in outpatient department in a relapsed state. This is substantiated by size of the file (big) and old in year record number. Files, most of which belong to these patients, are piling up in the records room, as an indication that they have been admitted several times in the hospital (Hospital records). When visiting the hospital, most of these patients are accompanied by family members who

are their supporters. When a patient is discharged, the therapeutic team usually expresses happiness together with the patient and family, thinking that they have achieved their goal of the promotion of health of the individual and family (Mavundla, Poggenpoel and Gmeiner 2001:4). The researcher has observed that within a week or a month, the very family member who accompanied the patient to the pre-discharge interview and who escorted the patient home thereafter, will bring this patient back.

Relapse of psychiatric patients is a problem in South Africa and other countries worldwide (Kazadi, Moosa and Jeenah 2008:53). In their study of the reasons associated with relapse in schizophrenia, Kazadi et al (2008:53) argue that despite recent therapeutic progress, relapse in schizophrenia is a common problem among South Africans.

As stated earlier, lack of comprehensive community support programmes as well as the chronicity of schizophrenia result in repeated episodes of inpatient hospital care (Mc Combs, 2002:38). The repeated episodes of admission to mental institution are referred to as revolving door syndrome (Cara,& Mc Rae, 2005: 142) When family members are not supportive to the users in terms of their care, ensuring medication is taken and involving them in community activities, the users end up in a relapsed state.

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The background has focused on the problem of schizophrenic users who run loose in the streets and who relapse. There seems to be an association between non compliance to treatment and relapse. People tend to have reasons for being non compliant to treatment which is what the researcher intends to find out (Perkins, 2002:1121).

1.3. Problem Statement

The researcher is concerned with the observation she made in Cape Town and even more in observing the similar thing in the Eastern Cape. The researcher, who has practised as a registered psychiatric nurse, while practising in Cape Town, once observed in the busiest taxi rank in Cape Town, a known (MHCU). The user seen in Cape Town had been discharged from the mental institution two weeks

before but there he was, in a relapsed state. The user referred to stayed with his family. The researcher also observed this similar behaviour in the Eastern Cape where she currently stays. In both instances, users were not wearing any clothes and they appeared unkempt. One of the users manifested signs of delusions of grandeur, as he claimed to be a healer (Uys & Middleton, 2004:749). Besides the MHCUs who wander about, there is a high readmission rate at the Fort England Hospital. In 2011, 70% of the MHCUs with schizophrenia admitted in the mental institution were readmissions. Re admission is a problem to staff overload as the units become congested. It drains the family financially. As these MHCUs become chronic, they become a liability to the state in terms of the grant, accommodation and medical resources (Kumar, Bhagat, Lou and Ng, 2006: 20).The problem is the movement of users in and out of the institution. When these users are discharged, they are sent home in the care of their families. The nagging question, of whether the care givers are capable enough to take care of the users, or not, has been answered by Mavundla, Toth and Mphelana (2009:357) when they state that care givers are not empowered to care for MHCUs.

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Symptomatic relapse in schizophrenia is both distressing and costly (Almond et al, 2004:2). Relapse of any condition puts economic burden on the health care system as the second line treatment is more expensive than the first line treatment. It also puts economic burden on the family as well, as they have to travel to the hospital to visit the admitted patient. The patients diagnosed with schizophrenia require a lot of support from their families. It is questionable if the families are offering enough support to the user as they are not empowered to care for the users. Based on the stated problems, the researcher wanted to establish the reasons that cause relapse (Almond et al, 2004:2).

It might not be appropriate for one to assume that their families have neglected the mentally ill person but there might be other reasons that contribute to the relapse, wandering about behavior and readmission of the mentally ill persons.

1.4. Purpose of the study

The purpose of the study was to explore and describe the reason for relapse in patients with schizophrenia who are admitted to Fort England Hospital and make recommendations for reducing relapse.

1.5. Research questions

The research was supposed to answer the following questions:

- What are the reasons for relapse in schizophrenic patients admitted at Fort England Hospital?
- What are the means for reducing the relapse rate in patients discharged from Fort England Hospital?

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1.6. Objectives of the study

Objectives of the study were to:

- Identify reasons for relapse in schizophrenic patients resulting in their readmission in Fort England Hospital.
- Determine means for reducing relapse in patients discharged from Fort England Hospital.

1.7. Significance of the study.

The recommendations made from this study will be useful to the following:

- Policy makers: Policies on prevention of relapse will be enhanced at hospital and community levels.
- Clinical level: The strategies for rehabilitation will improve as the family and community will be involved.

- To the MHCUs: Due to enhanced rehabilitation, MHCUs will suffer less stigmatization. They will be included in community activities and will be supported in the community.
- Research: A body of knowledge will be added to the already existing research knowledge.

1.8. Definition of terms

In case some terms were not clear, the researcher clarified some of the concepts.

Schizophrenia: It is a term used to describe a group of complex, severe conditions that are most chronic and disabling to mental illnesses. The conditions are characterised by patients experiencing a different reality from that of the people around them (Uys & Middleton, 2004:366). In this study schizophrenia will be regarded as a MHCU as described above.

Relapse: Mwaba & Molamu (1998:56) refer to relapse as occurring when a patient falls back into a former worse condition.

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Another theoretical definition of relapse is a state of slipping back into familiar patterns of previous behaviours (Kneisl &Trigoboff, 2009:55). In this study relapse is the slipping back into previous patterns of behaviour.

Reasons: Reasons it's a cause or an explanation for something that has happened or that somebody has done (Hornby, 2010:1223). In this study reasons are all the causes for relapse as given by the participants.

Discharge: Discharge is an act of officially allowing somebody to leave the hospital (Hornby, 2010:414). In this study discharge is a MHCU released from the mental institution

1.9 Method and design

The method that was used was the descriptive design. The design that has been used in the study is a quantitative approach. Burns & Grove (2001:37) describe

quantitative design as a formal, objective, systemic process to describe and test relationships and examine cause and effect interactions among variables.

1.10 Ethical considerations

1.10.1 Getting Permission

After submitting the proposal, the ethical committee of the University of Fort Hare gave ethical clearance for the study to be conducted. The Epidemiological and research unit from the Department of Health in Bisho also gave the researcher permission to conduct the research in a state facility. Permission to conduct the study in Fort England Hospital was sought from the authorities and was approved.

1.10.2 Informed Consent

Parahoo (2006:117) defines informed consent as a process by which researchers ensure that prospective participants understand the potential risks and benefits of participating in a study, and are informed about the right not to participate before they could sign up to participate in research.

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The respondents were informed that participation was voluntary and were free to withdraw at any time, should they feel the need to do so. The researcher obtained informed consent from the participants who were willing to participate in the study. Information about the study was given to prospective participants and they signed a letter of informed consent before responding to the questionnaire. The respondents were informed about the purpose of the study, the process of data collection and were informed that no risks would be involved.

1.10.3 Confidentiality and Anonymity

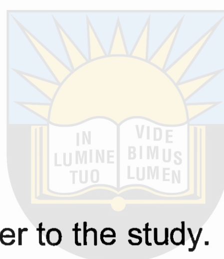
Brink (2008:35) indicates that the process of ensuring confidentiality refers to the researcher's responsibility to protect all data that are gathered during the study from

being divulged or made available to any other persons. Confidentiality and anonymity were maintained throughout the study.

Brink (2008:34) describes anonymity as the process of ensuring that the identities of the respondents remain secret. Respondents were told that they would be provided with results if they want them. There were no names attached to the questionnaires but codes were used and this ensured anonymity. Completed questionnaires and data were kept in locked cabinets and personal details were not revealed to anyone. Results of the study will be published without disclosing the identification of participants.

1.10 Overview of the chapters

This study consists of five chapters.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- Chapter 1 orientates the viewer to the study.
- Chapter 2 reviews the literature, specifically on relapse in patients with schizophrenia.
- Chapter 3 provides a detailed description of the method used in this study. In this specific research, quantitative research was used. In order to provide a clear idea of how the research results were analysed and obtained, sampling, data collection instruments as well as data analysis were discussed in this chapter.
- Chapter 4 consists of the presentation of the research results.
- Chapter 5 provides a discussion of the results and an interpretation in terms of theory. Recommendations are presented in this chapter.

1.11 Conclusion

As can be inferred from this chapter, the researcher was convinced about the need to conduct the study. The researcher conducted some literature search so as to get some ideas about the problem being researched.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In the previous chapter orientation to the study, problem statement, objectives, research questions and the significance of the study were discussed. The literature reviewed includes mainly studies on reasons associated with relapse especially in patients with schizophrenia. The literature pertaining to relapse in schizophrenia was carefully considered. Journals, books and online articles were selected for discussion in this study. Discussions shall revolve around the following: relapse, non compliance, psychosocial support and the cost of relapse.

2.2 Relapse

Relapse in schizophrenia is recognised as the re-emergence or the worsening of psychotic symptoms (Kneisl & Trigoboff, 2009:55). Some people tend to progress well; some may slip back to previous patterns of behaviour, especially in episodes of stress. This slipping back is referred to as relapse (Kneisl & Trigoboff, 2009:55). therefore the patient Psychotic symptoms which aid to early identification will be discussed below.

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Early identification

The symptoms for early identification of relapse include the following:

Positive symptoms

Delusions, a few examples of delusions will discuss below.

Delusion of persecution: a person has a false belief that he or she is being harassed, cheated, or persecuted (Sadock & Sadock, 2003:284). The patient will often think that he will be poisoned and as a result may not want to eat.

Delusions of grandeur: a person's exaggerated conception of his or her importance, power, or identity (Uys & Middleton, 2004:749). In the case of this study the user claimed to be a healer.

Delusions of reference; a person's false belief that the behaviour of others refers to him or herself; that events, objects, or other persons have a particular and unusual significance (Sadock & Sadock, 2003:284).

Hallucinations

Hallucinations may be characterised by the following:

Hallucinations affect the five senses, but the common ones are auditory (Kneisl & Trigoboff, 2009:384).

Speech problem presents with blocking, clang associations (words that rhyme), echolalia (repeating other persons word's), neologism and word salad which means incoherent use of words (Kneisl & Trigoboff, 2009:385).

Thought process

Thought process, in which case the thought process is distorted and no logic (Kneisl & Trigoboff, 2009:387).

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Behaviour

Behaviour becomes disorganised, the patient walks around aimlessly, picking up everything available and touching all objects. The behaviour may also be catatonic; patient may be rigid, hyperactive and assaultive (Kneisl & Trigoboff, 2009:374). In the case of this study, the observed patients were picking up objects from the rubbish bins.

Negative symptoms

Negative symptoms include flat affect, alogia, avolution and anhedonia. The four symptoms are described as showing no emotions, poverty of speech, lack of goal directedness and loss of interest in previously enjoyed activities (Kneisl & Trigoboff, 2009:374). The psychotic symptoms discussed above help in early identification of relapse

Implications of relapse to schizophrenic patients

Despite the fact that antipsychotics are effective, thirty to forty per cent of clients relapse within one year resulting to chronicity which builds drug resistance. Different

type of drugs needs to be used (Kneisl & Trigoboff, 2009:377). In that case the state must pay for the hospital expenses of the patient; provide food and medication for the patient. Relapse has economic implications to the family and the state. The family needs to visit the patient often. They need to use taxi fares to reach the hospital and the personal demands of the patient increase as he the patient needs his own toiletry and snacks at times.

Vulnerability after a period of stability

This is often caused by factors within the patient, family and the environment. Lack of support from the family makes the patient to lose hope and consequently fall in the hands of peers where drugs and alcohol may be used as a form of showing support. This disrupts the use of medication. When the patient has no insight she or he can stop the use of medication. About half of the patients with schizophrenia are non-adherent to treatment. This non adherence may be due to factors which are patient related namely, substance abuse, forgetfulness, anxiety about side effects, inadequate knowledge, lack of motivation and fear for stigma (Kazadi, 2008:52). A patient's decision to accept treatment is influenced by the patient's cultural beliefs in concepts such as witchcraft, ancestors, evil spirits and sorcery. The fact that the cause of mental illness is believed to be caused by the anger of ancestors, evil spirits, poison (idliso) and walking across harmful medicine (umeqo), delays the use of conversional medicine (Uys & Middleton, 2004:131). The choice of antipsychotic may also influence adherence.

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The patient needs to be monitored

Early identification of changes in the behaviour, speech and the thought process of the patient are important as discussed above. It has also been mentioned that people who care for these patient are not empowered thus making it difficult to elicit the changes in the sick person (Mavundla et al. 2001:4). While patients are treated with medication, there is also a need to educate the family and the community. Information should include medication and treatment compliance, side effects, mental illness and how it manifests as well as the early recognition of relapse. Harris, Williams and Bradshaw (2002, pg 198) state that the families should be trained to understand mentally ill people as well and assist other family members to manage their own stress. He further argues that families are a valuable source of help to the

patient in their recovery. Patients that are supported fully by their families do not relapse frequently like those who have no support system.

Pattern of relapse

Schizophrenia is characterised by a pattern of relapses which alternate with full or partial remission (Kneisl & Trigoboff, 2009:377). Some patients relapse within six month, others over a year and others after a long duration of stability. This is due to the factors already mentioned above. It can be said that factors surrounding this pattern are patient centred, family centred and psychosocial. The integrity of the client based on the level of understanding and education can influence the use of medication as educated patient usually have insight about medication. Families of people with mental illness shoulder the most part of the burden of caring. The difference in the pattern of relapse depends on how the family perceives the problem, searches for the solution, endure the situation and accept the situation. If the problem is too serious for the family they can go to a crisis and shock and become unable to manage the situation. The patient thus gets hospitalised. Lack of networks results in the increase of emotional stress due to lack of information. This results to the family being unable to give support to the mentally ill. Supported families can support the mentally ill and the member can sustain in the family, yet it is difficult for a non-supported family to support their sick relative thus the relapse of the sick member (Uys & Middleton, 2004:77).

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2.3 Non compliance

Kazadi et al (2008:52) alleged that the medication compliance rate for non psychiatric illnesses is 76% while that for psychiatric illnesses is 58%. About half of the patients with schizophrenia are not compliant to medication. The authors also argued that the patient centred causes for relapse are as follows: the presence of a co-morbid depressed mood, adherence, demographic factors, poly-pharmacology, patient centred factors and cost of relapse.

2.3.1 The presence of a co-morbid depressed mood

Symptoms indicating that the patient may be suffering from depression and who exhibit symptoms such as suicide ideation and social withdrawal may appear at any time during the course of schizophrenia and these may contribute to relapse and decrease in quality of life (Kazadi et al, 2008:58). At times patients stay alone with no company. This predisposes to depression which may also predispose to suicide. It is important to elicit incidents that have occurred to the client namely divorce, losing of a loved one, loss of income and being exposed to poor family relationships (Uys & Middleton, 2004:351). It should be considered that the greater the loss, the greater is the potential for suicide. Kazadi et al 2008 pg 58 argues that poor adherence due to lack of patient insight and fear of side effects appear to be the factors most likely to increase the risk of relapse. Lack of insight occurs when the patient was not fully prepared for discharge namely, not informed about the illness, effect of the medication, side effects of the medication and where to get the medication. Medication side effects are often the reason for noncompliance due to the fear as well as the symptoms that experienced by the patient. It happens that the patient does not have anyone to share the subjective feelings regarding to the medication thus depression sets in due to the patient's demographic status (living alone, recent divorce, difficult relationships, unemployment, poverty, recent criminal offence and the gender). Men are more successful in suicide than females (Uys & Middleton, 2004:351). The suicide rate of men is more than that of females. Both are exposed to social factors but men are more vulnerable hence the high rate of suicide. Men use more lethal methods to commit suicide, for example hanging, shooting and jumping (Uys & Middleton, 2004:351).

The failure of individuals with schizophrenia to take prescribed medications is one of the most serious problems in psychiatric care. It often leads to relapse of symptoms, rehospitalisation, homelessness, victimization of the patient by the community, or episodes of violence especially in men who use dagga and alcohol. Homeless MHCUs are often victims of relapse and rehospitalisation due to poverty, lack of support and inability to access medication (Kazadi et al, 2008:53).

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2.3.2 Adherence

Oehl, Hummer & Fleischhacker (2000:83), in their study of compliance with antipsychotic treatment found out that only about one third of patients with schizophrenia are reported to be fully compliant. Another third is partially compliant, meaning that these patients will either reduce the dose of the drug prescribed or fail to take medication from time to time. The remaining patients do not follow prescription at all, that is, not taking medication at correct times. Some patient report that they are not taking treatment due to side effects. Kazadi et al (2008:58) found out that partial adherence to treatment remains a therapeutic challenge and a factor that is difficult to quantify.

2.3.3 Demographic factors

Demographic factors have been alleged to play a role in treatment non-compliance. Discussion of the gender and age regarding treatment compliance follows:

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Patient related factors such as age, gender and social status influence compliance. Kazadi et al, 2008 pg 58 found that elderly, long term treated patients seem to be more compliant than younger ones or first episode patients. Older patient tend to forget taking medication than younger patients. Males are more prone to noncompliance as they use substances more than females.

Females are generally more compliant than men, especially than younger females more so than older ones (Kazadi et al, 2008:58). Women are focused than men especially younger women as they are not prone to forgetfulness. The reason discussed in this regard is the poorer health care of men in comparison to women in general and therefore their poor health has an impact in managing schizophrenia which may result to schizophrenia if not well controlled.

One reason for taking treatment is the patient's feeling of its positive effect on everyday life. During long term treatment, the patient's attitude towards antipsychotic medication and their perspective regarding subjective well being and quality of life is of major relevance (Oehl et al 2000:84). Women like to have a sense of wellbeing in daily activities. Demography has some impact on treatment compliance.

The level of education has an influence on how a patient will comply with treatment. Better educated individual has got a better understanding of the treatment use than the non-educated individual. Likewise Oehl et al (2000:84) argue that a negative attitude in the patients' social surroundings towards psychiatric treatment has a negative impact on compliance. In turn, the availability of relatives to support and assist or supervise medication is an important factor in enhancing compliance.

The flaring up of emotions in the family, on the other hand, has a negative influence on compliance. Poor social support, especially living alone, has also been associated with poor compliance. Social support helps so as to be able to establish rate of compliance. The social ranking of an illness may also be an essential point regarding compliance. If a patient feels that the social rank of an illness is low he will try to avoid anything connected with the illness, including treatment. Some patients with schizophrenia eat in rubbish bins and are in an unkempt state thus resulting to some patients not taking treatment as they do not want to be associated with such illness (Uys & Middleton, 2004: 75).

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A good stable patient health care provider relationship is a crucial determinant for compliance (Kazadi, 2008:58). It is necessary to deal with the subjective needs, concerns and fears of the patient. It is also important to spend enough time with the patient and to leave space to talk about problems concerning medication or side effects. A well structured treatment plan with strict adherence to appointments by treating both the physicians and patients contributes to better compliance. The nature of treatment may encourage non-compliance hence the discussion below.

2.3.4 Poly- pharmacology

Psychiatrists use a wide range of medication to treat mental illness. Schizophrenic patients usually respond to treatment with single anti psychotic drug. Poly-pharmacy is a problem since these patients may have other chronic diseases which they also have to take medication for. It is even worse where the patient has to also take traditional medicine. Unpleasant side effects are a major problem in schizophrenic patients. These side effects may cause subjective distress to the patient thereby affecting adherence to treatment (Perkins et al, 2002).

Oehl et al (2000:85), states that treatment may not be as effective as patients expect it to be. This is often related to unrealistic expectations concerning the medication's benefit risk ratio. If patients are in full remission they may stop taking medication because they experience no further symptoms and they think they no longer require medication. Poly-pharmacology is really problematic aspect. If the user is exposed to traditional medicine, he might put the Western medicine aside and use the traditional type, especially if his programme is to appease the ancestors (Uys & Middleton, 2004:132).

Running out of medication, some patients discontinue the treatment because they run out of medication; they will wait for their scheduled date. Sometimes they lose their medication and will not inform anyone and that will only be noticed when they relapse. The reasons for non compliance as discussed by discussed by Sadock & Sadock (2003:899) may include discomfort resulting from treatment (e.g. medication side effects), expense of treatment, decisions based on personal value judgements, religious and cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles or the presence of a mental disorder. Medication compliance has become a focus of increasing concern in the treatment of psychiatric disorders.

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2.3.5 Patient centred factors

Forgetfulness poses a challenge: some schizophrenic patients simply forget to take their treatment. More often schizophrenic patients become overwhelmed and muddled up if the treatment was not well explained (Jansen Pharmaceutica, 2010:1). They then forget to take treatment. Forgetting is normal for anyone which is why someone needs a reminder.

Where the patient lack skills, they do not cope. They get overwhelmed, anxious due to fear of occurrence of side effects and the felt side effects. Where the patient is not involved in his treatment, the family members often forget. Due to lack of coping skills, many people with schizophrenia stop their medication because they have difficulty taking their treatment (Jansen Pharmaceutica, 2010: 1). Many have been in and out of hospitals most of their lives and have never learned the skills to adhere to

a long term treatment schedule. All too often, people do not understand the information they receive from their doctor. Taking responsibility for one's own treatment and medication becomes easier when the doctor gives detailed information. The more a patient knows about his or her own illness and the medication, the more he becomes engaged in his treatment and the greater the commitment to get better.

Feeling better: very often people with schizophrenia who start to feel better decide on their own that they do not need the medication anymore. It is extremely important that patients are well informed about the risk of relapse when they stop taking medication. A relapse does not occur immediately. The delay that occurs between stopping medication and the return or increase of the symptoms makes it harder for the patient to connect medication to relapse prevention.

Morken, Widen & Grawe (2008:13) found out that non adherence to antipsychotic medication was associated with psychotic relapses and admissions to hospital. Users of depot antipsychotics had an increased frequency of relapses due to non adherence to treatment. When users of depot antipsychotics were adherent to medication, they had a low frequency of hospital admissions.

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Substance use complicates the management of schizophrenia. Substance use is common in South Africa; the commonly used substances are nicotine, dagga, alcohol, tik and cocaine. 15 to 25 % of patients with schizophrenia use dagga (Sadock BJ, 2003). Dagga exacerbates the symptoms of schizophrenia. People with pre existing major psychiatric disorder such as schizophrenia are vulnerable, in that dagga is likely to cause relapse as well as aggravates existing symptoms. Sadock BJ et al, (2003) argue that 3% of patients with alcohol abuse may show indications of psychosis. Most of the symptoms are similar to that of schizophrenia. Recurrent use of substances might lead to changes and abnormalities similar to those mediating some psychiatric disorders.

2.4 Cost of relapse

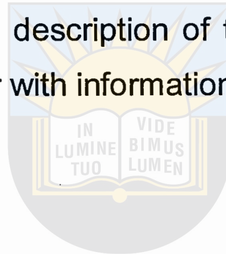
Relapse is one of the most costly aspects of schizophrenia (Almond et al 2004:346). Relapse in schizophrenia is both distressing and costly. Relapse increases the

economic burden on the health care systems because of its associated morbidity and re admissions to hospital (Kazadi et al, 2008:52). It can devastate the lives not only of patients, but also of their families. In their study they also found out that relapse is a major factor in generating high hospitalisation rated and costs.

2.5 Conclusion

The literature pertinent to the study has been reviewed; knowledge on non compliance, psycho social support, substance use, forgetfulness and cost of relapse has been discussed.

In the following chapter, a detailed description of the methodology incorporated in this study will be presented together with information on the sample used.



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CHAPTER THREE: METHODOLOGY

3.1 Introduction

In the previous chapter literature was reviewed pertaining to schizophrenia and relapse. In this chapter, a detailed description of the method that was used will be presented. In this specific research, a quantitative research approach was used. In order to provide a clear idea of how the research results were obtained, the following will be discussed: research design, sampling, data collection, instrument, as well as data analysis. The activities that were undertaken in the methodology were designed to answer the following questions:

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3.2 Research questions

- What are the reasons for relapse in schizophrenic patients admitted at Fort England Hospital?
- What are the means for reducing relapse to patients discharged from Fort England Hospital?

3.3. Objectives of the study

Objectives of the study were to:

- Identify reasons for relapse in schizophrenic patients resulting in their readmission in Fort England Hospital.
- Determine means for reducing relapse in patients discharged from Fort England Hospital.

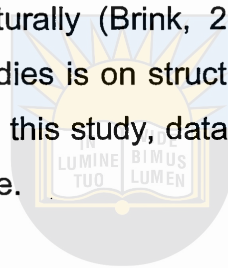
3.4 Research design

A research design encompasses the methodology and procedure employed to conduct scientific research. Research design means a plan that describes how, when and where data are to be collected and analysed (Parahoo, 2006:183). It is the

set of logical steps taken by the researcher to answer research questions (Brink, 2008:92). In order to meet the objectives of the study, the researcher must select the most appropriate design. The design selected will be discussed below.

3.4.1 Descriptive design

Descriptive design was used for the purpose of this research. Brink (2006: 103) states that descriptive designs are concerned with gathering and describing information from a representative sample of the population. They are used where more information is required in a particular field through the provision of a picture of the phenomenon as it occurs naturally (Brink, 2008:102). The emphasis in the collection of data in descriptive studies is on structured observation, questionnaires and interviews or survey studies. In this study, data collection will be conducted with the use of a structured questionnaire.



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3.4.2 Quantitative Approach

The quantitative approach was used. The main reason for using the quantitative research was to measure variables objectively and to examine, by numerical and statistical procedures, the relationship between them (Parahoo, 2006: 50). Data were collected in a structured manner, that is, information was gathered from all participants in a comparable and predetermined manner. Kumer (2005:12) alleges that the quantitative approach is structured. In this study, structured research aspects like objectives, design, sample and questions were predetermined. As quantitative research gathers empirical evidence, data gathering was conducted objectively and systematically using structured instrumentation (Polit & Beck, 2008:15). Discussion of the objectivity, validity and reliability of the instrument will be discussed later.

3.5. Research Methodology

Research methodology is defined as the process used to collect information and data for the purpose of making decisions, a detailed description of how the research will be conducted (Terreblanche, Durrheim &Painter, 2006:82).

3.5.1 Research population

Brink (2006: 257) describes the target population as the group which a researcher aims to draw a sample from. The population comprised 33 patients who were admitted at FEH more than once in a relapsed state, and who were diagnosed as having schizophrenia. At the time of the interview the patients had to be in touch with reality (not psychotic).

3.5.1.1 Inclusion criteria

For the participants to be included in the study, they had to meet the following criteria:

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- Patients with diagnosed schizophrenia according to DSM-IV-TR who had relapsed and had been re-admitted to the FEH, irrespective of the demographic characteristics.

- Patients who were 18-50 years were included in the study
- Patients who were not psychotic, meaning they were in touch with reality through the assistance of the professional nurse that was in the ward.

3.5.1.2 Exclusion criteria

- Patients with other mental disorders, other than schizophrenia as well as schizophrenic patients who had not relapsed.
- Patients with relapsed schizophrenia but are still in a psychotic state.
- Patients older than 50 years, to avoid including patients who might have dementia as dementia presents early in these patients (Wetherell & Jeste; 2003:8).

3.5.2 Selection of respondents

Respondents were selected through sampling. Sampling refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink, 2006:124).

The sampling method that was used by the researcher was the convenience sampling. Convenience sampling involves the choice of readily available respondents for the study, which means that the population elements have no equal chances of being selected to participate (Brink, 2006, 132). Participants were included because they were in the right place at the right time. Patients with a diagnosis of schizophrenia who were already admitted in the ward on the day of data collection were chosen. The researcher consulted with the professional nurse that was on duty to establish the participants who were in touch with reality. Such patients amongst others, were orientated to time, place and person. Cognitive aspects like reasoning, memory and judgement including the social aspect like interaction were considered in selecting the sample (Frisch& Frisch, 2011:6).

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Out of the 33 patients that were diagnosed with relapse schizophrenia, 16 were included in the study hence the researcher had inclusion and exclusion criteria. The sample size was 48.4% of the total population thus (n=16) in order to have a bigger capacity of the data source.

3.5.3 Data Gathering

3.5.3.1 Research Setting

The research was conducted at Fort England Hospital in Grahamstown which falls in the Eastern Cape Province in South Africa. Patients are admitted via Settlers hospital after they have been observed for 72 hours. Fort England hospital has two acute wards where they admit patients with disorders including schizophrenia, a female ward with 35 beds and a male ward with 30 beds. Patients are treated in these wards until they become stable and then discharged home.

3.5.3.2 Data collection instrument

The data were collected by the researcher. Questionnaires were used to collect the necessary data for the study. A questionnaire can be described as a method that seeks written or verbal responses from people to a written set of questions or statements (Parahoo, 2006:283). The questionnaire had 11 closed ended questions and 1 open ended question. Section A contained the demographic characteristics and Section B carried the behavioural characteristics. Section A of the questionnaire contained demographic information. In this study, demographic information is valuable in determining the trend of occurrence of relapse. Section B of the questionnaire carried closed ended questions and one open ended question. Closed ended questions yield data that allow for comparison between variables. The questionnaires were in both English and IsiXhosa. They were translated by the researcher. In the questionnaire the space for the name was substituted by code thus anonymity was maintained. The information was collected only from the participants who were the patients with relapsed schizophrenia. The participants were gathered in one room and were attended to individually. The tool was read to the each participant by the researcher. It took thirty to fort five minutes to complete the tool (5 took 45 minutes and 11 took 30 minutes). The structured questionnaire that was used was designed by the researcher.

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3.5.3.3 Gaining access to participants

Considering the fact that the mental health care users are a protected group, the researcher had to follow ethical procedure. The researcher got permission from the authorities for the group to be studied. The ethical committee of the University of Fort Hare gave ethical clearance for the study to be conducted. The Epidemiological research and surveillance unit from the Department of Health in Bisho also gave the researcher permission to conduct the research in state facility. The researcher received permission from the authorities of Fort England Hospital following a visit and explanation to management and to patients. The researcher came into contact with the participants during their morning reality orientation session and introduced herself as well as the purpose of the visit.

3.5.4 Data Analysis

To turn data into information, the researcher has to the data (Hofstee, 2006:117). After data have been collected, they need to be broken up into manageable trends. They must be scrutinised, checked and interpreted so that the readers can understand it too. For the purpose of this study, the raw data which was collected using questionnaires were categorised and interpreted. Section A carried the demographic characteristics and Section B contained the behavioural characteristics. A computer program called Statistical Package for Social Science (SPSS) was used (SPSS) version 18. Frequency tables, graphs and text have been used to interpret the results.

3.6 Validity and Reliability

3.6.1 Validity

Welman, Kruger & Mitchell (2005:144) define validity as the extent to which the research findings accurately represent what is really happening in the situation. To achieve validity, the questionnaire included question on the knowledge of patients about their illness. Questions were based on information gathered during the literature review to ensure that they were representative of what the patients should know about their illness. The questionnaires were distributed to participants by the researcher personally. Rephrasing for some questions was done to clarify the questions.

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3.6.2 Reliability

Reliability is concerned with the findings of the research and relates to the reliability of the findings (Welman et al 2005:145). Two experts were requested to view the questionnaire for authenticity (De Vos, 2005:162). The instrument was given to the two experts to assess the consistency of the results and the stability of the instrument. They approved that the instrument could be used.

3.7 Pilot Study

Pilot study was conducted to test validity of the research instrument. The questionnaire was given to two patients who were also admitted at FEH for relapse schizophrenia before the actual study was done to assess if questionnaire would be applicable and represent the selected population. They responded to the tool appropriately and completed it in 45 minutes.

3.8 Measurement

Variables

The following variables were measured in the study:

- Age of the patients, age ranged from 26 to 50 years
- Gender, 8 males and 8 females
- Race
- Source of income
- Substance use,
- Mode of transport to the clinic,
- Number of scheduled visits per month to the clinic,
- Monitoring of patients medication,
- If patient used medication regularly
- If patient had enough information about illness and treatment,
- Causes of re-admission of patients to clinic.

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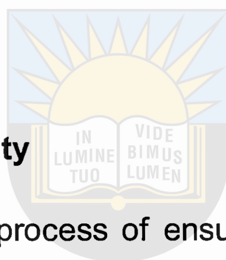
3.9 Ethical Issues

When conducting research, one has to recognise and protect human rights. To render the study ethical, informed consent was obtained from the participants. Confidentiality and anonymity were observed. The procedure to follow to get permission to conduct the study was observed and they are discussed below.

3.9.1 Informed Consent

Parahoo(2006:117) defines informed consent as a process by which researchers ensure that prospective participants understand the potential risks and benefits of participating in a study, they are also informed about the right not to participate before they could sign up to participate in research

The respondents were informed that participation was voluntary and were free to withdraw at any time. The researcher did not force any prospective respondent to participate before obtaining their permission. Information about the study was given to prospective participants and they signed a letter of informed consent before filling in the questionnaire.



3.9.2 Confidentiality and Anonymity

Brink (2008:35) indicates that the process of ensuring confidentiality refers to the researcher's responsibility to protect all data that are gathered during the study from being divulged or made available to any other persons. Confidentiality and anonymity were maintained throughout the study. Respondents were told that they would be provided with results if they wanted them.

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There were no names attached to the consent forms but codes were used. Completed questionnaires and data were kept in locked cabinets and no personal details would be revealed to anyone. The questionnaire was filled in a private consultation room to promote confidentiality.

3.9.3 Getting permission

The ethical committee of the University of Fort Hare gave ethical clearance for the study to be conducted. Epidemiological research and surveillance unit in Bisho also gave the researcher permission to conduct this study. Permission to conduct the study in Fort England Hospital was sought and was approved. The letter granting permission to conduct the study is available in the appendices.

3.10 Conclusion

In chapter three, the research methodology, data collection, population, sample, data collection instrument, research setting has been explained as well as ethical considerations. The following chapter will focus on how the data were analysed, converting raw data into information. Tables, text and graphs were used to differentiate between the variables.

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CHAPTER FOUR: PRESENTATION OF RESULTS

4.1 Introduction

In this chapter data that were collected were analysed. It is a fact that raw data on their own do not immediately make sense, data need to be teased out, a process called data analysis (Parahoo, 2006:375). Data was analysed through SPSS. The relationships between variables are discussed in this chapter.

4.2 Description of the sample

Brink (2006:124) defines sampling as part or fraction of a whole, or a subset of a largest set, selected by the researcher to participate in a research study. The sample was selected conveniently. Out of 33 patients only 16 met the criteria and they all agreed to participate in the research. The questionnaire was administered by the researcher. The sample consisted of 8 males and 8 females with percentages of 50% respectively. All the 16 questionnaires were completed. A computer program called Statistical Package For Social Science version 18 was used to analyse data. Frequency tables, graphs and text are used to interpret the results.

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4.3 Description of Variables

The variables analysed in the study include the demographic characteristics which are namely: age of the patients, gender, race and source of income. Other variables analysed were behavioural characteristics which included substance use, mode of transport to the clinic, number of scheduled visits per month to the clinic, monitoring of patient's medication, if patient used the medication regularly, and if patient had enough information about the illness as well as treatment, and causes of re-admission of patients to the hospital.

4.3.1 Demographic characteristics

Table 1 illustrates the summary of the demographic characteristics of participants that were interviewed. Demographic characteristics are further explained individually below the summary.

Table 1: The table below illustrates the summary of demographic characteristics of the patients diagnosed with schizophrenia and who have relapsed.

Demographic characteristic		Number	Percent
Age	26-35yr	4	25.00%
	36-45yr	5	31.25%
	46-50yr	7	43.75%
Gender	Male	8	50.00%
	Female	8	50.00%
Race	Black	13	81.25%
	Coloured	3	18.75%
	White	0	0.00%
Source of income	Disability grant	13	81.25%
	Cousin working	1	6.25%
	None	2	12.50%

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4.3.1.1 Age variable

Table 2: Shows the age of the participants that were interviewed, according to number and percentage

Age		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	26-35years	4	25.0	25.0	25.0
	36-45years	5	31.3	31.3	56.3
	46-50years	7	43.8	43.8	100.0
	Total	16	100.0	100.0	

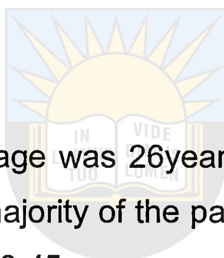

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Table 2 shows that the minimum age was 26years, and the maximum age was 50 years. The age distribution showed that majority of the patients, 43.75%, was aged 46 to 50 years. Age groups 26-35years and 36-45years recorded 25% and 31.25% respectively. Participants more than 46 years were more in number than the younger participants. The trend in this study is that older participants relapse more than the younger participants. Almond et al, 2004 supports the above mentioned statement.

4.3.1.2 Race variable

Figure 1: A graphical presentation of the relapsed participants with schizophrenia that were interviewed by the researcher according to their race.

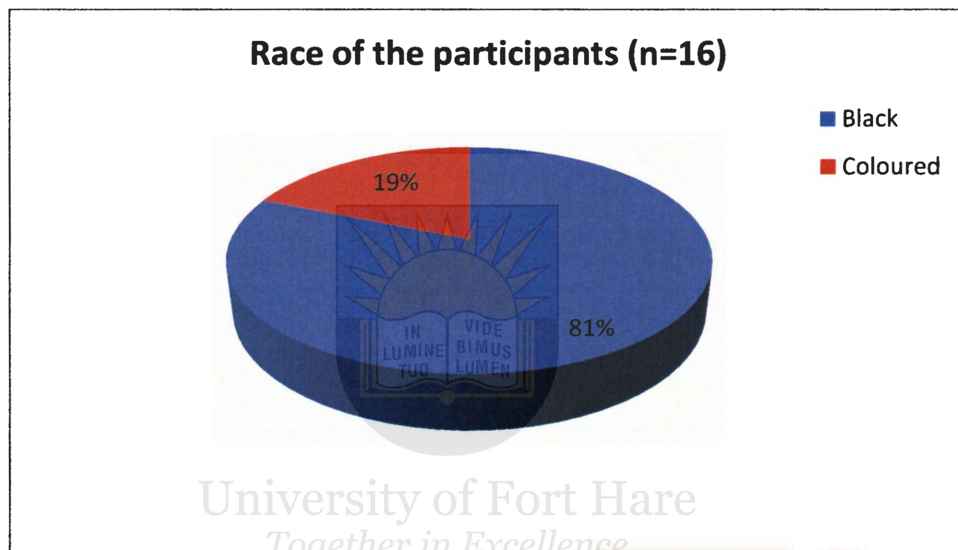

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Figure 1 shows the race of the participants that were interviewed. They are colour coded, the blue colour is for black patients and was 81% and the red colour is for coloured patients and was 19%. The results indicate a significant percentage in blacks admitted with relapse in the mental institution

4.3.1.3 Source of income

The major source of income was disability grant, 81.25%, followed by income from cousin working, 6.25%, and finally about 12.50% claimed they had no source of income. The findings indicate that the participants are dependent on social grant with no other source of income. The participants receive social grant and they reported that it is not enough to care for their basic as they must buy food, pay for travelling expenses to visit the clinic and buy toiletries.

Figure 2: A graphical presentation of the participants with relapsed schizophrenia that were interviewed by the researcher according to their source of income.

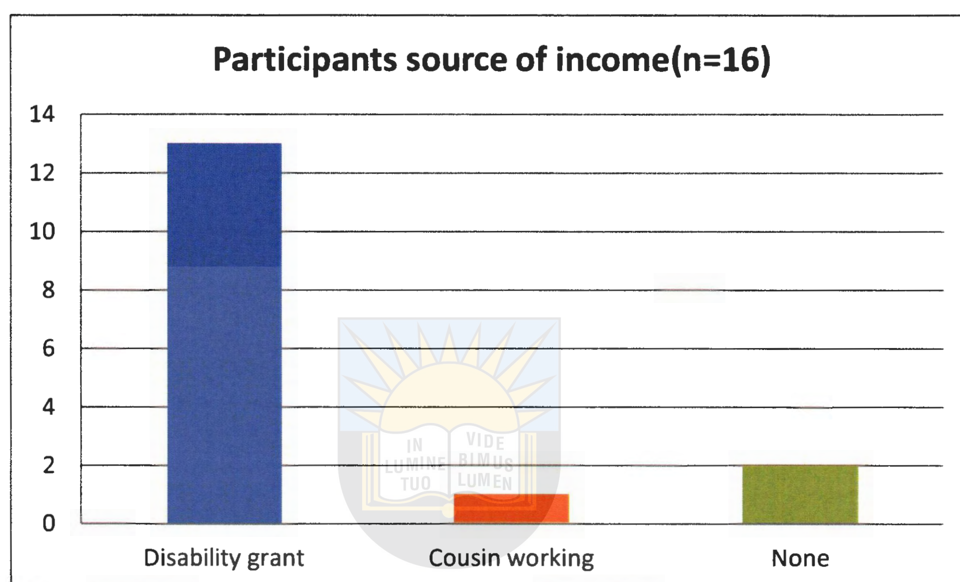

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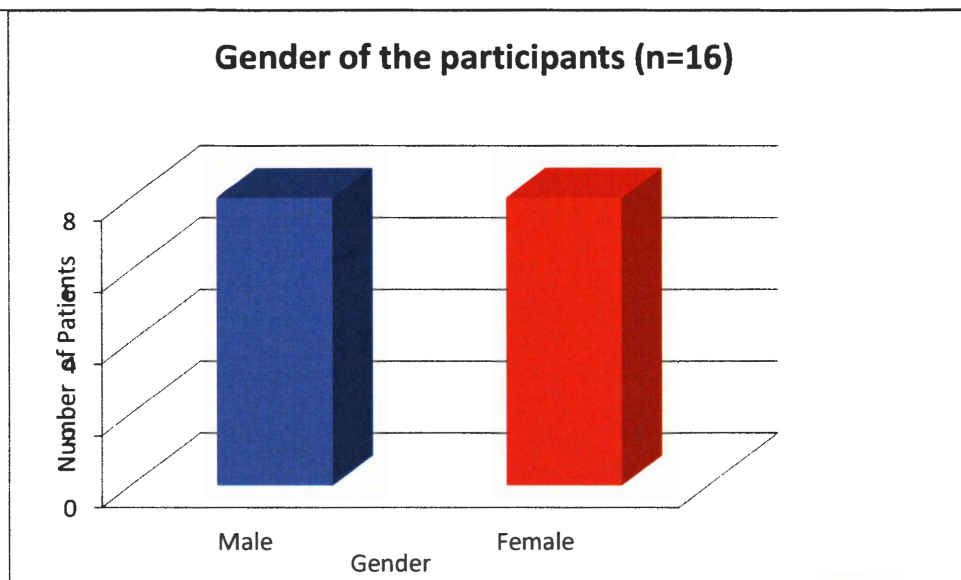
Figure 2 shows graphically the distribution of source of income of the participants that were interviewed in numbers. They are clearly indicated in colours, blue is for disability grant and 13 patients are depended on it, 1 patient orange colour coded is depended on a cousin and 2 patients that are colour coded in green do not have source of income

4.3.1.4 Gender

Figure 3: A graphical presentation of the participants with relapsed schizophrenia that were interviewed by the researcher by looking at their gender. Out of 16 participants 8 were males and 8 were females. This shows that relapses presents in both sexes and can be at same percentages.



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4.3.2 Behavioural characteristics

Table 3 illustrates the summary of the behavioural characteristics of the participants that were interviewed who were diagnosed with relapse schizophrenia during data collection.

Behavioural Characteristics		Number	Percent
Substance use	Dagga	1	6.25%
	Alcohol	2	12.50%
	No drug	7	43.75%
	Smoke	1	6.25%
	Dagga and Alcohol	5	31.25%
Mode of transport to the clinic			
	Own transport	1	6.25%
	Public transport	7	43.75%
	Walking distance	8	50.00%
No of scheduled visits per month to the clinic			
	A visit	16	100.00%
Patient's medication monitored by			

Patients	8	50.00%
Caregivers	8	50.00%
Does the patient use medication regularly?		
Yes	5	31.25%
No	11	68.75%
Does the patient have enough information about illness and treatment?		
Yes	9	56.25%
No	7	43.75%
Causes of re-admission of patients to clinic		
Treatment noncompliance	9	56.25%
No improvement on current drug	2	12.50%
Substance abuse	5	31.25%

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4.3.2.1 Substance abuse

Table 4: Shows the substances used by the participants with relapsed schizophrenia that were interviewed during data collection

Substances	Frequency	Percent	Valid Percent	Cumulative Percent
Dagga	1	6.3	6.3	6.3
Alcohol	2	12.5	12.5	18.8
No drug	7	43.8	43.8	62.5
Smoke	1	6.3	6.3	68.8
Dagga and alcohol	5	31.3	31.3	100.0
Total	16	100.0	100.0	

Table 3 shows the substance used by the participants that were interviewed by the researcher with relapsed schizophrenia during data collection. Out of 16 patients 1

patient is using dagga only, 2 patients are using alcohol, 1 patient is smoking and 5 patients are using alcohol and dagga, 7 patients are not using any drug. Substance abuse was very common among the participants. Substance abuse may exacerbate psychotic symptoms (Kneisl & Trigoboff, 2009:325)

4.3.2.2 Mode of transport

Figure 4: A pie graph presenting the mode of transport used by the participants with relapsed schizophrenia to reach the clinic.

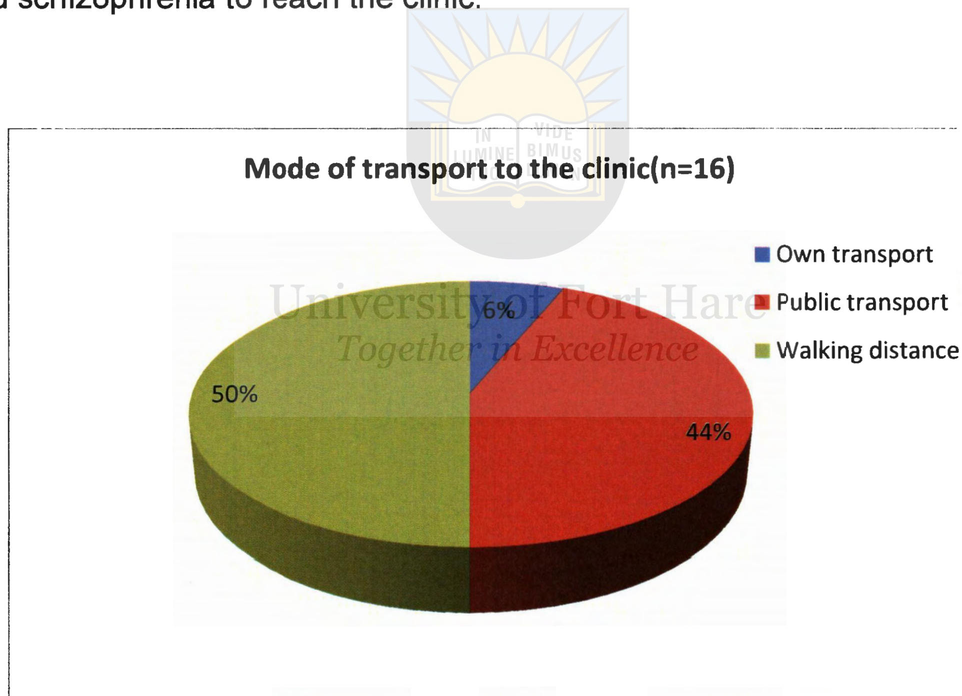

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Figure 4 illustrates graphically the mode of transport used by the patients. They are colour coded. Green colour represents the patient that walks to reach the clinic, red colour represents patients that use public transport and the blue colour represents patients that use their own transport.

4.3.2.3 Medication monitoring

Figure 5 shows the graphical presentation of the person who monitors the participants' medication

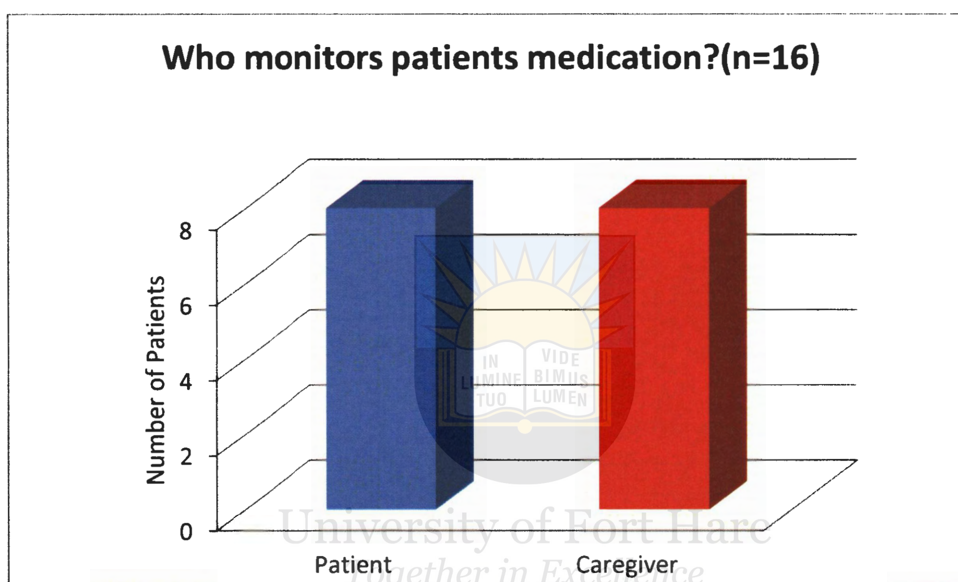

Figure 5 is a bar graph illustrating the monitoring of the patient's medication. The blue colour indicates the patients that monitor themselves and the red colour indicates the caregivers that monitor the patients' medication. Figure 5 shows that the patients' medications were equally monitored by the patients (50%) and the caregivers (50%). Some patients monitor their medication as they are staying alone with no one to support them and thus resulting to relapse. Patients that are monitored by care givers also relapse as some care givers are working and only come back late from work trusting the user has taken medication as prescribed.

4.3.2.4 Compliance to medication

Table 5: Table shows the frequency in taking medication by the participants with relapsed schizophrenia.

Compliance to medication	Frequency	Percent	Valid Percent	Cumulative Percent
yes	5	31.3	31.3	31.3
No	11	68.8	68.8	100.0
Total	16	100.0	100.0	

According to the table, only 5 participants are taking their medication regularly, and 11 patients are not taking their medication regularly as reported by the participants during the interview.

4.3.2.5 Factors resulting in readmission to hospital

Table 6: illustrates the factors that caused participants readmission to the hospital

Factors resulting to readmission to hospital	Frequency	Percent	Valid Percent	Cumulative Percent
non compliance to treatment	9	56.3	56.3	56.3
patient not getting better on the current treatment	2	12.5	12.5	68.8
substance abuse	5	31.3	31.3	100.0
Total	16	100.0	100.0	

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Table 5 shows the factors that caused the patients to be readmitted to the hospital. 9 patients were not compliant to treatment, 2 were not getting better in spite of taking their medication and 5 were due to substance abuse. The major cause of re-admission was treatment non-compliance (56.25%), followed by substance abuse (31.25%) and lastly no improvement on current drug (12.50%). Side effects, forgetfulness and lack of support may lead to noncompliance to treatment. The environmental factors and patient centred factors such as substance abuse may trigger schizophrenia thus resulting to relapse and the user will be admitted to the mental institution.

4.3.2.6 Scheduled visits to the clinic

Table 7 shows the number of scheduled visits per month to the clinic for the participants that were admitted at the hospital with relapsed schizophrenia during data collection.

Visits to the clinic	Frequency	Percent	Valid Percent	Cumulative Percent
One	16	100.0	100.0	100.0

According to the table, all 16 participants visit the clinic once in a month. The participants collect their medication once a month unless they need to see a health care provider for other problems.

4.3.2.7 Information about the illness

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Table 8: Shows the percentage of participants that have enough information about their illness

Enough information about the illness	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	9	56.25	56.25	56.25
no	7	43.75	43.75	100.0
Total	16	100.0	100.0	

Also, 56.25% of the participants claimed they did have enough information about illness and treatment. Out of 16 patients only 9 participants were having enough information about their illness. The participants were not psychotic; therefore they were able to explain their status.

4.4 Conclusion

The data have been analysed and discussed according to graphs and tables with some explanations. Findings elicited noncompliance due to various reasons namely: Patient centred factors, family support, poly pharmacy, cultural factors, and demographical factors such as education, gender and age. In the next chapter the results will be further discussed and the recommendations will be made.

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CHAPTER FIVE: DISCUSSION, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the results outlined in the previous chapter as well as the limitations of the study. Recommendations will be made. Results will be discussed as related to the research objectives.

5.2 Discussion of research results

The main purpose of the research was to study the reasons associated with relapse in patients with schizophrenia and to recommend strategies that can be used to reduce relapse. Section A of the questionnaire answered the demographical questions and Section B answered the behaviour related questions. Discussions will revolve around the following:

5.2.1 Age distribution

The participants were between the age of 26 and 50 years. The age distributions showed that majority of the patients, 43.75%, were between aged 46 and 50. Age groups 26-35yrs and 36-45yrs were recorded between 25% and 31.25% respectively. In this study older patients were recorded as having high relapse rate. These are the patients that have been diagnosed for a long time and due to treatment fatigue and fear of side effects they became noncompliant to treatment

5.2.2 Race

As regard to race, no white patients were hospitalised at the time of the research. However, black and coloured patients on admission were 81.25% and 18.75% respectively. Fort England Hospital admits all races, but there is a significant rise in patients who are black. These are the patients that do not have support system in the community and from family members. Some of them are unable to interpret the prescriptions thus resulting noncompliance resulting to relapse.

5.2.3 Source of income

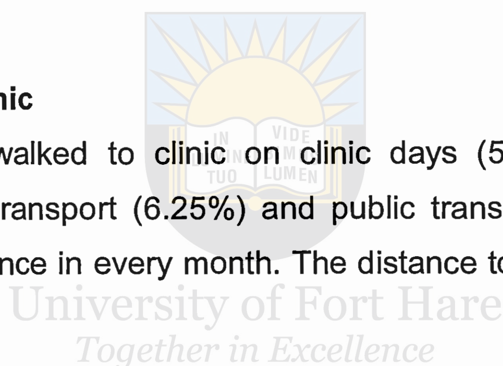
The major source of income was disability grant, 81.25%, followed by income from working care givers were recorded as 6.25%, and finally about 12.50% claimed that they had no source of income. The MHCUs depend solely on disability grant and they use it anyhow when they do not have a responsible caregiver. The user can use the money to buy dagga or alcohol.

5.2.4 Substance use

Substances commonly used as revealed in the study were dagga (6.25%), alcohol (12.50%), smoke (6.25%), dagga and alcohol combined (31.25%), and (43.75%) are non users of substances. Almost half of the patients abstained from all forms of substance use.

5.2.5 Transport to the clinic

Majority of the patients walked to clinic on clinic days (50%), other modes of transportation were own transport (6.25%) and public transport (43.75%). All the patients visited the clinic once in every month. The distance to the clinic is less than 5 kilometres.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5.2.6 Medication monitoring

Patients medications were equally monitored by the patients (50%) and the care givers (50%). Results showed that about 68.75% of the patients claimed that they did not use their medications regularly, and 31.25% agreed that they used their medications regularly. Also, 56.25% of the patients did not have enough information about illness and treatment, 43.75% claimed that they did have enough information about illness and treatment.

In eliciting the causes of readmission of patients to hospital, it was revealed that the major cause of re-admission was treatment non-compliance (56.25%), followed by substance abuse (31.25%), and lastly no improvement on current drug (12.50%).

It is evident that the patients relapse because they are non compliant to treatment. Non compliance can be enhanced by quite a number of reasons. Some of which will be described. Participants stay alone and no one supervises their medication intake and they stated that they forget to take their treatment. Patients that are monitored

by some caregivers relapsed and this is due to the fact that such caregivers are employed, they leave early in the morning and come back late. The participants stated that the medication is left with them sometimes, so that they can take it on their own.

Substance abuse is a major problem in South Africa. Substances are taken to escape from personal and psychological problems resulting to users not conforming to social values and norms (Uys & Middleton, 2004:400). Use of substance interferes with the person's daily living. Dagga and alcohol were most commonly used substance by the participants and the users stated that when they have taken these substances they do not see the need to take the medication. Kazadi et al (2008:58) emphasize that it is not clear enough that substance abuse in patients with schizophrenia results in relapse, but it does lead, to inter alia, increased psychosocial problems, infections, sexually risky behaviour, hostile and disorganised behaviour.

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The research questions which required the reasons for relapse to patients with schizophrenia have been answered in the results. The summary of the reasons for results is: Non compliance to treatment, substance use, and lack of support system, forgetfulness, poverty and stigmatisation by the community. The second question which is about the strategies for reducing relapse will be discussed in the recommendations.

5.3 Recommendations

Prevention of relapse in patients suffering from schizophrenia should take priority in the programs of Department of Health just like other chronic conditions. The recommendations include the following:

- The psychiatric clinics should be opened on daily basis to accommodate mentally ill users. Those who travel long distances must be spared the inconvenience.

- The primary health care revitalization project can also assist in reducing relapse in these patients. The outreach team should visit the patients at home to give education, provide support and monitor medication compliance.
- Community awareness regarding mental illness so as to reduce stigma to the mentally ill.
- The community development workers are the people who are more aware of their areas and they also need to be used as the support system for these patients.
- Educating people with mental illness and their families about their illness, its symptoms and their medication is the best way to encourage co operation with treatment.
- Involvement of the family in the treatment plan of the patients from the day of diagnosis and to introduce family meetings.
- Establishment of support groups where the patients will be able to discuss their problems regarding their illness, medication and how to deal with their problem. As most of these patients are not working they need to be kept busy even if they are doing hand work, therefore they are able to escape substance use in the community. Most MHCUs are not working and they more free time on their hand and they can spend it on support groups thus removing them from negative environmental factors where they abuse substance with their peers.

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5.4 Limitations of the study

The researcher identified the following limitations in this study:

This study was conducted in one district, therefore it cannot be generalised. The study, being quantitative can provide more information if it is augmented by qualitative approach and using the sample of caregivers. More information can be generated in which caregivers will describe the reasons for relapse.

5.5 Conclusion

This chapter concluded the study and made recommendations for practice. The researcher described the results, limitations and recommendations as indicated in the purpose of the study. The reasons associated with relapse in patients with schizophrenia were discussed and recommendations were made to reduce relapse rate. The recommendations should assist the heath care workers who provide care to the mental health care users.

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APPENDIX A: QUESTIONNAIRE

QUESTIONNAIRE **NAME:**

Choose only 1 option

1. Age

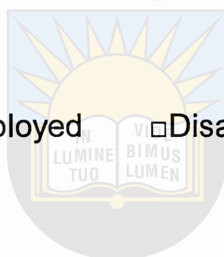
   □18-25 □26-35 □36-45 □46 and above

2. Race

   □Black □White □Coloured □Other

3. Source of income

   □Employed □Self employed □Disability grant



4. Gender

   □Male □Female

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5. Substance use

   □Dagga □Alcohol □Cocaine □Other drugs

6. Mode of transport to the clinic

   □Own transport □Public transport □Walking distance

7. No of scheduled visits per month to the clinic

   □1 □More than 1

8. Who monitors the patient's medication?

   □Patient □Care giver

9. Does the patient use medication regularly?

   □Yes □No

10. If no, what are possible reasons?

    □ Don't know about the medication □Side effects □Ignorance Other, explain--

11. What could be the contributing factor for the patient to be readmitted in the hospital?

□ Non compliance to treatment □ Patient not getting better on the current treatment □ Substance abuse Other, explain--------------------
----

12. Do you have enough information about your illness and treatment?

□Yes □No

THANK YOU FOR ANSWERING THE QUESTIONS

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APPENDIX B: REQUEST FOR PERMISSION FROM DEPT OF HEALTH

65 Woodlands Complex

Vrede Street

Durbanville

7550

20 July 2010

Nursing Director/Hospital Manager

Department of Health

Sir/Madam

University of Fort Hare
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RE: REQUEST TO CONDUCT A RESEARCH STUDY

I hereby request permission from your office to allow me to conduct a research study on "**Reasons associated with relapse in patients with schizophrenia".** The study will be conducted in Grahamstown. The study is towards Cur Degree under the Department of Nursing Sciences in the University of Fort Hare.

The objectives of the study are to:

- Identify the reasons associated with relapse in schizophrenic patients resulting in their readmission in Fort England Hospital.
- Determine strategies for reducing relapse to patients admitted at Fort England Hospital

The information will be the property of Fort Hare University.

The summary of the research findings will be distributed to your office.

I hope my request will be highly considered.

Kind Regards,

Babalwa Mtana.

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APPENDIX C: REQUEST FOR PERMISSION FROM THE INSTITUTION

65 Woodlands Complex

Vrede Street

Durbanville

7550

20 July 2010

The Manager

Department of Health

University of Fort Hare
Together in Excellence

RE: REQUEST TO CONDUCT A RESEARCH STUDY

I hereby request permission from your office to allow me to conduct a research study on. "**Reasons associated with relapse in patients with schizophrenia".** The study will be conducted in Grahamstown at Fort England Hospital. The study is towards Cur Degree under the Department of Nursing Sciences in the University of Fort Hare.

- Identify reasons associated with relapse in schizophrenic patients resulting in their readmission to Fort England Hospital
- Determine strategies for reducing relapse to patients admitted at Fort England Hospital.

The information will be the property of Fort Hare University.

The summary of the research findings will be distributed to your office.

I hope my request will be highly considered.

Kind Regards,

Babalwa Mtana.

APPENDIX D: CONSENT FORM

Informed Consent

I am Babalwa Mtana, doing masters with the University of Fort Hare. My research

study is **"A study on reasons associated with relapse in patients with schizophrenia".** The study will be in the form of questionnaires and will take a maximum of 15 minutes.

The answers will be recorded on the questionnaire. Your name will not be written in the questionnaire and no one will be able to link you to answers. You are free to withdraw from the study even if the interview is not completed. The study may result in psychological stress but support will be provided should the need arise. The study will benefit you in that, you will be able to identify the cause of relapse in patient you are rendering care to.

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The research results will be made available to you as participants. You are free to contact the researcher at any time to ask questions about the research and your rights.

Yours faithfully

Babalwa Mtana

Contact number: 078 684 3706

I………………………………………….. hereby agree to participate in research study on factors associated with relapse in patients with schizophrenia. I understand that I am participating freely and without being forced in any way to do so. I understand that my answers will remain confidential.

Signature of participant……………………………………..Date……………………

08/10 2010 11:02 FAX ☒001

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	23rd September 2010	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Ms Babalwa Mtana

Re: Factors associated with relapse in patients with schizophrenia

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.
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.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

University of Fort Hare
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FORT ENGLAND HOSPITAL

Private Bag X1002, Grahamstown, 6140. Tel: +27 (0)46 622 7003. Fax: +27 (0)46 622 7630.

RESEARCH PROPOSAL APPROVAL

Date: 01 Nov 2011

Dear Ms Mtana,

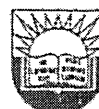
Thank you for your application to conduct research at Fort England Hospital. We are pleased to inform you that your research proposal has been approved by the Academic and Research Committee (as indicated below). A copy of our Research Policy is included herewith, for your information.

Yours sincerely,

Assoc. Prof. Mo Nagdee
Chair: Academic and Research Committee

Primary Investigator	Name	B. Mtana		
	Position	Fort Hare Nursing Science student; Mcu degree		
	Student or staff number	200041266		
	Telephone	078 684 3706		
	Email			
Research project	Title	A study on factors associated with relapse in patients with schizophrenia readmitted to Fort England Hospital		
	Supervising University / Institution	Fort Hare		
	Supervisor	Mrs Magadla / Dr Tshotsho		
	Ethics Approval from Supervising University / Institution	No	Yes (insert date) Univ. Of Fort Hare; 23 Aug 2010	
Fort England Hospital Approval	Academic and Research Committee (Dr Nagdee)	No	Yes (insert date) 1.11.11.	Signature
	Clinical Head (Dr Erlacher)	No	Yes (insert date) 02/11/11	Signature
	Hospital Manager (Mrs Holder)	No	Yes (insert date) [illegible]	Signature

OFFICE OF THE DEPUTY VICE-CHANCELLOR:
ACADEMIC AFFAIRS AND RESEARCH
Private Bag X1314, Alice 5700
Tel: 04060 22403
Fax: 0866282944
tsnyders@ufh.ac.za



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Application for clearance from the University of Fort Hare's Ethics Committee

Project Title: **Factors associated with relapse in patients with schizophrenia**

Chief Researcher: Babalwa Christina Mtana

Supervisor: Mrs NIN Magadla

Date of application: 10 August 2010

Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

23 August 2010

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