

THE KNOWLEDGE OF RELATIVES REGARDING MANAGEMENT OF DISCHARGED MENTAL HEALTH CARE USERS IN THE EAST LONDON DISTRICT

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THE UNIVERSITY OF FORT HARE

Together in Excellence

by

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DATE: MARCH 2014

DECLARATION

I declare that **THE KNOWLEDGE OF RELATIVES REGARDING MANAGEMENT OF DISCHARGED MENTAL HEALTH CARE USERS IN THE EAST LONDON DISTRICT** is my own work, that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any institution.

Full names: Ncinane Highman Ntuku

Signature:



Date:

2014 / 04 / 15



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DEDICATION

I would love to dedicate this work to the following people:

- My late parents, whose words of motivation and encouragement towards education still ring in my mind,
- My wife and two children (Ali and Soso), my family and the AmaNtshilibe clan as a whole for their direct and indirect support, and lastly
- My colleagues in the undergraduate degree course, especially the B.Cur group of 1986 (UFH), for their indirect pressure in support of completing these studies and also ex-colleagues at work for their words of support.



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The staff of Mdantsane clinics who willingly helped the researcher in identifying the participants;

The relatives of the mental health care users who voluntarily and willingly participated in this study and

To all my friends who have always supported me, without mentioning your names, thank you.



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ABSTRACT

The role of family members is very important to reduce the readmission of mental health care users to psychiatric institutions. The reason for this is that they are always with the patient and can easily identify the early signs of relapse. This could be achieved if they are well equipped with information on the management of the patient after being discharged from the hospital.

The purpose of this study was to determine the knowledge of relatives and their needs regarding the management of discharged mental health care users so as to prevent readmission. A quantitative design in the form of self-administered questionnaires was used to collect data from the adult relatives of mental health care users who had been discharged from the Cecilia Makiwane hospital and were continuing with treatment from Mdantsane clinics.

A probability sampling approach in a simple random method was used to identify and collect data from 108 participants who were included in this study. The results of the study revealed that the knowledge of relatives regarding the management of discharged mental health care users was inadequate as they had not been provided with the necessary information on the discharge of the patient. The results also revealed that relatives of mental health care users need more information in the form of health education on how to manage a discharged mental health care user.

In summary, the recommendations comprise a call for a continuous and periodical link between the health care professionals in psychiatric institutions and families of discharged mental health care users, probably through home visits and mental health awareness days.

KEY CONCEPTS

Knowledge; relatives / care givers; management; discharged; mental health care user; mental health unit

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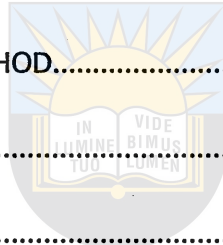


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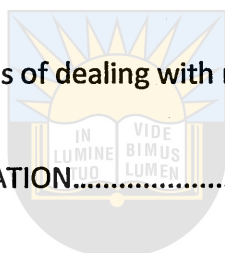
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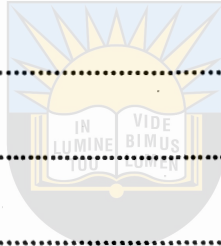


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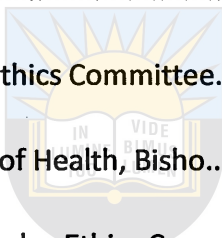
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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Chronically mentally ill mental health care users who live in the community may be able to care for themselves but most of the time they are not able to live on their own. In most instances they live with a family member who has to ensure that they receive the necessary care and support. These family members may include parents, spouses, siblings or offspring. On discharge from the hospital relatives should be informed what caring for a mentally ill individual should comprise of, to enable them to ensure that care takes place. This was the focus of the study under discussion.

Deinstitutionalisation is the 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 researcher expected that, on implementing this process, the staff of that psychiatric institution would already have prepared the relatives and, if possible, the community where the patient would reside. There would have to be a relative who would always be there for the patient to provide proper care in order to prevent readmission into the hospital. The basic needs, such as a proper place to stay, food, accessories for personal hygiene, clothing, and socialisation activities and so on, should be available so as to boost the mental health care user's self-esteem. The health facility where the patient will continue receiving treatment should be identified. Carrol (2004: 122) agrees about deinstitutionalisation, stating that this process assumes that support services for mental health care users will be available so that they will be able function outside the institutional setting.

According to Salter and Turner (2008: 153), 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. The relatives should be well educated on the early signs of mental illness and early signs of relapse and be encouraged to play a role, for instance in taking their family member for help as soon as possible before he or she becomes unmanageable and warrants readmission in hospital. Caring for patients in the community is more cost-

effective for the Department of Health than caring for inpatients. The results gained from this study could reduce the current burden on psychiatric nurses who have to deal with relapsed patients.

Kaplan and Sadock (2003: 1375) further recommend 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 when the public is actively involved.

Dolamo, in Mchunu (2009: 5), states that the achievement of an appropriate health care delivery system requires involvement of people at grassroots as part of the process so that the service can be utilised effectively. People at grassroots begin at home with an individual and the immediate family. These people are always together and see one another more frequently than a psychiatric nurse who is visited only for help.

Health care professionals cannot totally replace the relatives of the mental health care user; hence the nurse must encourage relatives themselves to continue to support the client in hospital or at home. As a source of social support, the relatives can be a key factor in the recovery of clients with psychiatric illnesses (Videbeck, 2004: 141).

The study by Davhana-Maselesele and Mashau (2009: 40-7) revealed that lack of knowledge among relatives hampered caring for their loved ones and that has exacerbated stigma and discriminatory practices. It is of importance that the assessment of the care needs of the mental health care user be carried out; that the family is involved; and the community services for follow-up care are identified.

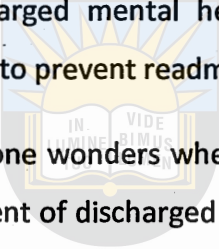
The process of discharging a mental health care user from the hospital back to the community is not an easy task. It needs communication, interaction and collaboration. The interdisciplinary team of the health facility team, mental health care users, relatives and community services have to engage in a discharge planning process (Uys, 2010: 305). This can promote the rehabilitation of the mental health care user, enhance deinstitutionalisation and prevent readmission.

1.2 PROBLEM STATEMENT

The researcher, who is a practising psychiatric nurse, has noted with concern that, when looking at the monthly statistics of the mental health unit at the Cecilia Makiwane hospital, the number of readmissions is at times greater than the number of newly admitted clients. The mental health care users are admitted from their homes in the community where there are relatives and into the mental health unit. This has triggered the researcher to conduct a study to investigate the knowledge that relatives have regarding management of discharged mental health care users, so as to prevent readmission into the mental health unit of the Cecilia Makiwane hospital.

What knowledge do relatives of discharged mental health care users have regarding management of mental health care users to prevent readmission was unknown.

Emanating from the above statements, one wonders whether the relatives have adequate knowledge with regard to the management of discharged mental health care users so as to prevent readmission into the mental health unit of the Cecilia Makiwane hospital.


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1.3 PURPOSE OF THE STUDY

The purpose of the study was to explore and describe the knowledge and needs of relatives regarding management of discharged mental health care users in order to prevent readmission into the mental health unit.

1.4 RESEARCH OBJECTIVES

The objectives of the study were to:

- determine the knowledge of relatives regarding management of discharged mental health care users to prevent readmission into the mental health unit
- identify the needs of relatives regarding their knowledge of the management of discharged mental health care users so as to prevent readmission

- based on the results, recommend guidelines to strengthen the relatives' knowledge, so as to prevent readmission of discharged mental health care users

1.5 RESEARCH QUESTIONS

- What is the relatives' knowledge regarding management of discharged mental health care users in order to prevent readmission into the mental health unit?
- What are the relatives' needs regarding their knowledge of the management of discharged mental health care users so as to prevent readmission?



1.6 SIGNIFICANCE OF THE STUDY

The results from this study will help to empower psychiatric nurses to devise strategies to fully involve relatives in the total care of their family members who are mental health care users, in order to prevent readmission.

The study will further promote the involvement by knowledgeable relatives in the care and management of discharged mental health care users as a means of reducing the readmission rates.

The recommendations from this study will assist the Department of Health in strengthening guidelines of preventing unnecessary readmission of mental health care users through involving their relatives in total care after being discharged from hospital.

1.7 DEFINITION OF THE KEY CONCEPTS

A relative:

is a person who is related to another by birth, parentage, or marriage (South African Oxford Secondary School Dictionary 2008: 519). In this study, a relative will either be the

grandfather, grandmother, father, mother, uncle, aunt, sister, brother, or any meaningful other.

Knowledge:

is the information and skills you have gained through experience or education (South African Oxford Secondary School Dictionary 2008: 339). In this study, knowledge will refer to the information and skills relatives have with regard to the management of a discharged mental health care user prior to readmission.

Management:

is the process of having something under your control (South African Oxford Secondary School Dictionary 2008: 374). In this study, this will mean the actions and skills used by relatives to deal with a discharged mental health care user so as to prevent readmission.

Discharge:

is to allow someone to leave (South African Oxford Secondary School Dictionary 2008: 173). In this study, this term will refer to the mental health care users who have been released from the mental health unit of Cecilia Makiwane hospital to continue with treatment from home at the nearest health facility.

A mental health care user:

This is an accepted term in the new Mental Health Act (Act No. 17 of 2002) for a psychiatric patient. Madela-Mntla (2010: 91) defines a mental health care user as a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user.

A mental health unit:

This is a designated ward in which mental health care users are admitted in a general hospital and in this research study it is at Cecilia Makiwane hospital in the East London district. This is where the researcher planned to identify the patients who had been admitted through consulting registers and whose relatives were invited to be participants in the study.

1.8 CONCEPTUAL FRAMEWORK

This study was guided by the Theory of Reasoned Action. The Theory of Reasoned Action points out the importance of attitudes and supports from significant others in contributing to health behaviours of the mental health care user (Corrigan, Mueser, Bond, Drake & Solomon, 2008: 120-121). In this study, the significant others were the relatives of the discharged mental health care user.

One of the most common reasons for the discharged mental health care user to be readmitted to the hospital is defaulting on medication. In enhancing medication adherence, family psycho-education was one of the strategies to be used. It aims at helping relatives become aware of the benefits of medication and the nature of side-effects. Psycho-educational efforts are based on empirical evidence, which has shown that understanding mental illness helps patients and their families cope more positively with the illness (Keltner, Schwecke & Bostrom 2007: 309).

The primary goal of psycho-education is to enlist the support of relatives in helping the discharged mental health care user adhere to the recommended treatment, including prescribed medication, and to monitor adherence to medication. Psycho-education is another strategy that falls under the Theory of Reasoned Action from which the researcher departed for this study.

This theoretical framework guided the study and enabled the researcher to link the findings to the existing body of knowledge. The relevance of this theory to the intended study will be discussed in detail as part of the literature review in chapter two.

1.9 RESEARCH METHODOLOGY

1.9.1 Research design

A non-experimental, descriptive design with a quantitative approach was used to gather information on the relatives' knowledge with regard to management so as to prevent readmission into the mental health unit of a discharged mental health care user. According to Babbie and Mouton (2002: 240), a research design is a structured framework for how the

researcher intends conducting the research process in order to solve the research problem. It is a blueprint for conducting a study and it maximises the control over factors that could interfere with the validity of the findings (Burns & Grove, 2009: 218). A descriptive design may be used to identify problems in current practice.

1.9.2 Research setting

The study was conducted with the relatives of mental health care users who had been admitted into the mental health unit of Cecilia Makiwane hospital and were receiving treatment from the clinics of the Mdantsane Sub-district. The mental health unit of the Cecilia Makiwane hospital, a hospital situated in Mdantsane Township, in the East London district of the Eastern Cape Province, has 25 beds to which male mental health care users can be admitted and also 25 beds for female mental health care users. It caters for the entire Buffalo City Municipality, including East London areas, Mdantsane, Bisho, Dimbaza, King Williams Town and the surrounding rural areas.

1.9.3 Population of the study

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According to Brink, van der Walt and van Rensburg (2006: 123), a compiled definition of a population by various authors states that it is the entire group of persons that is of interest to the researcher, or, in other words, that meets the criteria the researcher is interested in studying. The target population in this study was the adult relatives of mental health care users who had been admitted into the mental health unit of the Cecilia Makiwane hospital and were receiving treatment from the clinics of the Mdantsane Sub-district at the time of the research.

1.9.4 Sample and sampling method

1.9.4.1 Sample

Brink et al, (2006: 124) defines a sample as “a part or a fraction of a whole, or a subset of a larger set, selected by the researcher to participate in a research project”. The mental health unit of the Cecilia Makiwane hospital was visited to identify the patients by making use of admission registers and getting their addresses. A sample of relatives of mental health care users who had been admitted into the mental health unit of the Cecilia

Makiwane hospital and were receiving treatment from the clinics of the Mdantsane Sub-district was selected using a probability sampling method. According to Burns and Grove (2009: 349), this is a method whereby every member has a probability higher than zero of being selected for the sample.

1.9.4.2 Sampling

Sampling refers to the process of selecting a sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. Sampling criteria list the characteristics essential for membership in the target population (Burns & Grove, 2009: 366). The inclusion criteria for participants were as follows:

- Must be a relative of the mental health care user who had been admitted into the Mental Health unit of the Cecilia Makiwane hospital and currently was receiving treatment from the clinics of the Mdantsane Sub-district.
- Must have been with or seen the patient within the last three days before admission
- Must be able to communicate in English or IsiXhosa
- They must sign an informed written consent form

The following were the exclusion criteria for the study:

- Relatives of mental health care users who had been admitted in hospital but not at the Cecilia Makiwane mental health unit
- Mental health care users' relatives who were outside the catchment area of the Mdantsane Sub-sub district

1.9.5 Data collection method

Data were collected using an instrument developed by the researcher with the guidance of the statistician.

1.9.6 Research instrument

A questionnaire in a structured self-report form was used to gather information about the knowledge of relatives with regard to the management of a discharged mental health care

user. Burns and Grove (2009: 406) state that questionnaires are similar to interviews but are obtained as the participant's written responses. These authors further state that the questions in a questionnaire are presented in a consistent manner and there is less possibility for bias than in an interview.

The content of the questionnaire consisted of the following sections:

- A. Demographic data and
- B. the knowledge of relatives

These were to be based on the standard guidelines or formats used.

1.9.7 Reliability and validity

According to Babbie (2004:143), validity refers to the extent to which an empirical measure accurately reflects the concept it is intended to measure. The validity of the research questionnaire, especially its content, was assessed and approved by an expert in the field of psychiatric nursing and a statistician.

A pilot study was conducted with the first three interviews to determine the reliability of the research instrument.

1.9.8 Pilot study

According to Brink *et al.* (2006: 54), unforeseen problems can arise in the course of a project and the researcher can recognise and address these problems if a pilot study has been conducted. The pilot study is a small-scale trial run of the study that helps to obtain information for improving the project, making adjustments or assessing its feasibility (Polit & Beck, 2008: 51).

In the current study, the first three interviews with the relatives of mental health care users were conducted to confirm whether the research questionnaire yielded applicable results and these did not form part of the research. Some changes could be applied if there was a need.

1.9.9 Data analysis

Data analysis was done by using a computerised Statistical Package for the Social Sciences (SPSS) version 19.00 program and is presented using frequencies and percentages. This was done with the help of an experienced statistician.

1.10 LIMITATIONS OF THE STUDY

Burns and Grove (2009: 41) define limitations as the restrictions or problems in a study that may decrease the generalisability of the findings. The study was limited to the relatives of the mental health care users who had been admitted to the mental health unit situated at the Cecilia Makiwane hospital and was receiving treatment from the clinics of the Mdantsane Sub-sub district.



1.11 ETHICAL CONSIDERATIONS

According to McHaffie (2000:52-53), South Africa has a diverse society with different values, beliefs and standards which need to be considered and respected when conducting research. A range of ethical problems present themselves, not only to those actively engaged in research but to clinicians whose patients are involved in research projects, to educators and to managers. This author points out that ethics is a brand of philosophy which deals with thinking about morality, thus making a judgement about whether something is right or wrong.

It is every researcher's responsibility to ensure that the ethical code is maintained at all times (Brink *et al.* 2006: 30). Ethical approval to conduct the study was first obtained from the Ethics Committee of the University of Fort Hare. The researcher obtained further written approval to conduct the study from the following authorities:

- The Eastern Cape Provincial Department of Health, Mental Health Directorate, Bisho
- The Director of Nursing, Cecilia Makiwane Hospital, East London and

- The participants, relatives of the patients, who were requested to sign written consent forms before participation.

The ethical standards for nurse researchers, as stated in the Democratic Nursing Organisation of South Africa (1998: 2.3.2 – 2.3.4), were adhered to. These include:

- Planning and execution of nursing research in a way that will foster justice, beneficence and exclusion of harm or exploitation of participants
- The right to self-determination
- Confidentiality and anonymity
- Quality research



1.12 DISSEMINATION OF RESULTS

The commemorations of the mental health awareness days which are usually held during the mental health month of October will be the platform for the researcher to disseminate information through presenting papers to the community about the information yielded by the study. The researcher will take part in the health-related workshops and seminars and present a paper to disseminate the results of the study. The researcher is also a coordinator of students during their psychiatric nursing practice at the community mental health services facility in East London. The researcher is looking forward to sharing the results of the study with these students as another way of disseminating the information.

The researcher is also planning to publish the results in an accredited Journal.

1.13 CONCLUSION

In this chapter, “Research Proposal”, the researcher has tabled and discussed an overview of the steps and process of conducting the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter a detailed and focused orientation to the study was presented. In this chapter, the literature search that was undertaken to gather information in relation to the knowledge of relatives regarding the management of discharged mental health care users is discussed.

Burns and Grove (2009: 92) define a literature review as an organised written presentation of what has been published on a topic by scholars and its purpose is to convey to the reader what is currently known regarding the topic of interest. According to Polgar and Thomas (2008: 294), the literature review is a section of a research report in which the previous research that has been done in the area is reviewed and related to the present problem being studied. The information in literature that is expected of health care professionals to give to the relatives of mental health care users during the discharge planning is presented in this chapter. Relevant information in the previous studies is tabled here for the benefit of the relatives of mental health care users that they may know and manage them at home to prevent readmission. For the purpose of this study, the literature review in general is based on the information and knowledge expected to be given to the relative of a mental health care user prior to being discharged, so as to manage the mental health care user at home. The goal of this knowledge and information is to equip the relative to be able to manage the discharged mental health care user to prevent readmission to the mental health unit.

According to Engelbrecht and Kasiram (2012: 441-446), the deinstitutionalisation of mental health services has changed the structure and mode of caring for people with mental illness and the family and community are now regarded as the dominant care givers and providers. Families, friends and other carers play an important role in relation to supporting mental health care users and increasing the chances that positive health outcomes will be obtained (Barry, 2007: 48). This has been a longstanding approach by amaXhosa people towards people who are ill or suffering and is referred to as "Ubuntu". Ubuntu, a Nguni word for 'humanity', is the idea that people are not individuals but live in a community and must share things and care for each other (South African Oxford Secondary School Dictionary

2008: 681). This is well supported in an abstract by Engelbrecht and Kasiram (2012: 441-446) where it is stated that, in accordance with the principles of Ubuntu, people with mental illness should be well supported and cared for by their families and wider community. From his own experience and cultural background, the researcher knows that caring for mental health care users has been part of the practical implementation of Ubuntu by amaXhosa people. In the African context, caring is usually a family affair with multiple care givers, a system that allows the primary care giver times of relief from caring (Uys, 2010: 88). It is not clear whether the people lack knowledge regarding the management of mental health care users or else the end of Ubuntu amongst the people that nowadays results in a lot of mental health care users wandering aimlessly and also sleeping in the streets.

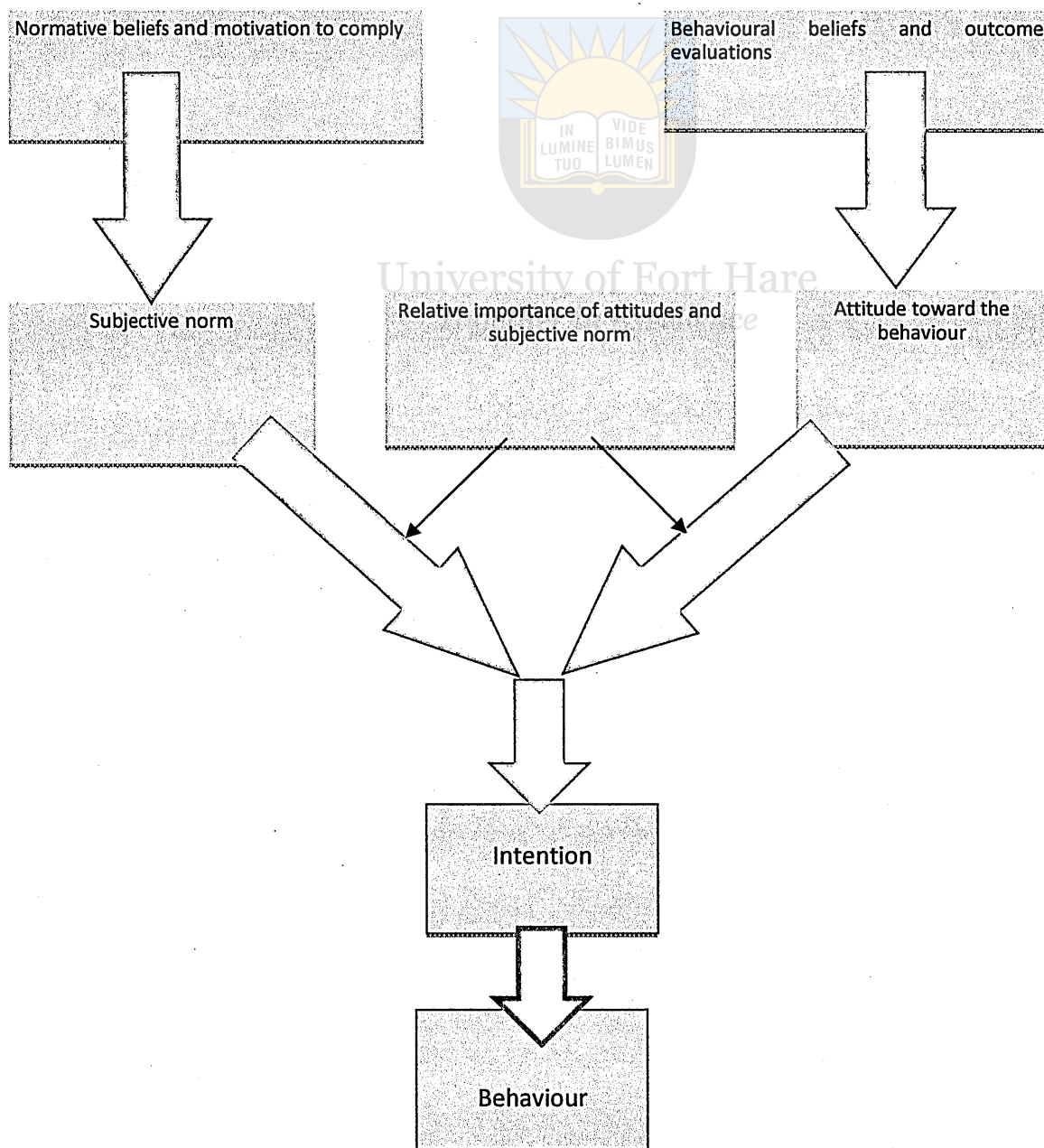
Hoeman (2008: 468) states that the findings of many studies highlight the contribution of social support to effective coping. This is the reason that other professional care givers assist mental health care users by tapping into the support of their family, friends and community networks. From experience, the researcher has noted that, if you build a relationship with a mental health care user, he or she will trust you, which will lead to cooperation and hope for better health. This is the same approach to follow with the relatives of mental health care users; if you win their trust through giving information, they will be cooperative and have hope that their family member will improve.

The plenary and breakaway sessions of the First National Mental Summit highlighted some of the key challenges in the mental health space in South Africa as stigma and discrimination; lack of infrastructure; poor information systems; and poor community support post discharge (Mutsago 2012: 14). From among the mentioned challenges, the researcher focused on the last one, namely, "poor support post discharge". The researcher sees the relatives of the mental health care user as the first people who have to give the required support post discharge. This is the main reason the researcher is conducting a literature review for investigating the knowledge of relatives regarding the management of discharged mental health care users. As stated in the previous chapter, this study was guided by the Theory of Reasoned Action.

2.2 CONCEPTUAL FRAMEWORK

This research study was guided by the theory of reasoned action. The **Theory of Reasoned Action** was developed by Icek Ajzen and Martin Fishbein (1980), and derived from previous research that started out as the theory of attitude, which led to the study of attitude and behaviour (http://en.wikipedia.org/wiki/Theory_of_reasoned_action). These authors' theory claims that all factors which influence behaviour only do so in an indirect way by influencing the attitude or subjective norms.

Figure 1: Schematic diagram of the Theory of Reasoned Action below adapted from Ajzen and Fishbein (1980)



Ajzen and Fishbein's theory also recognises that there are situations (or factors) that limit the influence of attitude on behaviour. According to Ajzen and Fishbein (1980: 5), this theory argues that people consider the implications of their actions before they decide to engage or not to engage in a given behaviour. If there is a need for the relatives of mental health care users to play a role in their care so as to prevent readmission, their knowledge regarding management of a discharged mental health care user will contribute much to whether to take action or not. The theory is based on the assumption that human beings are usually quite rational and make systematic use of the information available to them. This is the reason why the researcher investigated the knowledge of relatives regarding the management of a discharged mental health care user. If they have knowledge, do they use this knowledge to prevent readmission of patients to the mental health care unit? What are their needs with regard to their knowledge, so as to prevent readmission of discharged mental health care users to the hospitals?

The researcher believes that the relatives' knowledge can play an important role regarding the attitude and norms of certain people in helping mental health care users to adhere to their treatment regimen. The positive attitude of the relatives of mental health care users can contribute greatly in supporting participation and contributing to the better health of the patient.

2.3 EXPECTED KNOWLEDGE OF RELATIVES

Society regards people with mental illness as dangerous, make people uncomfortable, act strangely, are weak and do not react to people in a predictable manner (Uys, 2010: 85). This author further sees all these perceptions as based on a lack of knowledge and understanding of what mental illness is and how it is treated. Relatives should have knowledge regarding the medication used by mental health care users and be aware of the causes of relapse and the signs of relapse, as well as of the prevention of relapse and management of a discharged mental health care user during the time of relapse, so as to prevent readmission into the mental health unit. Relapse comprises the recurrence or marked increase in severity of the symptoms of a disease, especially after a period of apparent improvement or stability (Boyd 2012: 46). The researcher believes that the worse

stigma around mental illness is firstly around being admitted in the psychiatric institution and, secondly, worst still if you are readmitted, which is associated with institutionalisation.

2.3.1 Medication

When a mental health care user is admitted to hospital, he or she will be given medication that helps to reverse his condition and/or improve his or her mental disturbance. Mental health care users will be discharged from the hospital with the medication which has been found to be the best for his or her condition to be used at home. It is important for the nurses to know what to include when providing medication education to facilitate accomplishing the goal of increased medication adherence (Eisenmann, 2012: 42). Failure by health care professionals to give education regarding the medication can lead to non-compliance, the relapse of the mental health care user and, later on, readmission to hospital. Prior to the discharge of the mental health care user, relatives should know that the patient has improved because of the medication prescribed for him or her and be made aware that if the mental health care user stops taking medication, he or she may relapse. They should be well informed on the dosage of medication; how to take the medication; when to take the medication; common contraindications of the medication; signs of overdose; and common side-effects. This is often found as a pamphlet attached to the medication issued by a registered pharmaceutical company. Lastly, they should know what to do when problems regarding medication prevail.

2.3.2 Causes of relapse

Mental health care users who are discharged from tertiary facilities are frequently readmitted due to inadequate care in the community, which involves their relatives. This has been attributed to poor treatment adherence and defaulting; early discharge due to bed shortages; and substance abuse (Lund, Petersen, Kleintjes & Bhana, 2012: 403). The relatives of users of mental health care and other care givers should be given information on the possible causes of relapse that can lead to the patient being readmitted to the mental health unit. Kazadi, Moosa and Jeenah (2008: 52-3) identified poor compliance with treatment, substance abuse, stressful life events and depression as some contributing factors towards the relapse of schizophrenia, which is the common diagnosis for mental health care users and these also affect any other mental disorders.

2.3.2.1 Poor compliance with medication

Non-adherence regarding taking prescribed medication throughout treatment should be addressed by seeking the underlying reasons and working with the mental health care user and the relatives to address the issue (Howland, 2012: 15). Non-adherence with medication is the main problem that leads to relapse for both non-psychiatric and psychiatric patients. According to Kazadi *et al.* (2008: 53), this may be due to factors that are:

Patient-related (e.g. substance abuse, forgetfulness or lack of insight),

Health-related (e.g. poor patient/nurse relationship or poor access to services),

Socio-economically-related (e.g. low level of education), and

Treatment-related (e.g. complex treatment regimens)

Cultural attitudes, social attitudes and belief systems may be common reasons for poor adherence to treatment among South Africans and this needs to be taken into consideration (Kazadi *et al.*, 2008: 53).

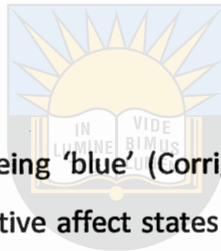
Non-adherence to psychiatric treatment undermines treatment effectiveness, increases risk of relapse and predisposes the patients to poorer outcomes. A systematic review found that one of four patients with psychosis do not keep scheduled post-discharge appointments, and almost one in three do not take medication as prescribed (<http://bjp.rcpsych.org/content/194/1/86>).

2.3.2.2 Substance abuse

In the case of substance abuse, the person shows a maladaptive pattern of substance use resulting in clinically significant impairment or distress (Uys & Martin, 2010: 446). These may be manifested in physical fights and destruction. This is also the time when the family members find the mental health care user unmanageable and decide to call the police for help. According to Kazadi *et al.* (2008:53) alcohol abuse and cannabis abuse were reported in South African studies as significant factors that contributed to relapse in all mental illnesses. These abuses can lead to forgetfulness, and alcohol has also been noted to diminish the effect of some medications.

2.3.2.3 Stressful life events

Pietersen and Middleton (2010: 196) define stressors as transient or ambient events that demand adaptive changes from the individual and that challenge their existing coping and competence. Action needs to be taken as soon as possible once the mental health care user is noted to be suffering from stress. Furthermore, stressors include a range of events, situations and experiences which the individual perceives as stressful and relatives need to know what these are. Stressful life events that lead to relapse may both be internal (e.g. thoughts and feelings) or external (e.g. death of a close relative). Unemployment and the loss of a close family member are reported as significant causes of relapse in South Africa (Kazadi *et al.*, 2008: 53).



2.3.2.4 Depression

Depression is a feeling of sadness or being 'blue' (Corrigan *et al.*, 2008: 7). According to Washton and Zweben (2008: 195), negative affect states such as feeling depressed, bored, stressed, emotionally exhausted, anxious, angry or frustrated can also be powerful triggers for alcohol and drug use. As discussed above, substance abuse can lead to relapse of mental health care users.

Depression in mental health care users has a poor outcome as it can lead to impaired functioning, personal suffering and even to suicide (Kazadi *et al.*, 2008: 53). When the mental health care user is noted to be depressed, the relatives have to take him/her to the health care professionals for help.

2.3.3 Signs of relapse

When the early signs of relapse prevail, the relatives should know what steps to take to prevent readmission. It is rare for these signs to develop abruptly; most of the time they show some days before the actual blow out. The relatives have a duty to take action before the mental health care user becomes totally unmanageable.

Uys (2010: 278) identified some of the signs of relapse as interpersonal sensitivity, depression, anxiety, somatic concerns, paranoid ideation and unusual thought content. The health care professionals should give health education talks to the relatives of mental health

care users about these. The relatives could use this information to build on or increase their knowledge of the management of a discharged mental health care user. Clark (2008: 903) tabulated the following as the characteristic signs of depression and mania and also the positive, negative and cognitive symptoms of schizophrenia, which relatives of mental health care users are expected to know.


Table 2.1: Symptoms of affective disorders adapted from Clark (2008: 903)

CHARACTERISTIC SIGNS OF DEPRESSION AND MANIA	POSITIVE, NEGATIVE AND COGNITIVE SYMPTOMS OF SCHIZOPHRENIA
<p>Depression</p> <ul style="list-style-type: none"> • Persistent sadness or despair • Disturbances in sleep patterns • Difficulty falling asleep • Early morning awakening • Difficulty waking up • Alterations in eating habits • Significant weight gain • Significant weight loss • Diminished energy levels • Decreased interest in sex • Difficulty concentrating • Social withdrawal 	<p>Positive Symptoms</p> <ul style="list-style-type: none"> • Hallucinations: sensory experiences that occur without sensory input (may occur in any sensory modality) • Delusions: distortions of inferential thinking that lead to misperceptions of experiences and erroneous beliefs • Thought disorder: unusual thought processes characterized by difficulty organizing thoughts or expressing them • Disorders of movement: clumsiness or lack of coordination, involuntary movements or unusual mannerisms
<p>Mania</p> <ul style="list-style-type: none"> • Persistent euphoria • Grandiosity (inappropriately high self-esteem) • Psychomotor agitation • Decreased sleep • Racing thoughts and distractibility • Poor judgment and impaired impulse control • Rapid or pressured speech 	<p>Negative Symptoms</p> <ul style="list-style-type: none"> • Flat or blunt affect: lack of emotional response, facial inexpressiveness, diminished body language • Anhedonia: inability to experience pleasure • Diminished ability to plan and execute activity • Infrequent speech <p>Cognitive Symptoms</p> <ul style="list-style-type: none"> • Poor executive function: inability to process information and make decisions based on its interpretation • Poor attention span: inability to sustain attention • Memory difficulties: inability to retrieve and use recently learned information

2.3.4 Prevention of relapse

The relatives of mental health care users should be provided with information that will enhance their knowledge on actions to prevent relapse. Boyd (2012: 46) has identified relapse prevention programmes that involve patients and relatives as follows: educate them about the illness; enable them to cope with the chronic nature of the illness; teach them to recognise early warning signs of relapse; educate them about prescribed medications and the need for compliance; and inform them about other disease management strategies, such as stress management and exercise.

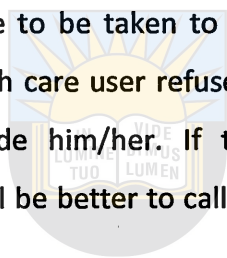
The following strategies, of which the relatives should have knowledge, can help in preventing relapse of the mental health care users (<http://www.camh.ca>):

- 
- The logo of the University of Fort Hare is a circular emblem. It features a sun with rays at the top. Below the sun is an open book with the Latin motto 'IN LUMINE TUO VIDE BIVMUS LUMEN' written on its pages. The entire emblem is set against a light blue background with a subtle grid pattern.
- Identify signs of relapse and work with a professional to develop a relapse prevention plan;
 - Take medication as prescribed, and speak to the doctor if it is not working or if side-effects are too unpleasant;
 - Recognise situations that may trigger symptoms and try to avoid them or reduce exposure to them;
 - Learn about the disorders. Psychoeducation which is the formal learning about mental illness by the individual and family members reduces the rate of relapse;
 - Apply skills learned during the treatment process to deal with symptoms;
 - Practise techniques such as meditation, anger management and positive thinking to deal with stressful situations; and, lastly,
 - Develop a structured routine which helps to pursue lifestyle choices and activities that increase a sense of balance in life, such as relaxation training, stress management, assertiveness training and conflict resolution.

2.3.5 Actions to deal with relapse

It is important to work towards preventing relapse as the consequences of psychotic relapse have been found to be damaging to both psychiatric clients and their families, as well as having a detrimental effect on the financial resources of mental health services (<http://ideas.repec.org/a/wkh/dmhout/v10y2002>). If the relatives of mental health care users are well informed about the medication of the patient, the early signs of relapse and the common causes of relapse, they can easily notice that the mental health care user is relapsing; hence they can take action immediately.

The first and main important action is to identify what could have led to the relapse and to deal with it. The patient will then have to be taken to the health care professionals for further intervention. If the mental health care user refuses, a close relative or a friend can be approached to come and persuade him/her. If the mental health care user is uncooperative and unmanageable, it will be better to call the police for help before he/she harms other people.



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2.3.6 Mental health resources

The relatives of mental health care users should have knowledge of the mental health resources available in their vicinity, as these contribute a lot in management and retaining the mental health care user within the community. Uys (2010: 88) states that the families of mental health care users usually shoulder the greatest part of the burden of caring for them and they are the main resource for the person suffering from mental illness. This is the reason why the relatives should be informed about the available mental health care resources, as they may help to relieve their burden. Mental health resources are composed of both the organisations and programmes that are offered towards improving the mental health of the mental health care users, their relatives and the community at large so as to prevent mental illness and promote mental health. Mental health resources contribute in increasing self-reliance to the clients; reduce dependence on hospitals and other forms of institutional treatment; and enhance clients' abilities to live full lives in the community (<http://mhresources.com>). Uys (2010: 88) furthermore states that mental health resources provide an array of services, including Assertive Community Treatment (ACT); case management; counselling and psychotherapy; medication education and monitoring; living

skills education; parenting skills training; supportive housing; vocational support; psychosocial rehabilitation; and family education about mental illness.

The presence of the non-governmental organisations has contributed towards change in life of the mental health care users in the Buffalo City Municipality of the Eastern Cape Province, especially for those who are making use of them. These include organisations such as the South African National Council on Alcoholism (SANCA), which deals with mental health care users who have become mentally disturbed due to drug and alcohol abuse. The Family and Marriage Society of South Africa (FAMSA) is a non-governmental organisation dealing with family problems which may lead to family disorganisation due to stress and depression. Life-line is a non-governmental organisation which gives counselling over the telephone or, when one visits them. The rehabilitation centre (REHAB) deals with both physical and mental disabilities and also visit homes to engage the families. Sophila and Workbench Protective workshops are there to occupy mental health care users during the day. The Department of Social Development is a government mental health resource that helps mental health care users with disability grants, accommodation and also food parcels. The South African Police Service also helps with containing violent, aggressive and unmanageable mental health care users who are dangerous to themselves, the family and the community, by transporting them to the psychiatric institutions (Mental Health Act No. 17 of 2002). The relatives of mental health care users have to be made aware of these services and be encouraged to make use of them.

2.4 MANAGEMENT OF A DISCHARGED MENTAL HEALTH CARE USER

Care givers report that they feel more in control when they have adequate information and less stressed when they believe they are adequately prepared to manage at home (Nigolian & Miller, 2011: 53). Nigolian and Miller furthermore state that a care giver's lack of knowledge leads to a lack of confidence, which contributes to an increased risk of error as well as readmission. It is not important only to continue with treatment when the patient is discharged, but the mental health care users need to be rehabilitated. According to Hoeman (2008: 1), rehabilitation is an active intervention to achieve maximum function and to improve quality of life. The relatives can play an important role here if they know that they

need to involve themselves by contributing towards prevention of relapse and health promotion, which are seen as critical to better and improved outcomes.

The relatives of mental health care users should be able to help and contain them within the community as long as they comply with all the information that was shared with them by the health care professional prior to discharge from the mental health unit. The relatives should play a key role in the management of a discharged mental health care user, so as to keep him or her within the community and prevent readmission in the hospital.

The researcher sees the readmission of mental health care users as a failure in management by the health care professionals and the relatives of mental health care users. Availability of health care clinics for the continuity of care should be identified before the patient is discharged. The following are some of the common excuses for the mental health care users not continuing their treatment when they are at home and these really need to be considered and addressed:

2.4.1 The health care facility for follow-up care

Mental health care users may complain that the health care facility is far and at times they have no money for transport. Booyens (2000:597-7) sees it as important for a health care facility to provide quality service to the consumers. This involves appropriateness, equity, accessibility, effectiveness, acceptability and the efficiency of the health care facility. The service should provide what the individual or community needs at the right time, without discrimination and should be available at a reasonable distance. The service should be provided to satisfy the reasonable expectations of the consumers, achieve their intended benefits and rendered in a cost-effective manner without waste of resources. If this could be achieved, it will be supporting one of the goals of the current democratic government of South Africa led by the African National Congress which says, "Better health for all" (www.anc.org.za/docs/anctoday/2008/at32.htm). The relatives of mental health care users should have knowledge of this and have to participate and involve themselves with the developments in the health care facility. The management of mental health care users is achieved if the health care facility is of a high standard, especially regarding staff and medication.

2.4.2 Location

The mental health care user may complain that the clinic is far from home and, as a result, refuse to attend and then relapses. There might be no transport or no money for transport to reach the clinic. Again, there might be no clinic at all nearer to the home. This at times needs the intervention of social development towards things like disability grants and the department of health to arrange mobile clinics. The relatives of the mental health care user need to be supported and be made aware of these problems. One of the major priorities of the government is 'Better health for all' and this should be accessible, hence the communities have to make demands for this priority to be met (www.anc.org.za/docs/anctoday/2008/at32.htm).

2.4.3 Treatment

The mental health care user may complain about the unavailability of treatment at the nearest clinic or that the treatment causes side-effects for him or her. The health care professionals should identify the clinic nearest to the mental health care user prior to discharge and also make sure that the prescribed treatment will always be available. If the treatment is not available, the patient may relapse and this may lead to readmission. Again, both the relatives and the mental health care user should be given health education around the importance of treatment, including information about the side-effects and how to deal with them.

2.4.4 Health care professionals

The mental health care user may complain that the health care professionals at the clinic display a negative attitude in being uncaring, unfriendly and even shouting at them. They may complain that the health care professionals take long time before attending to them. The experienced mental health care practitioners have a duty to visit the clinics and give in-service training to the primary health care staff regarding caring for mental health care users. They should know that some of the mental health care users are impatient; hence attending to them may need priority.

The four points discussed above are some of those the researcher believes are very important in dealing with both the mental health care users and their relatives; hence users

and relatives should be involved in a planning session for discharge where all this will be discussed prior discharge from hospital.

2.5 EXPECTED ROLE OF THE RELATIVES

While listening to the "Umhlobo wenene" radio station's "Breakfast Eyondlayo Ekuseni" programme (10 May 2012), the listeners were asked whether relatives of mental health care users were taking care satisfactory of them? One hundred percent of the people who responded to the question showed that a lot still needs to be done, especially by health care professionals. The common response was that the relatives look after the mental health care users only on the day when they have to collect their disability grants or when they have to go and see doctors for review. The following are some of the key roles that need to be played by relatives of mental health care users so as to prevent relapse and readmission into hospitals.

2.5.1 Continuous support

Psycho-education as a family intervention enhances the capacity to solve an identified problem and use strategies to reduce levels of expressed emotion, stress and family burden. Psycho-education has proved to reduce the risk of relapse, improve medication adherence and educate families about mental illness (Asmal, Mall, Kritzinger, Chiliza, Emsley & Swartz, 2011: 367). From this statement it is clear that relatives' support in the care of the mental health care users is of outmost importance in preventing their relapse and readmission into the hospital. The most needed support is in reminding the mental health care user about the treatment, appointment dates and also accompanying him/her to the clinic.

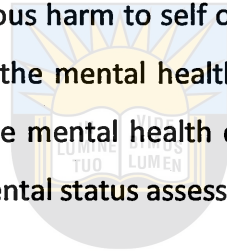
2.5.2 Provision of basic needs

The relatives have to try by all means to provide the basic needs for the mental health care user. These are well prioritised in Maslow's hierarchy of needs tabulated as follows: the fundamental needs, the psychological needs and self-actualisation needs (Boyd, 2012: 66). Upon discharge, many clients' basic needs regarding money, housing, food and clothing are not being met (Drury, 2008), hence it is important to invite the family members of the

mental health care user into a pre-discharge meeting to address these aspects. This is very important to avoid the issue of discharging patients with psychiatric disorders to shelters or the streets but back to their homes.

2.5.3 Involvement of police

The new Mental Health Act by the National Department of South Africa (Act No. 17 of 2002) gives the police department an important and difficult role to play in helping the families and communities of mental health care users who are difficult to handle. Madela-Mntla (2010: 111) states that section 40 of the Act allows the South African Police Service to intervene when they have a reason to believe that a mental health care user suffers from mental illness and is likely to inflict serious harm to self or others. It is the duty of relatives to summon for help from police when the mental health care user is unmanageable. The police personnel can help to contain the mental health care user by taking him/her to an appropriate health establishment for mental status assessment and further management.



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2.6 XHOSA PEOPLE, CULTURE AND MENTAL ILLNESS

According to Kozier, Erb, Berman, Snyder, Lake and Harvey (2008: 58), people of certain cultures may perceive home remedies or complementary therapies superior and more dependable than traditional health care practices. These authors state that cultural rules, values and beliefs give people a sense of being stable and able to predict outcomes. Narayan (2012: 44-5) further stresses the importance of taking into consideration cultural values, beliefs and practices when dealing mental health care users and their families. This author states that those cultural values, beliefs and practices that are beneficial to the patients' health and well-being should be permitted and even encouraged. Those that are neither helpful nor harmful should be accommodated, if possible, as it is likely what people believe helps does help. Lastly, the cultural values, beliefs and practices that are harmful should be changed, if possible, through patient and family education.

It is a common observation for mental health care workers who have had the experience of working in African communities that many of their patients seek alternative therapies of either the religious or the traditional variety in place of, or in addition to 'Western'

psychiatric care (Olugbile, Zachariah, Kuyinu, Coker, Ojo & Isichei, 2009: 149-150). These authors state that the theoretical perspectives that seek to explain such behaviour suggest a relationship between belief systems, cultural practices and conceptualisation of mental disorder. This also involves the rural Xhosa people who have retained social cohesion through traditional custom purity of language and the dominant role of ancestor worship, traditional medicine and witchcraft in life-style, beliefs and ceremonies (<http://informahealthcare.com/doi/abs/10.3109>). Furthermore, abstracts concepts are limited and ego defence mechanisms include projection, displacement and rationalisation, but cognitive disturbances *per se* are not regarded as important. Major attention is paid to severe conative and affective disturbances, ascribed to object or spirit instrument by a traditional "witchdoctor". Therapy with Xhosa people is community-orientated as far as possible, unless uncontrollably violent behaviour necessitates referral to a mental hospital. It is of utmost importance, when the health care professionals engage the relatives of mental health care users in their care, that they take into consideration their cultural background. The relatives need to have knowledge regarding the western medicine used to help the mental health care users while in hospital and to relate this to the traditional medicine used by Xhosa people.

Diagnosing in African indigenous healing may be better conceived as being related to theories of causation (Asmal *et al.*, 2011: 368). These authors listed examples which the researcher is familiar with when looking at Xhosa people. They say spirit possession is the suggested etiology of Amafufunyana. The term ukuthwasa is used to describe the state of emotional turmoil a person goes through on the path to becoming an indigenous healer. If these people are unable to undergo or complete the process of ukuthwasa, a retrospective diagnosis of ukuphambana (madness) may be given. Bewitchment (ukuthakathwa) is another diagnosis associated with evil spirits witchcraft.

2.7 EFFECTS OF CARING FOR A MENTAL HEALTH CARE USER ON THE RELATIVES

Uys (2010: 89) states that relatives looking after a mental health care user usually do this due to the emotional bond between them, perceive it as their duty, at times feel guilty and often they do not have a choice. Continuous, long-term care giving has been noted to lead

to significant stress that is often referred as the 'family burden' or the 'care-giving burden'. Mental health problems exact a toll on the relatives of mental health care users and the costs of mental disorders to the family are both economic and emotional (Clark, 2008: 905). The author furthermore states that relatives of mental care users may also be faced with dealing with dependence and bizarre behaviours in those affected and may experience feelings of frustration, anger and guilt. The relatives of mental health care users have to be given information on what can be expected to happen in the process of caring for the mental health care users. The stresses of caring for the mental health care user can lead to them abandoning the patient, or chasing the patient out of the home, followed by relapse and readmission.

Major mental disorders may also prevent family members from carrying out their expected family roles and mental illness in a family member often increases stress for the entire family. This may contribute to family communication problems and perceptions of social stigma for both client and family (Clark, 2008: 905).

Uys (2010: 91-7) has pointed out guidelines for families with a family member who is mentally ill, namely creating an environment with low stress (e.g. developing appropriate expectations); working on managing disturbing behaviour successfully (e.g. analysing the circumstances of violence and dealing with them); and promoting social reintegration and rehabilitation (e.g. encouraging independent life skills which can improve the patient's functioning). The relatives of mental health care users have to be given this information as it can help to improve their knowledge on tolerating and managing a discharged mental health care user and prevent readmission.

2.8 IMPORTANCE OF HEALTH EDUCATION

Education about the symptoms and treatment of mental illness should be provided to the mental health care user in a language that is readily understood by him or her and, with his or her permission, to relatives and others involved in the day-to-day life who may also benefit from education about the illness, its effects on functioning and its treatment. Uys (2010: 258) states that teaching patients and their families about the condition from which the patient is suffering, its treatment and management, is one of the most empowering

interventions the nurse can implement. This can help in the building of the interrelationships between the mental health care users and their relatives, and hence improved support from the relatives. Elder, Evans and Nizette (2009: 445) refer to this strategy as psychoeducation, which is the provision of information about a person's mental illness to that person and/or his or her family.

Healthcare professionals should not only consider the format in which to present information, but they should also think about the order of information, as this can affect people's understanding and memory of the information (Barry, 2007: 70). This will involve having an understanding of the level of education of the people to whom information is given. It is important to convey why information or a skill is necessary or what the benefits will be to the relatives. Giving health education talks to relatives of mental health care users by health care professionals is another way of disseminating information that can improve the knowledge of relatives regarding the management of discharged mental health care users.

Lastly, Nigolian and Miller (2011: 54) state that the patient's cultural practices must be taken into account to provide successful discharge education.

2.9 IMPORTANCE OF HOME VISITS

The relatives of mental health care users have to be well informed about the importance of home visits. Their knowledge with regard to this will encourage them to go to the extent of inviting the health care professionals to visit the family, observe and deal with their differences, attitudes and problems around the patient. A home visit is usually aimed at gaining an understanding of the client and the family or care givers as people and their physical, social and emotional context (Uys, 2010: 307). Furthermore, the author reveals that a study done in KwaZulu-Natal found out that even one visit to the family after the patient's discharge makes a significant difference to the relapse rate of the patient. One of the important reasons for home visits is to assist the patient and family to solve problems and access appropriate resources to address their needs. Lastly, home visits usually focus on health education to promote healthy behaviours.

Collaboration between health care professionals and relatives of mental health care users should be encouraged so that there is adequate care for the mental health care user. This is the reason why the health care professionals are encouraged to conduct home visits so as to build a better relationship with the relatives of the mental health care user.

Some of the advantages of home visits identified by Carroll (2004:60) include the fact that they cost less than hospital care, with better outcomes, especially when chronic health issues are involved. The health care professionals gain access to families to provide health education and other prevention strategies. The health care professionals also have to conduct home visits to facilitate family participation and promote family focus.

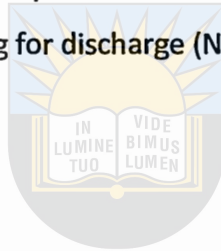
2.10 HEALTH CARE PROFESSIONALS AND DISCHARGE PLANNING

The pre-discharge setting provides the perfect place for mental health care professionals, including nurses, to address homelessness. Providing stable housing for psychiatric clients post-discharge is consistently associated with beneficial results, such as reduced instances of substance abuse; lower rates of hospital use; higher quality of life; and several other positive mental health outcomes (Kyle & Dunn, 2008). Health care professionals have a duty to ensure that the relatives of mental health care users are well informed and have adequate knowledge to manage the patient at home to prevent readmission prior to when the patient is discharged from the hospital. Uys (2010: 305) states that discharge planning is an interdisciplinary process that helps mental health care users and relatives to develop feasible post-hospital plans for care. The author further states that the foundation of discharge planning is a thorough knowledge of the available resources for care in the community.

The purpose of discharge planning is, ideally, to return the mental health care user to his/her prior environment or other suitable community-based setting (Elder, Evans & Nizette, 2009: 213). Another relevant action to be taken by health care professionals is to consider the functioning of the mental health care user prior to his/her becoming ill and to devise a nursing care plan that will improve his/her condition towards better functioning as well as they possibly as they can.

The researcher believes that it is the duty of health care professionals to make sure that the relatives and the community are empowered to take care of mental health care users so that readmission may be prevented. Empowerment means finding ways for people in a community or population to acquire skills and knowledge so that they can participate in decision making about their health (Carroll, 2004: 2). The researcher also believes that it is the duty of health care professionals to empower the relatives of mental health care users 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.

Acknowledging the importance of ethnicity or culture and asking the relatives to provide this information both help when planning for discharge (Nigolian & Miller, 2011: 54).



2.11 CONCLUSION

In this chapter, the literature reviewed covered the following areas with regard to knowledge of relatives about the management and care of discharged mental health care users:

- Knowledge of relatives with regard to the medication, signs of relapse, causes of relapse, actions for dealing with relapse and mental health resources
- Management of a discharged MHCU
- Xhosa people, culture and mental illness
- Expected role of relatives
- Effects of caring for a mental health care user on the relatives
- Importance of health education
- Importance of home visits by health care professionals
- Health care professionals and discharge planning

In conclusion, it is evident from this literature review that, with cooperation, more information and education, the knowledge of relatives regarding the management of discharged mental health care users can be enhanced, so as to prevent readmission into the hospital.



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CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains the research methodology that was used. The purpose of the research methodology is to inform the reader how the investigation was carried out and what was done to solve the research problem or to answer the research questions (Brink, et al. 2006: 191). All steps that were taken to investigate the knowledge of relatives regarding the management of discharged mental health care users in order to prevent readmission are explained in this chapter.



3.2 RESEARCH DESIGN

Parahoo (2006: 184) states that, in order to meet the aims and objectives of a study, researchers must select the most appropriate design. This depends largely on the beliefs and values of the researcher; the resources available; how accessible the participants are; and whether the research is ethically sound. In this non-experimental research study, a quantitative and descriptive design in the form of a self-administered questionnaire was used to collect data from relatives of mental health care users. A quantitative research design gathers evidence that is rooted in objective reality directly and indirectly through beliefs or hunches and this evidence is gathered systematically using formal instruments to gather the needed information (Polit & Beck, 2008: 15-16). This research design was used to gather information on the knowledge of relatives regarding the management of discharged mental health care users so as to prevent readmission.

3.3 RESEARCH SETTING

The study was conducted with the relatives of mental health care users residing in Mdantsane Township. This study was contextual as the results are only valid for Mdantsane township participants, with whom the study was conducted (LoBiondo-Wood, 2006: 561). This township falls under the East London sub-district of the Buffalo City Metropolitan in the

Eastern Cape Province. There are eleven clinics that provide different kinds of programmes for the community, including mental health care users. Of these eleven clinics the one in Zone 2 has since been incorporated into the Nontyatyambo Health Centre. This is an African, Xhosa-dominated township which is also seen as the second biggest in South Africa (<http://www.southafrica.net/za/en/articles/entry/articles.net-mdantsane-east-london>).

Cecilia Makiwane hospital is the only hospital in this township that admits mental health care users who are suffering from acute psychosis and are unmanageable at home.

3.4 STUDY POPULATION

A population is defined as the total number of units from which data can potentially be collected and this comprises a theoretical population (Parahoo, 2006: 256). The population in this study comprised relatives of mental health care users who had been discharged from the Cecilia Makiwane hospital mental health unit and who were receiving treatment from Mdantsane township clinics. Relatives were fathers, mothers, brothers, sisters, uncles, aunts, sons, daughters, and guardians who met the criteria to be included as it was prescribed in the research proposal. In each household, one adult relative in the family had to respond to the self-administered questionnaire, provided that he or she met the inclusion criteria. The researcher received permission to visit the clinics from the Buffalo City Sub-district manager in January 2013 and started visiting the clinics to identify the population. The mental health coordinators in each clinic helped the researcher in identifying mental health care users who had been discharged from the Cecilia Makiwane hospital mental health unit. This was not easy, as the mental health care users came from Cecilia Makiwane hospital with prescriptions only to continue with treatment at the clinics. The prescription did not indicate whether the mental health care user had been admitted to the hospital or not. The solution was to ask each mental health care user on follow-up days whether they had been admitted or not. The mental health care users about whom the coordinators were not sure whether they had been admitted or not, were traced through the hospital admission registers. This was done after the researcher received permission from the hospital manager in May 2013. The process of identifying the population of the study was done and completed in the period January to May 2013. A total of 162 mental health care users who had been discharged from the hospital and were receiving treatment from

Mdantsane township clinics were identified, with the result that 162 relatives made up the population of this study.

3.5 STUDY SAMPLE AND SAMPLING METHOD

The researcher completed the process of identifying the target population and decided to identify a sample for the study. A probability sampling approach whereby each individual had a chance of being included in the sample was chosen (Joubert & Ehrlich, 2007: 95). A simple random sampling method was used to select a sample. A sample is a subset of the population, usually with the implication that it resembles the population closely on key characteristics (Sapsford, 2007: 7). The required two-thirds (66, 6 percent) sample of participants from the 162 relatives forming the population was drawn by means of a fishbowl technique. The researcher had to pick 108 participants from the target population so as to make the 66, 6 per cent sample for the study.

The names and addresses of mental health care users who had been discharged from the hospital were put in a list numbered from 001 to 162. These started with those names that had addresses from Zone 1 to Zone 18. This was the researcher's sampling frame. The researcher wrote numbers from 001 to 162 on similar slips which were later folded into similar shapes. These were put in a bowl, which was shaken to mix them and the researcher started selecting one slip at a time. The number selected was marked on the sampling frame and the slip was folded again and put back in the bowl.

For fear of the possibility that some families might not be found, the researcher decided to increase the number by 10 participants. The selection continued until 118 slips were collected as the required sample for the study. The researcher had now to design and develop a research instrument for the data collection process.

3.6 RESEARCH INSTRUMENT

A research instrument in the form of a self-administered questionnaire, which was made easy enough to be completed by participants was drawn. This was designed and developed by the researcher in consultation with a statistician. The research instrument was, in turn,

presented to and approved by the University of Fort Hare research ethics committee. Parahoo (2006: 298) states that, with a self-administered questionnaire, the participants write their responses on the questionnaire or the researcher can read the questions and record the responses on the questionnaire. The first section (**Section A**) of the instrument consisted of the biographical data of the participants. The biographical data consisted of seven items that would identify each relative individually as a participant in this research study. These items included the following; relation to the patient, gender, age, school level, status of marriage, religion and employment. The participant had to mark (tick/cross) what was relevant to him or her only.

The second section (**Section B**) had a list of statements (B1 to B5) related to what the relatives ought to know about continuing care and management of the mental health care users in the community in order to prevent relapses. Statement B1 asked whether the relative was invited to a pre-discharge planning session by the hospital mental health unit with emphasis on medication and had to mark either 'yes' or 'no'. Statement B2 listed possible signs of relapse and each relative had to mark what was relevant regarding the mental health care user. Statement B3 covered the possible triggers of relapse and statement B4 presented actions for dealing with relapse and the participant had to mark (tick/cross) either 'yes' or 'no'. In the last statement (B5), the participant had to indicate by a mark (tick/cross) only one of his or her first and the most relevant sources of information from those listed regarding caring for the mental health care user at home ones (See **Annexure 'A'**: Research questionnaire in English or **Annexure 'B'**: Research questionnaire translated into isiXhosa).

On designing and developing the research instrument, the researcher considered four important items that are mentioned by Polit and Beck (2008: 426-7) for constructing questionnaires. These are the following:

1. clarity; questions should be clearly worded and be unambiguous
2. ability of respondents to give information; respondents must be able to answer the questions
3. bias; the wording of the questions should minimise the risk of response bias

4. sensitivity; questions must not ask things that are sensitive to the respondents, that is, private in nature

The information for the statements was drawn from the literature review that presented knowledge that relatives of mental health care users should have in order to manage users them at home after their discharge from hospital. From this, the researcher had to do a pilot study with the instrument (research questionnaire).

3.7 PILOT STUDY

A pilot study is commonly defined as a smaller version of a proposed study that is conducted to refine the methodology (Burns & Grove, 2009: 44). Furthermore, it is developed much like the proposed study, using similar participants, the same setting, the same treatment, and the same data collection and analysis techniques. This is supported by Polit and Beck (2008: 213) who define a pilot study as a small-scale version or trial run, designed to test methods to be used in the larger study and is sometimes referred to as a feasibility study. A pilot study was carried out with the three relatives of mental health care users who had been discharged from the Cecilia Makiwane hospital mental health unit but came from another area, that is, Duncan Village and Braelyn extension. It was from the results of the pilot study that the researcher finally decided to have the questionnaires translated into isiXhosa. Some psychiatric terms were too difficult to be understood by the participants and they had to ask help from the researcher to complete the questionnaires. A linguist from Walter Sisulu University translated the questionnaire into isiXhosa (See Annexure 'B': Translated questionnaire). Bell (2010: 151) states that all data-gathering instruments should be piloted to test how long it takes recipients to complete them; to check that all questions and instructions are clear; and to enable the researcher to remove any items that do not yield usable data. The researcher had to prove the validity and reliability of the research instrument.

3.8 VALIDITY AND RELIABILITY

3.8.1 Validity

According to Joubert and Ehrlich (2007: 117), validity refers to the extent to which a measurement instrument actually measures what it is meant to measure. In this study, the validity was ensured through the instrument which was designed to contain only items that were relevant to measure the required knowledge of relatives to manage a discharged mental health care user. This instrument had simple and straightforward wording. It was simple and easy to understand as it only required the knowledge of relatives and nothing else. No sensitive questions were asked. All questions were derived from literature around the prevention of relapse and readmission into a mental health unit. These included knowledge of relatives regarding medication used by the mental health care user; knowledge about causes of relapse and identifying signs of relapse; and taking action to deal with a relapsing mental health care user.

The researcher submitted the questionnaire to the supervisor, who holds a doctoral degree and is lecturing psychiatric nursing, the statistician, and also the research ethics committees of the University of Fort Hare, the East London Complex hospital and the Department of Health epidemiology section of the Eastern Cape Province.

3.8.2 Reliability

Reliability concerns the extent to which a test or procedure produces similar results under constant conditions on all occasions (Bell, 2010: 119). The questionnaires that were piloted with three participants from another area (Duncan Village), showed consistency with the results of participants from the area (Mdantsane Township) where the actual study was conducted. The participants who were involved in the pilot study were not included in the actual study during data collection. The participants were well informed about their rights in participating in this study, they volunteered freely and willingly to participate. A linguistic translated the questionnaires into isiXhosa, the language of the participants, so that they would be comfortable in responding. The questionnaires were distributed by the researcher to minimise any possible bias; the researcher made himself available to clarify where there was a need; and then collected the questionnaires.

Then the research questionnaire was ready to be used for the actual data collection process.

3.9 DATA COLLECTION

This is a process of selecting participants, gathering data from these participants and its steps are specific to each study, depending on the research design and measurement methods (Burns & Grove, 2009: 441). A questionnaire that was designed to measure the knowledge of relatives on management of a discharged mental health care user was used to collect data. The researcher waited for permission from the relevant authorities before starting to conduct data collection. The researcher used addresses from clinic and hospital files as a guide to reach the homes of the mental health care users.

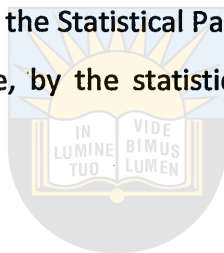
On arrival at each house, the researcher would introduce himself, the topic and the purpose of the research study, explain the ethical considerations around the study and then invite any relative to volunteer and join as a participant. Any relative who participated in the study had to meet the inclusion criteria. Furthermore, the researcher had to read the letter of invitation to the participant and ask him or her to sign consent (**See Annexure 'C': Participant consent form**) to participate, which was later on destroyed to prevent any other person, even the researcher, from linking the participant to the study.

On the first day, the researcher managed to distribute ten (10) research questionnaires, which was not easy to do as the addresses were not in order and the researcher was not familiar with Zone 1 where data collection began. There was an agreement between the researcher and the participants that these would be completed and collected by the researcher the following day. On the following day, only six (6) of the ten (10) distributed questionnaires were completed. The researcher had to wait for these to be completed before proceeding to other houses. From this experience the researcher decided to wait for each questionnaire to be completed by the participant before visiting the next participant. The pace of distributing the questionnaires delayed the data collection process but at the end there was a 100% return. Whenever a family was visited and a relative completed the questionnaire, it was given a code from 001 till the researcher reached 108 participants. These were then inserted in a data spreadsheet formulated by a statistician. This was done to prepare the sample for data analysis. One hundred percent ($n = 108$) of the questionnaires were returned, as they were distributed and collected by the researcher.

The process of data collection was started and completed in the period May to July 2013. Each research questionnaire was completed within 25 to 35 minutes. The collected data had to be analysed.

3.10 DATA ANALYSIS

According to Brink et al. (2006:170), data analysis entails categorising, ordering, manipulating and summarising the data and describing them in meaningful terms. The results of the questionnaires that were completed during data collection were recorded in the data spreadsheet designed by the statistician. These were sent to the statistician for data analysis. Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 19.00, a computer programme, by the statistician. The results are presented in Chapter 4.



3.11 ETHICAL CONSIDERATIONS

Ethical considerations required the following: The researcher first presented a research proposal to a panel of lecturers who were experienced in supervising research studies in the Department of Nursing Sciences. On approval, the proposal was presented to the University of Fort Hare Research Ethics Committee. The researcher received the clearance certificate (See Annexure D) as well as an approval from the Eastern Cape Department of Health, epidemiology section (See Annexure E), to conduct the study. The East London Hospital Complex Ethics Committee gave permission (See Annexure F) to visit the hospital, the Cecilia Makiwane hospital manager (See Annexure G) for the use of admission registers, and, lastly, the East London sub-district manager (See Annexure H) gave permission to visit the Mdantsane township clinics.

All participants in this study were invited to respond to the self-administered questionnaires after the purpose of the study was explained to them. They were informed that their participation was to be voluntary; that confidentiality and anonymity would be maintained throughout in this study; and that their names would not appear in the completed study.

Lastly, they were informed that they were free to withdraw from participating without any type of penalty and they had to sign consent (See Annexure C).

3.12 SUMMARY

In this chapter a detailed process of the research methodology was described, starting from the design and development of the instrument. The identification of the target population, the description and the selection of the sample, were presented and the process of piloting the research instrument to prepare it for the actual data collection was also presented. The process of data collection was explained and how data would be analysed was introduced. In the following chapter (Chapter 4) data analysis will be described in further detail and the results will be tabled.



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CHAPTER FOUR

RESULTS AND INTERPRETATION

4.1 INTRODUCTION

This study is based on the process of discharging a mental health care user from the hospital back to the community. Such a process requires effective communication, interaction and collaboration with both the patient and the home-based care giver. As such, it becomes important to establish how much knowledge the home based care giver has about the psychiatric condition of the patient in terms of the medication; signs of relapse; possible factors contributing to the condition; ways of dealing with possible relapse; and available sources of information.

The main purpose of this study was to explore and describe the knowledge and needs of relatives regarding management of discharged mental health care users. Adequate knowledge can prevent and/or minimise the rate of readmissions of previously discharged mental health patients into the mental healthcare facility. The specific research questions of interest in this study were:

- Are the relatives provided with any information on management of mental health patients on the discharge of the patient?
- What type of information, if any, do these relatives receive?
- Are the relatives aware of the possible signs of relapse?
- What do the relatives consider to be the factors that can trigger relapse?
- How would the relatives handle the situation in the event of a relapse?
- What are the major sources of information on management of mental health patients?
- Is there any association between provision of mental health patient management information and the relatives' understanding of triggers and signs of relapse, as well as action to take in the event of a relapse?

- Are the different sources of information associated with relatives' understanding of triggers and signs of relapse, as well as action to take in the event of a relapse, known?
- Is there any association between the relatives' understanding of triggers and their knowledge of signs of relapse and their actions in the event of a relapse?
- Is there any association between action taken in the event of a relapse and the signs of a relapse?

4.2 STATISTICAL METHODS

This statistical report presents the answers to the above questions, besides providing a description of the respondents used in this study. The data were analysed using frequency distribution tables as a way of summarising the responses. Associations were tested using the chi-square test for independence, followed up by odds ratios and their confidence intervals. In order to test associations between binary variables, the Fisher's exact test was also used as a follow-up confirmatory test for the chi-square test. This is because the chi-square test may sometimes miss some otherwise significant associations in the cases of highly sparse contingency tables. Significance of an association was determined using the p-value, where associations with p-values less than the significance level would be considered as statistically significant – otherwise they are considered not statistically significant. Odds ratios were computed only for those cases in which significant associations were detected.

Odds ratios less than 1 indicate negative associations while those greater than 1 indicate positive associations. If the odds ratio is equal to 1, it is indicative of no association between the variables. The further away the value is from 1 in either direction, the stronger the association between the variables. These were computed in order to determine the direction and strength of the associations. Given together with the odds ratio estimates are the corresponding confidence intervals. These intervals provide the range of possible values that the odds ratio estimates can take at a particular confidence level. In this case 95% confidence intervals were used.

All tests for statistical significance were carried out at a 5% level of significance. The statistical analysis was carried out using the SPSS (Statistical Package for the Social Sciences) software version 19. The results of the analysis are presented below.

4.3 SAMPLE DESCRIPTION

The sample was made up of 108 respondents of which 71 (65.7%) were females. This suggests that the majority of mental health patients are taken care of by their female relatives, mostly mothers (30.6%), followed by sisters (17.6%). About 29.6% of the care-giving relatives were of some relationship other than those provided by the researcher. Table 4.1 shows the complete distribution of care giver relationships with the patients.

Table 4.1: Care giver's relationship with patient

RELATIONSHIP	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Father	5	4.63	5	4.63
Brother	12	11.11	17	15.74
Uncle	1	0.93	18	16.67
Cousin	3	2.78	21	19.44
Mother	33	30.56	54	50
Sister	19	17.59	73	67.59
Aunt	3	2.78	76	70.37
Other	32	29.63	108	100

The majority of the care givers were in the over 55 year old age group (36.1%), followed by 21.3% in the 36 to 45 year age group. As shown in Table 4.2, below, the age group with the least number of care givers was the 46 to 55 year age group.

Table 4.2: Age group of care-giving relative

AGE	Frequency	Percent	Cumulative Frequency	Cumulative Percent
18-26 yrs	19	17.59	19	17.59
27-35 yrs	16	14.81	35	32.41
36-45 yrs	23	21.3	58	53.7
46-55 yrs	11	10.19	69	63.89
Over 55 yrs	39	36.11	108	100

The grade 4 to 7, grade 8 to 10 and grade 11 to 12 educational levels were equally represented in the sample, with 31 respondents each constituting 28.7%. The least represented was the grade 1-3 educational level, which presented a mere 2.8%.

Table 4.3: Educational level of care giver

EDUCATION	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Gr 1-3	3	2.78	3	2.78
Gr 4-7	31	28.7	34	31.48
Gr 8-10	31	28.7	65	60.19
Gr 11-12	31	28.7	96	88.89
Tertiary	12	11.11	108	100

The majority of the care-giving relatives were found to be single (62%); 20.4% were widowed; and 13.9% were married, while the rest were divorced.

Table 4.4: Marital status of care giver

MARITAL STATUS	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Single	67	62.04	67	62.04
Married	15	13.89	82	75.93
Divorced	4	3.7	86	79.63
Widowed	22	20.37	108	100

Only two (1.9%) respondents were from an African traditional religious background, 38 (35.2%) were of other religious backgrounds and the rest were Christians. An overwhelming majority of 90 (83.3%) respondents were unemployed and the rest were equally distributed between fully employed and the casually employed. As such, this sample was made up of predominantly unemployed respondents.

4.4 CARE GIVER'S KNOWLEDGE WITH REGARD TO MEDICATION

Only 39 (36.1%) of the respondents had been provided with information to assist them with managing the patient on discharge. Of these, all received information about the medication

the patient needs to be taking and where it can be collected. Only one of these respondents did not receive information about how the medication should be taken. As for the common side effects of the medication and what to do in the event of such occurrences, 28 (71.8%) admitted to having received the information. All those who were given information about the side effects were also the only ones who had received information about the action to take in the event of side effects of the medication manifesting. Those who had not been informed about the side effects also did not know how to handle the situation if side effects presented themselves.

A significant association between knowledge of the side effects and knowledge of mental health resources in the community was detected (Chi-sq = 10.54, $p = 0.0012$, OR = 11.1). The odds ratio of 11.1 shows that those who have information about the side effects are about 11 times as likely to know about mental health resources in their communities as those without knowledge of the sides effects. In fact, only about 18% of those who did not know about the side effects knew about mental health resources in their communities, while 75% of those who knew the side effects also knew about mental health resources in their communities. Exactly the same association existed between knowledge of action to take in the event of side effects and knowledge of mental health resources in their communities. This suggests that, whenever information about side effects is provided, care givers are also informed about where they can access resources to help them with the management of discharged mental health patients in their care.

It can be seen from Table 4.5 that 59% (23) of the respondents were given information about the mental health care resources available in their communities. Generally, rather few relatives of mental health care users admitted to having been given information at the time of discharge from the health care facility about how they could best manage the patient at home. The complete frequency distribution of information provided to relatives is given in Table 4.5.

It is rather disturbing that the situation is like this, because the expectation is that all home-based care givers should be equipped with information that will facilitate management of the discharged patient. If care givers are armed with such information, readmissions may be limited to only a few rather special cases. However, it is encouraging to note that, where the

information is provided, all the care givers are informed about the medication, where it can be collected, and how it is used. Side effects can easily be misunderstood to indicate relapse, therefore it is important that, as much as possible, home-based care givers should be well-informed about the possible side effects and how these can be handled. It is equally important that all the relatives should be informed about any resources available within their communities that can facilitate their care of discharged mental health care users. This study shows that, of those who receive some information on discharge, not all are informed of the availability of such resources in their neighbourhood.

Table 4.5: Information received on discharge of patient

Did you get information about the following?	No	Yes
The medication the patient is taking	0 (0%)	39 (100%)
Where to collect the medication	0 (0%)	39 (100%)
How the medication is administered	1 (2.6%)	38 (97.4%)
Common side effects of the medication	11 (28.2%)	28 (71.8%)
Action to take in the event of side effects	11 (28.2%)	28 (71.8%)
Available mental health resources	16 (41%)	23 (59%)

4.5 CARE GIVER'S KNOWLEDGE ABOUT THE SIGNS OF A RELAPSE

The majority of the respondents believed that wandering aimlessly (64.5%), aggressive behaviour (80.6%), restlessness and agitation (67.6%), withdrawal (56.5%), talking to oneself (57.4%), hearing voices (56.5%), poor personal hygiene (55.6%), violent behaviour (70.4%) and insomnia (68.5%) are signs of relapse. The rest of them did not consider these as signs of relapse. On the other hand, the majority of the respondents did not believe that suicidal tendencies (79.6%), public undressing (66.7%), abusive behaviour (57.4%), muteness (54.6%), suspiciousness (58.3%), overly irritableness (82.4%), refusing to eat (70.4%), fear of the unknown (71.3%), incessant praying (83.3%) and tearfulness (85.2%) are signs of relapse. About 99% of them could not identify any other sign as a sign of relapse. The respondents were split equally as to whether seeing things that others cannot see are a sign of relapse. These results are shown in Table 4.6.

Table 4.6: Care giver's knowledge of signs of relapse

Which of the following are signs of relapse?	No	Yes
Wandering aimlessly	38 (35.2%)	70 (64.8%)
Suicidal tendencies	86 (79.6%)	22 (20.4%)
Aggressive behaviour	21 (19.4%)	87 (80.6%)
Restlessness and agitation	35 (32.4%)	73 (67.6%)
Withdrawal	47 (43.5%)	61 (56.5%)
Public undressing	72 (66.7%)	36 (33.3%)
Talking to oneself	46 (42.6%)	62 (57.4%)
Abusive behaviour	62 (57.4%)	46 (42.6%)
Hearing voices	47 (43.5%)	61 (56.5%)
Mute	59 (54.6%)	49 (45.4%)
Suspicious	63 (58.3%)	45 (41.7%)
Poor personal hygiene	48 (44.4%)	60 (55.6%)
Overly irritable	89 (82.4%)	19 (17.6%)
Refusing to eat	76 (70.4%)	32 (29.6%)
Fear of the unknown	77 (71.3%)	31 (28.7%)
Violent behaviour	32 (29.6%)	76 (70.4%)
Incessant praying	90 (83.3%)	18 (16.7%)
Insomnia	34 (31.5%)	74 (68.5%)
Tearfulness	92 (85.2%)	16 (14.8%)
Seeing what others cannot see	54 (50%)	54 (50%)
Other	107 (99.1%)	1 (0.9%)



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Some of the signs that the respondents felt did not suggest the onset of a relapse can very well be signs of relapse. It would be detrimental for the patient's health if such signs are ignored. It is necessary, therefore, to educate the home-based care givers about all the possible signs of a relapse and preferably to attach a score of the likelihood of relapse associated with each sign. That will go a long way in assisting care givers with the ability to identify signs of relapse and seek advice in good time.

4.5.1 Associations among care givers' knowledge of signs of relapse variables

Tests for associations among the questions assessing the care givers' knowledge of the signs of relapse were carried out. All possible pairwise associations were tested, but only the ones that were found to be statistically significant are presented in this section. The values of the chi-squared test statistics and corresponding p-values, the Fisher test's p-values, the odds ratios and the 95% confidence intervals of the odds ratios are presented in a table below each interpretation.

4.5.1.1 Association between wandering aimlessly and other relapse signs

Responses to wandering aimlessly as a sign of relapse were found to be statistically and significantly associated with responses to suicidal tendencies, aggressive behaviour, restlessness, poor personal hygiene and violent behaviour as signs of relapse. Of these associations only the association with suicidal tendencies was found to be negative, with the rest being positive.

These results suggest that those who consider wandering aimlessly as a sign of relapse are less likely to associate suicidal tendencies with a relapse, compared to those who do not consider wandering aimlessly as a sign of a relapse. This is reflected in the odds ratio estimate of 0.3, which is less than 1. However, all the other odds ratios are greater than 1. Based on the odds ratios below, respondents who consider wandering aimlessly to be a sign of relapse are more likely to also consider aggressive behaviour, restlessness, poor personal hygiene and violent behaviour as signs of a relapse, compared to those who do not consider wandering aimlessly as a sign of a relapse.

Table 4.7: Associations between wandering aimlessly and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Suicidal tendencies	4.54	0.033	0.045	0.3	(0.11-0.56)
Aggressive behaviour	5.51	0.019	0.024	4.3	(1.94-9.74)
Restlessness and agitation	8.28	0.004	0.005	4.3	(1.94-9.74)
Poor personal hygiene	10.82	0.001	0.001	4.0	(1.80-8.90)
Violent behaviour	4.38	0.036	0.048	3.4	(1.54-7.48)

4.5.1.2 Associations between suicidal tendencies and other relapse signs

The results in the table below show that those who consider suicidal tendencies to be a sign of relapse have also demonstrated being overly irritable and tearful to be signs of relapse. The odds ratios are greater than 1, which suggests a positive association. This means that those who see suicidal tendencies as a sign of a relapse strongly believe that irritability and tearfulness are also signs of relapse. Specifically, those who take suicidal tendencies to be a sign of relapse are nine times as likely to consider irritability, and at least 15 times as likely to consider tearfulness as signs of relapse, compared to those who do not take suicidal tendencies to be signs of a relapse.

Table 4.8: Associations between suicidal tendencies and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Overly irritable	3.86	0.040	0.033	9.0	(3.77-21.51)
Tearfulness	10.17	0.001	0.004	15.3	(5.99-38.98)

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4.5.1.3 Associations between aggressive behaviour and other relapse signs

Aggressive behaviour as a sign of relapse has already been found to be associated with wandering aimlessly as a sign of relapse. In this case, it was also found to be positively and significantly associated with restlessness and violent behaviour. The results show that those who believe that restlessness is a sign of relapse are 5.6 times as likely to believe that restlessness, and 11 times as likely to believe that violent behaviour, are signs of a relapse, compared to those who do not. This suggests that those who consider aggressive behaviour to be a sign of relapse are more likely to also consider restlessness and violent behaviour as signs of relapse. Note that the p-values are very small, suggesting there is a very strong association between the variables under consideration.

Table 4.9: Association between aggressive behaviour and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Restlessness and agitation	7.28	0.007	0.010	5.6	(2.47-12.89)
Violent behaviour	17.15	<.0001	<.0001	11.0	(4.51-29.96)

4.5.1.4 Associations between restlessness and the rest of the relapse signs

Besides the association with aggressive behaviour found above, restlessness was also found to be associated with refusing to eat, violent behaviour and insomnia. However, the association with refusing to eat was not statistically significant, based on the 95% confidence interval. Note that the 95% confidence interval contains 1, which implies that 1 is a possible value that the odds ratio can take and if that happens, there would be no association to talk about. However, the associations with the other two relapse signs were statistically significant and positive. This means that those who believe that restlessness is a sign of relapse are more likely to consider violent behaviour and insomnia as signs of relapse. Specifically, they are 3.7 times as likely to believe that violent behaviour and 4.3 times as likely to believe that insomnia are signs of a relapse, compared to those who do not believe in restlessness as a sign of relapse.

Table 4.10: Associations between restlessness and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Refusing to eat	8.23	0.004	0.004	1.5	(0.68-3.09)
Violent behaviour	4.35	0.037	0.045	3.7	(1.66-8.15)
Insomnia	7.01	0.008	0.014	4.3	(1.94-9.74)

4.5.1.5 Associations between withdrawal and the rest of the relapse signs

Withdrawal was found to be significantly associated with muteness only. Note that the association with hearing voices has a chi-squared p-value of 0.033 and a Fisher p-value of 0.05. In this case, the more reliable test would be Fisher's test, whose p-value is right on the boundary, being exactly equal to the level of significance. In such cases, a decision would be reserved until a confidence interval is computed. In this case, the confidence interval contains 1, which means that the association is not statistically significant. The association with muteness as a sign of relapse is clearly significant and positive. This means that those who believe withdrawal to be a sign of relapse are 12.3 times as likely to believe that muteness is also a sign of relapse, compared to those who do not consider withdrawal as a

sign of relapse. Therefore, those who consider withdrawal to be a sign of relapse are more likely to consider muteness as a sign of relapse as well.

Table 4.11: Associations between withdrawal and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Hearing voices	4.56	0.033	0.050	0.5	(0.22-1.02)
Mute	35.69	<.0001	<.0001	12.3	(4.94-30.1)

4.5.1.6 Association between public undressing and the rest of the relapse signs

The results below show that those who consider public undressing to be a sign of relapse are more likely to also consider abusive behaviour and suspicious as signs of relapse. In fact, those who take public undressing to be a sign of relapse are 2.9 times as likely to also consider abusive behaviour, and 2.7 times as likely to consider suspicious behaviour, as signs of relapse, compared to those who do not believe that public undressing is a sign of relapse. As such, public undressing has significant positive associations with abusive and suspicious behaviours.

Table 4.12: Associations between public undressing and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Abusive behaviour	5.47	0.019	0.024	2.9	(1.32-6.31)
Suspicious	4.29	0.038	0.062	2.7	(1.23-5.81)

4.5.1.7 Associations between talking to oneself and the rest of relapse signs

Talking to oneself was found to be significantly associated with being irritable and with insomnia. The associations were such that those who believe talking to oneself to be a sign of relapse were 0.4 time as likely to believe that being overly irritable is a sign of relapse. Note that the odds ratio in this case was less than 1, which means there is a significant negative association. This means that those who consider talking to oneself is a sign of relapse are less likely to also consider irritability as a sign of relapse, compared to those who do not believe talking to oneself is a sign of relapse.

On the other hand, the odds ratio for the association between talking to oneself and insomnia is 2.9, which is greater than 1. This means these two relapse signs have a positive association, that is, those who believe talking to oneself is a sign of relapse are more likely to also believe that insomnia is a sign of relapse. Specifically, those who take talking to oneself as a sign of relapse are 2.9 times as likely to consider insomnia as a sign of relapse, compared to those who do not take talking to oneself as a sign of relapse.

Table 4.13: Associations between talking to oneself and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Overly irritable	3.99	0.046	0.072	0.4	(0.17-0.82)
Insomnia	5.35	0.021	0.035	2.9	(1.32-6.31)

4.5.1.8 Associations between poor personal hygiene and other relapse signs

Poor personal hygiene was found to be statistically significantly associated with refusing to eat and insomnia. The odds ratios are greater than 1, meaning that the associations are positive. This means those who believe that poor personal hygiene as a sign of relapse are 2.9 times as likely to consider refusing to eat, and 2.5 times as likely to consider insomnia as signs of relapse, compared to those who do not believe that poor personal hygiene is a sign of relapse. This suggests that believing in poor personal hygiene as a sign of relapse is associated with believing that refusing to eat and insomnia are also signs of relapse.

Table 4.14: Associations between poor personal hygiene and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Refusing to eat	12.16	0.001	0.001	2.9	(1.32-6.31)
Insomnia	4.16	0.042	0.060	2.5	(1.14-5.35)

4.5.1.9 Association between irritability and the rest of the relapse signs

Irritability was already found to be significantly positively associated with suicidal tendencies and significantly negatively associated with talking to oneself. Here, irritability has been found to be significantly associated with insomnia and tearfulness. However, the association with these relapse signs are of opposite directions. Those who believe that irritability is a sign of relapse are less likely to believe that insomnia is also a sign of relapse,

compared to those who do not believe that irritability is a relapse sign as reflected by an odds ratio estimate of 0.2. On the other hand, those who believe that irritability is a sign of relapse are more likely to believe that tearfulness is also a sign of relapse, as evidenced by an odds ratio estimate of 13.7.

Table 4.15: Association between irritability and other relapse signs

Relapse sign	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Insomnia	7.46	0.006	0.012	0.2	(0.07-0.37)
Tearfulness	5.13	0.024	0.035	13.7	(5.44-34.32)

4.5.1.10 Rest of the significant inter relapse sign associations

Besides the above associations, five other pairs of association were found to be statistically significant. These are presented together in this subsection.

Abusive behaviour was found to be significantly associated with public undressing and suspicious behaviour. The association with public undressing has already been discussed above. The association between abusive behaviour and suspicious behaviour was found to be positive and statistically significant (Chi-sq = 5.3; p = 0.021). The odds ratio for this association was found to be 2.7 with a 95% confidence interval of (1.23; 5.81). This means that the association is positive and is such that those who believe that abusive behaviour is a sign of relapse are 2.7 times as likely to consider suspicious behaviour as a sign of relapse, compared to those who do not take abusive behaviour to be a sign of relapse.

Hearing voices was found to be significantly associated with refusing to eat (Chi-sq = 11.4; p = 0.001). The odds ratio for this association was 2.7 with a 95% confidence interval of (1.23; 5.81), which indicates that it is positive. This means that respondents who take hearing voices to be a sign of relapse are more likely to consider refusing to eat as a sign of relapse too, compared to those who do not believe that hearing voices signals a relapse.

Muteness was also found to be positively significantly associated with incessant praying (Chi-sq = 9.15; p = 0.003), besides being positively associated with withdrawal. The odds ratio for this association was 3.1 with a 95% confidence interval of (1.43; 6.86). This means that care givers who believe that muteness is a sign of relapse are 3.1 times as likely to

believe that incessant praying is also a sign of relapse compared to those who feel that mute is not a relapse sign.

Suspicious behaviour and refusing to eat were also found to have a statistically significant positive association (Chi-sq = 10.74; $p = 0.0001$) with an odds ratio of 4.3 and a 95% confidence interval of (1.94; 9.74). This means that those who find suspicious behaviour to be a sign of relapse are 4.3 times as likely to consider refusing to eat as a sign of relapse, compared to those who do not believe suspicious behaviour is a relapse sign.

The last association that was found to be statistically significant was the one between violent behaviour and insomnia (Chi-sq = 7.23; $p = 0.007$) with an odds ratio of 4.7 and a 95% confidence interval of (2.10; 10.67). This means those believing that violent behaviour is a sign of relapse are more likely to also believe that insomnia is a sign of relapse compared to those who do not believe violent behaviour signals a relapse.

4.6 CARE GIVER'S KNOWLEDGE OF POSSIBLE TRIGGERS OF RELAPSE

All respondents were sure that defaulting on treatment would trigger a relapse. The majority believe that death of a relative (73.2%), lack of socialisation (83.3%), lack of family support (54.6%) and unemployment or being broke (76.9%) would not necessarily trigger a relapse. On the other hand, 97.2% of the respondents believed that drug abuse would trigger a relapse. The results of this analysis are displayed in Table 4.16 below.

The majority of the respondents seem to believe that treatment defaulting and drug abuse are the only serious causes of a relapse. However, death of a relative, lack of socialisation or family support and financial instability are conducive to a stressful environment which, in turn, creates an environment conducive to a relapse. As in the case of signs of a relapse, it might be necessary to educate care givers about the potential triggers of a relapse. In fact, that would be more important than knowing the signs of a relapse because knowledge of the triggers is a preventative measure and prevention is always better than treatment in all health conditions.

Table 4.16: Care giver's knowledge of triggers of relapse

Can the following trigger mental disturbances?	No	Yes
Defaulting on treatment	0 (0%)	108 (100%)
Death of a relative	79 (73.2%)	29 (26.8%)
Drug abuse	3 (2.8%)	105 (97.2%)
Lack of socialisation	90 (83.3%)	18 (16.7%)
Lack of family support	59 (54.6%)	49 (45.4%)
Unemployment and no money	83 (76.9%)	25 (23.1%)
None of the above	108 (100%)	0 (0%)
All of the above	108 (100%)	0 (0%)

4.6.1 Associations among care givers' knowledge about triggers of relapse variables

As in the case of signs of a relapse, tests for associations among care givers' knowledge about triggers of relapse were carried out. The only possible triggers considered here are the death of a relative, lack of socialisation, lack of support from relatives and lack of income. This is because it was only on these variables that a diversity of responses was found. In the rest of the variables, the responses were unanimous and no reasonable associations could be tested in those cases.

4.6.1.1 Association between death of a relative and the rest of the possible triggers

Death of a relative was found to be highly associated with lack of socialisation, lack of family support and lack of income/money as triggers of relapse. Those who believe that death of a relative triggers a relapse also believe that lack of socialisation, family support and income/money trigger a relapse. Note that all the odds ratios are greater than 1, which means the associations are positive. Those who consider death of a relative to be a trigger of a relapse are actually about 78 times as likely to believe that lack of socialisation is a relapse trigger, compared to those who do not take death of a relative as a trigger of relapse. Similarly, they are four times as likely to believe that lack of family support can trigger a relapse and about eight times as likely to consider lack of income/money can result in a relapse.

Table 4.17: Associations between a relative's death and other relapse triggers

Relapse trigger	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Lack of socialisation	58.84	<.0001	<.0001	77.70	(22.34-27.62)
Lack of family support	11.70	0.0006	0.0001	4.0	(1.80-8.90)
Lack of income/money	10.47	0.0012	0.0036	8.2	(3.45-19.31)

4.6.1.2 Association between lack of socialisation and the rest of the possible triggers

The lack of socialisation was found to be associated with lack of family support and money, besides being associated with death of a relative. Those who believe that lack of socialisation can trigger a relapse are about five times as likely and about 14 times as likely to believe that lack of family support and lack of income/money, respectively, can cause a relapse.

Table 4.18: Associations between lack of socialisation and other relapse triggers

Associations	Chi-sq	Prob	Fisher's p-value	OR	95% CI
Lack of family support	20.99	<.0001	<0.0001	5.2	(2.28-11.71)
Lack of income/money	12.75	0.0004	0.0011	13.7	(5.44-34.32)

Note that, in this case, treatment defaulting and drug abuse were not considered for associations. This is because just about all the care givers believe that these definitely cause a relapse. Since all care givers unanimously agree that these two trigger relapse, there was no need to subject them to any further analysis.

4.7 CARE GIVER'S KNOWLEDGE OF DEALING WITH A RELAPSE

The majority of the respondents believe that dealing with a relapse should involve the police (73.2%) and persuading the patient to seek medical help at a clinic (100%). They were generally against locking the patient away (93.5%); running away leaving the patient alone (95.4%); and overdosing the patient with treatment (100%). About 57% believe that organising people to restrain the patient or calling paramedics (51.9%) would not be an

appropriate way to deal with a relapse. The rest of the results are shown in Table 4.19 below.

These results seem to suggest that the care givers have a reasonably good understanding of how to handle a relapse. However, the fact that quite a good number of them believe that calling the police would be appropriate could be a bit worrying. Police are not necessarily trained to handle such cases and there actually is a real possibility that just the sight of them could worsen the situation for the patient. This is because the police are basically associated with arrest and this might agitate the patient and worsen his or her condition.

Surprisingly, the respondents seem to be divided as to whether calling paramedics would be appropriate. Paramedics are probably better prepared to handle medical conditions than the police and one would have expected the respondents to prefer paramedics over the police. This would probably be dependent on the nature of the relapse. Police are likely to be called in the event of a relapse being evidenced through some form of violent behaviour. However, in general, the respondents seemed to be relatively aware of what they need to do in the event of a relapse.

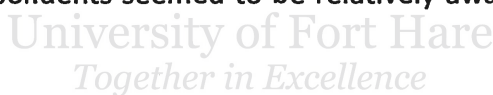


Table 4.19: Care giver's knowledge of dealing with relapse

What is the best way of dealing with a relapsing patient?	No	Yes
Organise people to restrain the patient	61 (56.5%)	47 (43.5%)
Lock the patient away in a room	101 (93.5%)	7 (6.5%)
Call the police	29 (26.8%)	79 (73.2%)
Run away and leave patient alone	103 (95.4%)	5 (4.6%)
Overdose patient with treatment	108 (100%)	0 (0%)
Call paramedics	56 (51.9%)	52 (48.1%)
Persuade the patient to seek medical help	0 (0%)	108 (100%)
None of the above	108 (100%)	0 (0%)
All of the above	108 (100%)	0 (0%)

4.7.1 Associations among variables of dealing with relapse

The only statistically significant association was the one between calling the police and calling ambulance personnel (Chi-sq = 4.79; p = 0.0286). For this association, the odds ratio estimate was 0.4 with a 95% confidence interval of (0.20; 0.95). This shows that the association is negative, meaning that those who would call the police in the event of a relapse are less likely to also call the ambulance personnel. This sound reasonable, because once the police are called it would normally become their discretion to call the ambulance personnel. Similarly, once the ambulance personnel are called, they are the ones who would assess the need for the police and call them, not the care giver as such. This association shows that it is unlikely that both the police and the ambulance would be called in the event of a relapse.

4.8 CARE GIVER'S SOURCES OF INFORMATION

The major source of information for the care givers was just their own experience (62%). Very few respondents received information from the elders (4.6%), books and magazines (8.3%), health professionals (14.8%) and the media (10.2%). These results are shown in Table 4.20.

It is of great concern that the care givers basically depend on their own experience in managing discharged mental health patients. Only about 15% indicated getting the information from health professionals. This calls for a possible intervention in which health professionals, and possibly social workers, make a deliberate effort to equip care givers of discharged mental health patients with information that will enable them to manage the patients once discharged. Books and magazines, as well as the media, are probably good sources of information, but these assume that the care givers are literate enough to use such sources. This assumption is not necessarily valid and therefore such sources may not be effective.

Table 4.20: Sources of information

Where did you get information on home-based care of patient?	No	Yes
Learn from elders	103 (95.4%)	5 (4.6%)
Books and magazines	99 (91.7%)	9 (8.3%)
Health professionals	92 (85.2%)	16 (14.8%)
Experience	41 (38%)	67 (62%)
Print and electronic media	97 (89.8%)	11 (10.2%)
Other	108 (100%)	0 (0%)

4.9 ASSOCIATION WITH INFORMATION PROVISION

Tests for associations between provision of information on discharge and relapse signs and triggers as well as source of information were carried out. The chi-squared statistic values, odds ratios and their corresponding confidence intervals are shown in the tables below. The odds ratios corresponding to wandering aimlessly, aggressive behaviour and poor personal hygiene are all less than 1, while the one for unfounded fears is greater than 1. This shows that information provision was found to be significantly negatively associated with relapse signs such as wandering aimlessly, aggressive behaviour and poor personal hygiene and positively associated with unfounded fear. This means that those care givers who were provided with information on the discharge of the patient were less likely to consider wandering aimlessly, aggressive behaviour and poor personal hygiene as signs of a relapse, compared to the uninformed ones. However, they were more likely to consider unfounded fears to be a sign of a relapse.

As for the triggers of a relapse, only family bereavement was found to have a significant association with information provision. The association was found to be positive, with those who received information being almost five times as likely to consider family bereavement as a potential relapse trigger, compared to those did not receive any information when the patient was discharged. As would be expected, those who got information on discharge of the patient were less likely to rely on their own experience in managing the discharged patient, compared to those who did not receive information. This is reflected by an odds

ratio of 0.2 for the negative association between information provision and information source.

Table 4.21: Information provision vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Wandering aimlessly	4.90	0.0268	0.0360	0.3	(0.15;0.70)
Aggressive behaviour	10.55	0.0012	0.0002	0.2	(0.08;0.41)
Poor personal hygiene	5.22	0.0223	0.0274	0.4	(0.17;0.82)
Unfounded fear	4.53	0.0333	0.0461	3.4	(1.54;7.48)

Table 4.22: Information provision vs relapse triggers

Relapse trigger	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Relative's death	8.71	0.0032	0.0060	4.7	(2.10;10.67)

Table 4.23: Information provision vs information source

Information source	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Own experience	11.44	0.0007	<0.0001	0.2	(0.09;0.48)

4.10 ASSOCIATION WITH INFORMATION SOURCE

The care givers' source of information was found to be significantly positively associated with aggressive behaviour, withdrawal tendencies and insomnia. Note that the odds ratios for these associations are all greater than 1. This means that those who rely on their personal experiences in managing the discharged patients are more likely to consider aggressive behaviour, withdrawal tendencies and insomnia to be signs of relapse, compared to those who rely on information provided by health professionals on discharge of the patient.

While those who get information from health professionals consider family bereavement to be a trigger for a relapse, those who rely on their own experiences are less likely to consider that as a relapse trigger (OR = 0.1). They are also less likely to consider lack of socialisation (OR = 0.1) and lack of family support (OR = 0.3) as potential triggers of a relapse, compared

to those who do not rely on their own experiences, and are also less likely to call ambulance personnel in the event of a relapse (OR = 0.2).

Table 4.24: Information source vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Aggressive behaviour	4.07	0.0436	0.0498	3.4	(1.54;7.48)
Withdrawal tendencies	8.19	0.0042	0.0053	3.4	(1.54;7.48)
Insomnia	6.77	0.0093	0.0113	3.7	(1.66;8.15)

Information source vs relapse triggers

Relapse trigger	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Relative's death	24.18	<.0001	<0.0001	0.1	(0.04;0.24)
Lack of socialisation	29.26	<.0001	<0.0001	0.1	(0.04;0.22)
Lack of family support	11.19	0.0008	0.0013	0.3	(0.11;0.56)

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Information source vs relapse actions

Relapse action	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Call ambulance	16.58	<.0001	<0.0001	0.2	(0.09;0.44)

4.11 ASSOCIATION WITH FAMILY BEREAVEMENT

The results in the Table 4.25 show the relapse signs and actions in the event of a relapse that were found to be significantly associated with bereavement in the family. These show that those who believe family bereavement can result in a relapse are more likely to consider suicidal tendencies (OR = 6.2) to be a sign of a relapse and also more likely to call ambulance personnel (OR = 4.3) in the event of a relapse. On the other hand, they are less likely to consider aggressive behaviour (OR = 0.1), restlessness and agitation (OR = 0.2), violent behaviour (OR = 0.2) and insomnia (OR = 0.2) to be signs of a relapse.

Table 4.25: Bereavement vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Suicidal tendencies	4.87	0.0274	0.0342	6.2	(2.68;14.20)
Aggressive behaviour	12.18	0.0005	0.0016	0.1	(0.04;0.24)
Restlessness and agitation	12.44	0.0004	<0.0001	0.2	(0.06;0.34)
Violent behaviour	6.61	0.0101	0.0165	0.2	(0.09;0.44)
Insomnia	7.53	0.0061	0.0096	0.2	(0.09;0.44)

Table 4.26: Bereavement vs relapse actions

Relapse action	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Call ambulance	15.42	<.0001	<0.0001	4.3	(1.94;9.74)

4.12 ASSOCIATION WITH LACK OF SOCIALISATION

The associations with lack of socialisation have a very similar pattern to those of family bereavement given above. Those who believe lack of socialisation can trigger a relapse are more likely to consider suicidal tendencies to be a relapse sign (OR = 12.3) and are more likely to call ambulance personnel in the event of a relapse (OR = 4.7). On the other hand, they are less likely to consider aggressive behaviour (OR = 0.1), restlessness and agitation (OR = 0.2), withdrawal (OR = 0.4), violent behaviour (OR = 0.2) and insomnia (OR = 0.1) to be signs of relapse.

Table 4.27: Lack of socialisation vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Suicidal tendencies	7.72	0.0055	0.0100	12.3	(4.94;30.35)
Aggressive behaviour	12.87	0.0003	0.0012	0.1	(0.02;0.15)
Restlessness and agitation	8.12	0.0044	0.0109	0.2	(0.07;0.37)
Withdrawal tendencies	4.71	0.0300	0.0383	0.4	(0.17;0.82)
Violent behaviour	6.96	0.0083	0.0121	0.2	(0.06;0.34)
Insomnia	12.40	0.0004	0.0014	0.1	(0.05;0.29)

Table 4.28: Lack of socialisation vs relapse actions

Relapse action	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Call ambulance	23.26	<.0001	<0.0001	4.7	(2.10;10.67)

4.13 ASSOCIATIONS WITH LACK OF FAMILY SUPPORT AND INCOME

Those who believe that lack of family support can trigger a relapse are more likely to call ambulance personnel in the event of a relapse (OR = 2.7), compared to those who do not feel family support can trigger a relapse. Similarly, those who believe lack of income can trigger a relapse are more likely to call ambulance personnel in the event of a relapse (OR = 3.1). Lack of income as a relapse trigger is negatively associated with violent behaviour. Care givers who believe lack of income can trigger a relapse are less likely to consider violent behaviour as a sign of relapse, compared to those who do not believe lack of income can trigger a relapse.

Table 4.29: Lack of family support vs relapse actions

Relapse action	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Call ambulance	6.14	0.0132	0.0199	2.7	(1.23;5.81)

Table 4.30: Lack of income vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Violent behaviour	5.27	0.0218	0.0270	0.2	(0.09;0.44)

Table 4.31: Lack of income vs relapse actions

Relapse action	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Call ambulance	10.11	0.0015	0.0025	3.1	(1.43;6.86)

4.14 ASSOCIATIONS WITH ACTION TAKEN IN THE EVENT OF A RELAPSE

In this subsection, actions that care givers would take in the event of a relapse are tested for associations with the relapse signs.

Table 4.32: Restrain patient vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Withdrawal tendencies	6.57	0.0104	0.0119	0.4	(0.16;0.76)
Violent behaviour	6.34	0.0118	0.0186	2.0	(0.91;4.21)

The results in the table above show that care givers who would restrain the mental health care user with the help of others were less likely to be the ones who consider withdrawal (OR = 0.4) as a sign of a relapse and more likely to be those who believe violent behaviour (OR = 2) to be a sign of a relapse. This means that those who would restrain the patient are twice as likely to consider violent behaviour as a sign of relapse, compared to those who would not restrain the patient.

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Table 4.33: Call police vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Unfounded fear	5.04	0.0248	0.0319	0.2	(0.09;0.48)

Those who would call the police in the event of a relapse are less likely to be the ones who believe unfounded fear to be a sign of a relapse. This is reflected in the odds ratio of 0.2, which is less than 1.

Table 4.34: Call paramedics vs relapse signs

Relapse sign	Chi-sq	p-value	Fisher's p-value	OR	95% CI
Aggressive behaviour	5.66	0.0174	0.0272	0.4	(0.20;0.95)
Poor personal hygiene	7.13	0.0076	0.0115	0.3	(0.16;0.76)
Violent behaviour	16.37	<.0001	<.0001	0.2	(0.09;0.48)
Insomnia	10.01	0.0016	0.0019	0.3	(0.13;0.65)

The care givers who would call paramedics are less likely to be the ones who believe that aggressive behaviour, poor personal hygiene, violent behaviour and insomnia are signs of a relapse. Note that all the odds ratios for these associations are less than 1, indicating that the respondents are less likely to consider these potential relapse signs as relapse signs.

4.15 SUMMARY

This section presents a summary of the results found in this study according to the specific research questions of the study.

- Are the relatives provided with any information regarding management of mental health care users on discharge?

Relatives of discharged mental health care users are generally not provided with information on how they can best manage the patients when they are discharged. Only 36% of the relatives admitted to having received some information regarding the medication that the discharged mental health care users need. Not all, but the majority, were given information about potential side effects of the medication. This could be due to the fact that some of the medication may not have any serious side effects worth alerting the relatives to.

- What type of information, if any, do these relatives receive?

The information was predominantly about the medication to be taken, where to collect it and how it is administered, as well as the resources available in the communities. However, not everyone who got information about medication was given information about resources in their communities.

- Are the relatives aware of the possible signs of relapse?

The relatives could identify some of the signs of relapse. The majority of them agreed that aggressive and violent behaviour, restlessness and agitation, wandering aimlessly and insomnia are signs of relapse. The majority disagreed about suicidal tendency, public undressing, irritability, refusing to eat, fear of the unknown, incessant praying and tearfulness being signs of a relapse.

- What do the relatives consider to be factors that can trigger relapse?

The relatives unanimously agreed that defaulting on treatment and drug abuse are the most obvious triggers of a relapse. The majority did not consider death of a relative, lack of socialisation and lack of money as potential triggers of relapse. Their opinions were split over whether lack of family support could be a trigger, with 54.6% of them actually ruling it out as a possible trigger.

- How would the relatives handle the situation in the event of a relapse?

The majority of the relatives believe that calling the police and persuading the mental health care user to seek medical help in the event of a relapse would be good ways of handling the situation. Locking the mental health care user away in a room, running away leaving the him or her alone and overdosing him or her with treatment were out of the question for most of them. They were split over calling paramedics, with about 48% opting for calling paramedics.

- What are the major sources of information on the management of mental health care users?

The majority of the care givers got information on the management of mental health care users more from their own experiences (62%) than from anywhere else. Of concern is the fact that only 14.8% said they got their information from health professionals. Very few admitted to getting the information from elders, books and magazines and other media.

- Are there any associations among the relatives' knowledge of signs of relapse?

Care givers who believe wandering aimlessly is a sign of a relapse are more likely to believe that aggressive behaviour, restlessness and agitation, poor personal hygiene and violent behaviour are also signs of a relapse. Such care givers are less likely to consider suicidal tendencies as signs of a relapse. Care givers who believe that suicidal tendencies are a relapse sign were found to be more likely to believe that irritability and tearfulness are also signs of a relapse. Aggressive behaviour, restlessness and violent behaviour were found to be mutually positively associated, while restlessness was individually found to be positively associated with insomnia, besides aggressive and violent behaviours. Muteness and

withdrawal were found to be positively associated. This would be expected, since withdrawn people are usually loners and therefore quiet people.

Those who considered talking to oneself to be a sign of a relapse were less likely to associate irritability with a relapse, but positively associated insomnia with a relapse. Refusing to eat was found to be associated with poor personal hygiene, suspicious behaviour and hearing voices.

These associations give an idea of what behaviours the care givers consider to be indications of a relapse, as well as how the care givers themselves link these behaviours among themselves. With the knowledge of how care givers associate the different potential signs of relapse, it would be possible to design an educational programme for home-based care givers of discharged mental health care users. This would assist care givers with regard to which individual behaviours or combinations of behaviours to look out for in the mental health care user in their custody.

- Is there any association between provision of mental health patient management information and the relatives' understanding of triggers and signs of relapse, as well as actions to take in the event of a relapse?

It was found that care givers who received information from health care professionals were less likely to consider wandering aimlessly, aggressive behaviour and poor personal hygiene to be signs of a relapse, while being more likely to take unfounded fears to be a sign of a relapse. It was also found that they were more likely to consider bereavement in the family to be a trigger of a relapse. Since these get their information from healthcare professionals they were less likely to depend on their own experiences in taking care of the discharged mental health care user in their custody. However, no significant associations were found between information provision and the possible actions they would take in the event of a relapse.

- Are the different sources of information associated with relatives' understanding of triggers and signs of relapse, as well as with action to take in the event of a relapse?

Those who depend on their own experience as a primary source of information were more likely to consider aggressive behaviour, withdrawal and insomnia as signs of relapse. Such

care givers were found to be less likely to take bereavement in the family, lack of socialisation and lack of family support to be potential triggers of a relapse and were less likely to call paramedics in the event of a relapse, compared to those who use other sources of information.

- Is there any association between the relatives' understanding of triggers and their knowledge of signs of relapse and their actions in the event of a relapse?

Those care givers who linked bereavement in the family with a relapse were more likely to consider suicidal tendencies as a sign of a relapse and were less likely to take aggressive behaviour, restlessness and agitation, violent behaviour and insomnia as signs of a relapse. In the event of a relapse, such care givers were found to be more likely to call paramedics.

Lack of socialisation as the trigger of a relapse was found to be positively associated with suicidal tendencies as a sign of a relapse. That is, those who think lack of socialisation triggers a relapse are more likely to see suicidal tendencies as a sign of relapse. However, they were less likely to consider aggressive behaviour, restlessness and agitation, withdrawal, violent behaviour and insomnia as signs of a relapse. These care givers were more likely to call paramedics in the event of a relapse. Those who considered lack of family support to be a relapse trigger were also more likely to call paramedics in the event of a relapse. However, no other associations with lack of family support as a relapse trigger were found to be statistically significant.

Those who take lack of income to be a trigger for relapse were less likely to associate violent behaviour with a relapse and were more likely to call paramedics in the event of a relapse.

As can be seen from the above, regardless of what signs they believe to be relapse signs and what factors could trigger a relapse, care givers are more likely to call paramedics in the event of a relapse.

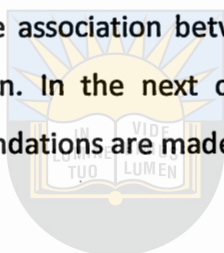
- Is there any association between action taken in the event of a relapse and the signs of a relapse?

Three actions, namely, calling police, calling paramedics and restraining the mental health care user were found to be associated with certain signs of a relapse. Those who would

restrain the patient are less likely to be the ones who consider withdrawal as a sign of relapse and are more likely to be those who think violent behaviour is a sign of a relapse. On the other hand, those who would call the police are less likely to be the ones who think unfounded fear is a sign of relapse, while those who would call paramedics are less likely to be the ones who would consider aggressive behaviour, poor personal hygiene, violent behaviour and insomnia as signs of a relapse.

4.16 CONCLUSION

In this chapter, results obtained from the data analysis have been tabled and their interpretation has been presented. The association between variables was discussed and the summary of the results was given. In the next chapter, further discussion and a conclusion are presented and recommendations are made.



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CHAPTER FIVE

DISCUSSION, CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

In the previous chapter, the data analysis was discussed, results were presented and interpreted. This was achieved with the help of a statistician. In this chapter, the results of the study that were revealed in the previous chapter are discussed further, the conclusion that was reached is presented and recommendations are tabled. It is relevant for the researcher to recall the purpose of the study, the objectives of the study and the questions that were considered in the study.

5.1.1 Purpose of the study

The purpose of the study was to explore and describe the knowledge and needs of relatives regarding the management of discharged mental health care users with the purpose of preventing readmission into the mental health unit.



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5.1.2 Objectives of the study

The objectives of the study were to:

- determine the knowledge of relatives regarding management of discharged mental health care users to prevent readmission to the mental health unit
- identify the needs of relatives regarding their knowledge of the management of discharged mental health care users so as to prevent readmission
- recommend guidelines based on the results of the study to strengthen the relatives' knowledge so as to prevent readmission of discharged mental health care users

5.1.3 The research questions of the study

- What was the relatives' knowledge regarding management of discharged mental health care users in order to prevent readmission to the mental health unit?

- What were the relatives' needs regarding their knowledge of the management of discharged mental health care users so as to prevent readmission?

5.2 SUMMARY

In this research study, the researcher investigated the knowledge of relatives regarding the management of discharged mental health care users in the East London district. The study was conducted with the relatives of mental health care users residing in the Mdantsane Township who were receiving treatment from the Mdantsane clinics at the time. These were relatives of mental health care users who had been discharged from the Cecilia Makiwane hospital mental health unit. The study was conducted with the relatives so that information which could help to prevent readmission of mental health care users into the mental health unit could be gathered.

The results of the study have been tabled and are discussed below.

5.3 DISCUSSION

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The discussion is based on the key and prominent results, whether positive or negative, so as to reach the best conclusion about the study and provide recommendations.

The researcher would like to indicate that the findings around the demographic data indicate the number of unemployed participants as high due to the fact that the study was conducted during the day and during the week. During this time, those who are employed are at work. The participants were also those who had time to visit patients at the hospital and had time to discuss the patient with the health care professionals. The females are shown to be the care givers as they comprised most of the participants in this study. They had also visited the mental health care users in the hospital while they had been admitted.

The question regarding discharge and medication was aimed at gathering information on the process of discharge planning. This is the time when a multidisciplinary team usually meets to plan and discuss what strategies would be best for managing the mental health care user at home after having been discharged from hospital. The findings indicate that a high number of participants (63.9%; n = 69) was not given information on how to manage

the mental health care user at home. This also indicates that the relatives were not involved so as to play a role in the management of the patients in the community to prevent possible readmission in the hospital. The relatives had no knowledge of proper and professional ways of handling a discharged mental health care user. Medication management and educating the client and significant others are the key components of nursing care in the home setting (Schultz & Videbeck 2009: 79). From these results, it was also clear that the mental health care users who were admitted due to drug abuse, family problems, teenage problems, social problems and others were never provided with information about or referred to relevant organisations like SANCA, FAMSA, LIFELINE, REHAB or Social Development.

The results indicate that the participants would mostly see a mental health care user as sick only when he or she reached a stage of being unmanageable at home. Being unmanageable included signs such as aggressive behaviour (80.6%; n = 87), violent behaviour (70.4%; n = 76), insomnia (68.5%; n = 74), restlessness and agitation (67.6%; n = 73) and wandering aimlessly (64.8%; n = 70). Relatives immediately seek help when the mental health care user is suicidal.

Regarding the causes of relapse, the participants seemed to agree that defaulting with treatment 100%; n = 108) and use of drugs (97.2; n = 105) were the main causes of relapse among the mental health care users. It was clear that relatives of mental health care users did not identify the death of a relative; poor support; poor socialisation; and having no job as possible causes of the relapse of the mental health care user. The researcher associates this with the lack of knowledge among the relatives regarding the causes of mental disturbance. These findings concur with Kazadi et al (2008: 53) who state that non-adherence with medication is the main problem that leads to relapse and also that substance abuse have been reported as the significant contributing factors to relapse in all mental illnesses.

It was interesting to find that all relatives (100%; n = 108) were aware that when the mental health care user demonstrated signs of relapse, he or she immediately had to be persuaded to seek psychiatric help. Action taken by most relatives to help the mental health care user clearly was belated action. Most participants would consider calling the police (73.2%; n =

79) to assist with handling the mental health care user. This indicates that the action was taken when the mental health care user had become unmanageable. Policemen, as stated in the mental health act should be summoned when the patient is a danger to self, others at home, or the community.

The findings around sources of information about managing a discharged MHCU indicate that most participants (62%; n=67) are coping from their own experience. It is disappointing that few participants (14.8%; n = 16) had gained information from health care professionals. Schultz and Videbeck (2009: 58) state that family caregivers need an ongoing relationship with a knowledgeable health professional in the community who can provide information, support and assistance.

5.4 CONCLUSION

The results of the study comprise a call on health care professionals to involve relatives in the care of mental health care users. The participants deal with discharged mental health care users without the full support of the health care professionals. The researcher observed the warm welcoming attitude of relatives when visiting them to conduct interviews. They took it as a casual visit of support for the mental health care user and the entire family. It came from them without being questioned that they had never had a visit from the health professionals.

The relatives rely on their own experience to manage the mental health care users in the community. Their experience comes from the time the mental health care user became mentally disturbed and showed abnormal behaviour in front of them till he or she was admitted into the hospital. They had no professional knowledge or skills for handling the mental health care user. It is really not good to hear that mental health care users are discharged without their relatives being provided with knowledge or skills.

From these findings it is clear that follow-up care of discharged mental health care users is absolutely not provided by health care professionals, with the result that the relatives are not knowledgeable regarding the management of a discharged mental health care user. Relatives need to be educated by health care professionals on how to manage a discharged

mental health care user so as to prevent readmission. Recommendations based on the results of this study are presented in the following section.

5.5 RECOMMENDATIONS

- Discharge planning is said to be an essential process in the psychiatric field in order to prevent recurrent and unnecessary readmission to psychiatric units (<http://www.hiwandi.com/isrn/psychiatry/2012/638943>). Discharge planning promotes collaboration in helping the mental health care user to relate with the relatives, other consumers, the care givers and the relevant service providers. Each mental health care user is unique, hence discharge planning should be individualised. The researcher recommends that fully-fledged discharge planning should be conducted, with a multidisciplinary team in the psychiatric unit together with relatives of the mental health care user discussing the best strategies for managing the patient at home.
- The researcher recommends that collaboration with NGOs should be established, whereby, if it is found that a mental health care user who has been admitted could gain more from psychotherapy, he or she would be referred accordingly. The important role played by NGOs around the management of a discharged mental health care user has already been discussed in Chapter 2 (literature review) of the study.
- As integration of Mental Health services into Primary Health Care seems to have been chosen by the government as the best strategy for looking after the interests of both the mental health care users and their families in the community, the researcher would like to recommend that the gap between the admission wards / psychiatric institutions and primary health care could be closed. This could be achieved by creating good relations between the relatives of mental health care users and the health care professionals. The health care professionals should go back to basics: when a patient is about to be discharged from hospital, his or her family should be visited to prepare them to accept the patient. This is the time when the family should be educated about the condition of the patient and be explained everything around the best medication and what to do so as to keep the patient mentally healthy and prevent relapses.

- It is recommended that the mental health practitioners market the importance of mental health services by giving continuous mental health education talks in the communities on mental health awareness days. This should be undertaken throughout the year, not only in July during the mental illness month or in October during the mental health month.
- Self-help groups in the community for the relatives of mental health care users should be established by mental health practitioners. This could be another type of support group therapy through which members of the community can help each other to relieve stress through sharing their problems regarding the management of discharged mental health care users.
- Another recommendation is the bringing back the fully-fledged Community Mental Health Services which have been disbanded around each and every psychiatric institution in the Eastern Cape Province. Community Psychiatric Services served as a link between the psychiatric institutions where the patient was admitted and the mental health care user and his or her family after being discharged from hospital. The service strove for primary health care prevention of mental illness which was more focused on education regarding identification of early signs of mental disturbance and causes of mental illness. The service also focused on secondary prevention of mental illness which encouraged continuous taking of medication as prescribed by the doctor, frequent reviews by doctors, and tracing of defaulters by mental health practitioners. Lastly, the service was looking at tertiary prevention of mental illness and this included rehabilitation of those who had been diagnosed with mental illness. The researcher recommends for this service to be revisited to see where it failed to deliver to our people and the entire community, and try to correct the mistakes as it was an ideal service that linked the psychiatric institutions and the community where the patient resided after being discharged.

5.6 LIMITATIONS

The research study was done with the Mdantsane township clinics that are under the East London district of the Buffalo City Metropolitan Municipality and as a result cannot be generalised to the entire Eastern Cape Province. The study was limited to relatives of mental health care users who had been admitted at the Cecilia Makiwane hospital mental health

unit. All the participants were Africans and Xhosa speaking. The study did not include the relatives of mental health care users who had been residing in the rural areas and those who had been admitted to other mental health care institutions, like the Tower, Komani, Fort England and Elizabeth Donkin psychiatric hospitals.



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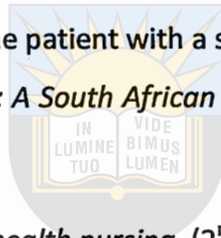
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ANNEXURE 'A'

SELF-ADMINISTERED QUESTIONNAIRE IN ENGLISH



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RESEARCH QUESTIONNAIRE IN ENGLISH

A. DEMOGRAPHIC DATA

From below, tick what is relevant about you in this study:

A1. Relation to the patient:

1) Father		2) Brother		3) Uncle		4) Cousin	
5) Mother		6) Sister		7) Aunt		8) Other	

A2. Gender:

1) Male		2) Female	
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A3. Age:

1) 18-26yrs		2) 27-35yrs		3) 36-45yrs		4) 46-55yrs		5) 56+ yrs	
-------------	--	-------------	--	-------------	--	-------------	--	------------	--

A4. School level:

1) Gr 1-3		2) GR 4-7		3) Gr 8-10		4) Gr 11-12		5) Tertiary	
-----------	--	-----------	--	------------	--	-------------	--	-------------	--

A5. Marital status:

1) Single		2) Married		3) Divorced		4) Widowed	
-----------	--	------------	--	-------------	--	------------	--

A6. Religion:

1) Methodist		2) Zion		3) Baptist		4) Faith	
5) Presbyterian		6) ATR		7) Apostolic		8) Other	

A7. Work:

1) Fully employed		2) Unemployed		3) Casual job	
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B. KNOWLEDGE WITH REGARD TO

B1. MEDICATION

In the following question, please tick Yes or No

Item	Yes	No
1) On discharge, were you provided with the information to enable you to manage the mental health care user at home?		

If "Yes", were you provided with information on the following (Tick Yes or No)

Item	Yes	No
2) What medication the patient is taking		
3) Where to collect medication		
4) How to take medication		
5) Common side effects of the medication		
6) What to do in the event of side effects		
7) The available mental health resources in your community		

B2. SIGNS OF RELAPSE

The patient showed signs of mental disturbance and ended up being admitted in the hospital. From below, tick all the signs that will indicate that the patient is becoming sick again.

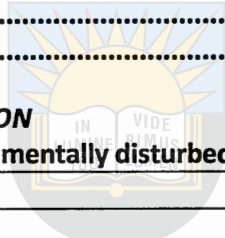
1) Wandering aimlessly	2) Suicidal	3) Aggressive	4) Restless and agitated
5) Withdrawn	6) Undresses in public	7) Talking to self	8) Abusive
9) Hearing voices alone	10) Mute	11) Suspicious	12) Poor personal hygiene
13) Irritable	14) Did not want to eat	15) Fears of unknown	16) Violent
17) Praying day and night	18) Insomnia	19) Tearful	20) Seeing things not seen by people

21) Other signs (mention them)

.....

.....

.....



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B3. TRIGGERING FACTORS OF THE CONDITION

Can the following lead to the patient being mentally disturbed again? Tick YES or NO

Item	Yes	No
1) Defaulting of treatment		
2) Death of a relative		
3) Abuse of drugs		
4) Lack of socialisation		
5) Lack of support from relatives		
6) No job, no money		
7) None of the above		
8) All of the above		

B4. ACTIONS TO DEAL WITH RELAPSE

Which of the following will be the best way to deal with a relapsing patient? (Tick Yes or No)

Item	Yes	No
1) Organise people to restrain the patient		
2) Lock him/her in a room so that he/she cannot disturb you		
3) Call police		
4) Run away and leave the patient alone		
5) Overdose patient with treatment		
6) Call ambulance personnel		
7) Immediately persuade the patient to visit the clinic for help		
8) None of the above		
9) All of the above		

B5. GENERALLY

Who provided you with the most information about managing a mental health care user at home? (Tick ONLY one)

1) Learned from elders	2) Read books & magazines	3) Health professionals
4) Own experience	5) Media (radio, TV, etc.)	6) Other

ANNEXURE B

SELF-ADMINISTERED QUESTIONNAIRE TRANSLATED INTO ISIXHOSA



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IMIBUZO YOPHENGULULO NGESIXHOSA

A. INKCUKACHA ZOMTHATHI-NXAXHEBA

Apha ngaphantsi, phawula okunxulumene nawe kolu phengululo.

A1. Unxibelelwano lwakho nomguli:

Utata		Umnakwe		Umalume		Umzala	
Umama		Udade		Umakazi		Okunye	

A2. Ubuni bakho:

Indoda		Ibhinqa	
--------	--	---------	--

A3. Iminyaka yakho:

18-26yrs		27-35yrs		36-45yrs		46-55yrs		56+ yrs	
----------	--	----------	--	----------	--	----------	--	---------	--

A4. Amabanga emfundo:

Gr 1-3		GR 4-7		Gr 8-10		Gr 11-12		Tertiary	
--------	--	--------	--	---------	--	----------	--	----------	--

A5. Ubume bomtshato:

Anditshatanga		Nditshatile		Ndaqhawula umtshato		Ndingumhlolo/kazi	
---------------	--	-------------	--	---------------------	--	-------------------	--

A6. Inkolo:

Methodist		Zion		Baptist		Faith	
Presbyterian		ATR		Apostolic		Other	

A7. Umsebenzi:

Uphangela isigxina		Awuphangeli		Uyatorha	
--------------------	--	-------------	--	----------	--

B. ULWAZI MALUNGA

B1. NAMAYEZA

Kulo mbuzo ulandelayo, phawula u-EWE okanye u-HAYI

Ibakala	Ewe	Hayi
1.1 Ekukhululweni komguli esibhedlele, ingaba wanikezwa ulwazi lokwenza ukuba ukwazi ukumnonophela ekhaya?		

Ukuba impendulo ngu "Ewe", ingaba wanikwa ulwazi malunga noku kulandelayo, (phawula u-Ewe okanye u-Hayi)

Ibakala	Ewe	Hayi
1.2 Ngawaphi amayeza asetyenziswa ngumguli		
1.3 Umele ukuba aye kuwafumana phi		
1.4 Uwasebenzisa njani amayeza		
1.5 Impawu zokuba amayeza awadibani nomguli		
1.6 Mawenzeni xa kukho impawu zokungadibani kwamayeza nomguli		
1.7 Indawo ezikhoyo ekuhlaleni eziligalelo kunonophelo lwengqondo		

B2. NEMPAWU ZOKUBUYELA EMVA KWEMPILO

Umguli wabonakalisa iimpawu zokuphazamiseka engqondweni wade waya kulaliswa esibhedlele, apha ngaphantsi phawula zonke iimpawu eziya kuthi zibonakalise ukuba impilo yomguli ibuyela emva.

1. Ukujikeleza esithubeni		2. Ukufuna ukuzibulala		3. Ukuba nomsindo ogqithisileyo		4. ukungahlali ndaweninnye	
5. Ukuzihlalela yedwa		6. Ukukhulula ahambe ze		7. Ukuthetha yedwa		8. Ukuba krwada	
9. Ukuva amazwi yedwa		10. Ukusuka athi cwaka		11. Ukuhlala enorhano		12. Ukuba ahlale engcolile	
13. Ukuba nochuku		14. Ukungafuni ukutya		15. Uloyiko lwento angayaziyo		16. Ukuba ndlongo-ndlongo	
17. Ukuthandaza imini nobusuku		18. Ukungabi nabuthongo		19. Ukuba nyembezana		20. Ukuba nemibono	

(21) Ezinye impawu (zichaze)

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B3. IZINTO EZIVUSELELA IMEKO YOKUGULA

Ingaba oku kulandelayo kungakhokelela ekuphazamisekeni ngokwasengqondweni kwakhona? Phawula u-Ewe okanye u-Hayi

Ibakala	Ewe	Hayi
1. Ukungawasebenzisi amayeza		
2. Ukusweleka kwesizalwane		
3. Ukusebenzisa iziyobisi okugqithisileyo		
4. Ukunganxibelelani nabanye abantu		
5. Ukungabikho nkxaso kwizalamane		
6. Ukungangaphangeli, ukungabi namali		
7. Nanye kwezi zingentla		
8. Zonke ezi zingentla		

B4. IINDLELA ZOKUJONGANA NOKUBUYELA EMVA KWEMPILO

Kwezindlela zilandelayo, ziziphi ezingondoqo ekuqubisaneni nokubuyela emva kwempilo? Phawula ngo-Ewe okanye u-Hayi

Ibakala	Ewe	Hayi
1. Khangela abantu bambophelele		
2. Mtshixele egumbini ukuze angakuphazamisi		
3. Mbizele amapolisa		
4. Mbaleke umshiye yedwa		
5. Mnike amayeza ngokugqithisileyo		
6. Mbizele abenqwelo yezigulana		
7. Zama ukumbuyisela kwicandelo lezempilo ngokukhawuleza		
8. Nanye kwezi zingentla		
9. Zonke ezi zingentla		

B5. NGOKUTHE GABALALA**Ngubani okunike ulwazi lokunonophela umguli ngokwasekhaya? (Phawula kube kanye)**

Ndifunde kwabadala	Kukufunda ezincwadini namaphephandaba	Kwabaqeqeshelwe ezempilo
Ngamava am	Kwezosasazo kunomathotholo nomabonakude njalo-njalo	Okunye



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ANNEXURE 'C'

PARTICIPANT: CONSENT FORM



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CONSENT FORM

REQUEST: CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Researcher: Mr Ncinane Highman Ntuku

The researcher is a student at the University of Fort Hare (student number 8603392) who has registered for research Masters in nursing degree. The title of the study is: **The knowledge of relatives regarding management of discharged mental health care users in the East London district.**

You are invited to participate in the abovementioned study project. The purpose of the study is to explore and describe the knowledge and the needs of relatives regarding the management of discharged mental health care users in order to prevent readmission into the mental health unit. You will not benefit directly from the study but the information obtained may help to develop ways of preventing readmission of mental health care users.

There should be no risks or discomfort in this study as you will be sharing your own knowledge. You will be required to respond to a self-administered questionnaire lasting for thirty to forty minutes.

I will keep the completed questionnaires of participants and your name will not be linked with the information gathered. Your identity will not be revealed when the study is reported or published.

If you have any questions about the study or about participating in the study, feel free to ask me. You may call me at 043-7424762 (work) or 043-7414010 (home).

Your participation in this study is totally voluntary; you are under no obligation to participate. You have the right to withdraw at any time of your participation if you care to, without penalty.

.....

The research study has been approved by relevant people in the Department of Health and research committees of the University of Fort Hare.

I have discussed the above points with the participants. It is my opinion that the participant understands the risks, benefits and obligations involved in participating in this study.

.....

.....

Researcher

Date

I understand that my participation is voluntary and that I may refuse to participate or withdraw my consent and stop taking part at any time without penalty.

I hereby freely consent to take part in this research study.

.....

.....

Participant

Date



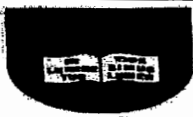
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ANNEXURE 'D'

**CLEARANCE CERTIFICATE: UNIVERSITY OF FORT HARE ETHICS
COMMITTEE**



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ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number: TSHO2 1SNTU01

Project title: **The Knowledge of relatives regarding management of discharged mental health care users in the East London district**

Nature of Project: **Masters**

Principal Researcher: **Ncinane Highman Ntuku**

Supervisor: **Dr N Tshotsho**

Co-supervisor:

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

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.

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Gideon de Wet
Dean of Research

19 November 2012

ANNEXURE 'E'

PERMISSION

**EASTERN CAPE DEPARTMENT OF HEALTH EPIDEMIOLOGY AND
SURVEILLANCE SECTION**



University of Fort Hare
Together in Excellence

om:

To: 0437439139

07/03/2013 17:11

#466 P. 001/001



Eastern Cape Department of Health

Enquiries: Zonwabele Merile
Date: 07th March 2013
e-mail address: zonwabele.merile@impilo.ecprov.gov.za

Tel No: 083 378 1202
Fax No: 043 642 1409

Dear Mr NH Ntuku

Re: The knowledge of relatives regarding the management of discharged mental health care users in the East London district

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 will 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. You will not impose or force individuals or possible research participants to participate in your study. Research participants have a right to withdraw anytime they want to.
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



Ikonwiso eliqaqambileyo!

ANNEXURE 'F'

**PERMISSION
EAST LONDON COMPLEX HOSPITAL ETHICS COMMITTEE**



University of Fort Hare
Together in Excellence

Ethics Committee: E. L HOSPITAL COMPLEX

Postal Address :

C/o East London Health Resource Centre
PO Box 12882
Amalinda
5252

Telephone : 043 -709 2032

Physical Address :

Cheltenham Road
East London
5201 South Africa

Fax no.: 043 - 7092386

19th December 2012

Ncinane Highman Ntuku
3 Twist Street
Amalinda
East London
5200



Dear

RE: The knowledge of relatives regarding the management of discharge mental health care users in the East London district

We acknowledge receipt of the above mentioned proposal.

Having gone through your proposal, the committee has no ethical problems noted.

Please be advised that the committee has granted you the consent to do the research.

Yours sincerely

**Dr P Alexander – Chairman Region C Ethics Committee
Ophthalmologist EL Hospital Complex**

ANNEXURE 'G'

**PERMISSION
CECILIA MAKIWANE HOSPITAL MANAGER**



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Province of the
EASTERN CAPE
HEALTH

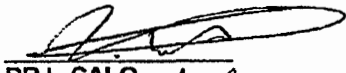
Cecilia Makiwane Hospital • East London Hospital Complex • East London
Private Bag X 9047 • East London • 5200 • South Africa
Tel: 043 708 2135 • Fax: 043 760 2252 • e-Mail: siphokazi.peter@lmpilo.ecprov.gov.za

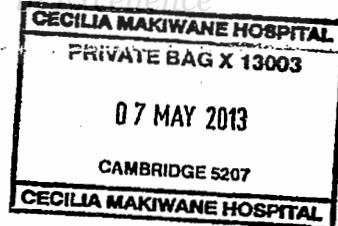
TO: MR N. NTUKU
FROM: DR GALO: MANAGER – MEDICAL SERVICES
SUBJECT: RE: REQUEST TO CONDUCT RESEARCH ON THE KNOWLEDGE OF RELATIVES REGARDING THE MANAGEMENT AND DISCHARGE OF MENTAL HEALTH CARE USERS IN THE EAST LONDON DISTRICT
DATE: 6 MAY 2013

Dear Mr Ntuku

Permission to conduct research is granted for findings to be concluded. Please ensure that adequate information is attached to study participants as well as ensuring confidentiality.

Regards


DR L. GALO
DATE 07/05/13
MANAGE: MEDICAL SERVICES
CECILIA MAKIWANE HOSPITAL
EAST LONDON HOSPITAL COMPLEX



**MEDICAL SUPERINTENDENT
CECILIA MAKIWANE HOSPITAL
PRIVATE BAG X 9047 EAST LONDON 5200**

DR LUNTU GALO

United In achieving quality health care for all

24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za



Ikamva elizakambileyo!

ANNEXURE 'H'

**PERMISSION
EAST LONDON SUB-DISTRICT MANAGER**



University of Fort Hare
Together in Excellence



Amathole District

Buffalo City Sub-district:

Enquiries: Mrs N.V.Nelani

9 Vincent Road, Vincent, East London, 5200, Eastern Cape
Private Bag x 9015, Main Post Office, East London, 5200, Eastern Cape
Tel No. +27 (0)43 711 1100 Fax No. +27 (0)43 721 1972
Website www.ecdoh.gov.za

To:	MR NCINANE HIGHMAN NTUKU
From:	Acting Buffalo City Sub-District Manager
Subject:	Agreement for research study to be conducted in Buffalo city Sub District
Date:	07/ 01/ 2013

Dear Researcher

Permission is herewith granted to you to conduct research in Buffalo City Sub District as requested. Kindly familiarize yourself with the conditions below before commencing with your study.

1. The researcher will conduct the study without compromising client's confidentiality and the smooth running of the service.
2. The researcher will not provide/publish any reports/statements without prior discussion with and permission of the sub district.
3. A copy of a letter of approval by the ethics committee, Research proposal, Research tools will be submitted to the sub district office before commencing the study.

I accept the conditions as stated in the abbreviated version of Department of Health Agreement Clause for researchers.

NCINANE HIGHMAN
NTUKU
Full Name & Surname

Signature

2013/01/07
Date

L. A. MFAZWE
Witness Name & Surname

Signature

07/01/2013
Date