

**FACTORS ENHANCING READMISSION OF MENTAL HEALTH CARE
USERS TO A MENTAL HEALTH UNIT IN EAST LONDON**

AS DESCRIBED BY THEIR CAREGIVERS

by

Nozizwe Patricia Mahashe

(Student number: 201206425)

A dissertation submitted in fulfilment of the requirements for the
degree Magister Curationis (Psychiatric Nursing Science)

In the

School of Health Sciences

at the

University of Fort Hare

Supervisor: Mrs N. Magadla

Co-Supervisor: Dr. N.Tshotsho

Date of Submission: September 2014

Student number: 2012064

DECLARATION

I, Nozizwe Patricia Mahashe, declare that **FACTORS ENHANCING READMISSION OF MENTAL HEALTH CARE USERS TO A MENTAL HEALTH UNIT IN EAST LONDON AS DESCRIBED BY THEIR CAREGIVERS** is my own work and has not been submitted before in any institution

Signature:

Date:

ACKNOWLEDGEMENTS

I would like to acknowledge and extend my heartfelt gratitude to the following people who have enabled me to complete this work successfully:

To almighty God, my saviour, thank you for your blessings. You made all things possible.

To the University of Fort Hare for admitting me to do my studies so that I can fulfill my dreams.

To the Govin Mbeki Research and Development Centre for supporting me financially.

To my supervisor, Mrs. N.Magadla, for guiding and supporting me throughout my work. Your continuous patience, support and encouragement will always be remembered.

To my co supervisor, Dr. N.Tshotsho, for your suggestions on the research.

To Mrs. D. Murray, who was my co-coder and who also coached me.

To the participants who shared their knowledge willingly.

To Dr. K. Sukeri for his support and guidance.

Finally, to my family, my husband, Sipiwo/Mawawa who was always there for me, supporting and motivating me throughout this study, and my children, Sikelelwa and Sibabalwe for their understanding and support. You mean a lot to me and I thank God for providing me with such a wonderful family .

ABSTRACT

Readmission of mental healthcare users is a global challenge and concern which is associated with high costs. Readmission has negative effects as it is believed to promote dependency, demoralize patients and cause workload for staff. Readmissions also bring a burden to caregivers and affect the caregiver's health.

In the light of this background, the aim of the study was to explore and describe factors enhancing readmission of mental health care users (MHCUs) to a mental health unit in East London as described by their caregivers. The objectives of the study were to: explore factors enhancing readmission of mental health care users in a mental health unit in East London as described by their caregivers and to document recommendations elicited from the findings of the study.

A qualitative approach was used to collect and analyze data. The study used a descriptive and explorative design. Sampling was done using the purposive non-probability method. Unstructured face-to-face interviews were conducted using an interview guide. Fifteen (15) caregivers of MHCUs who had been readmitted to a mental health unit in East London were interviewed. The interviews were recorded and transcribed verbatim.

The findings of this study suggest that non adherence to treatment, refusing to take treatment, defaulting treatment, denial, indulging in substance abuse, stigma, effects of disease, violence and aggressive behavior are the factors enhancing readmission of MCHUs to a mental health unit in East London.

A better understanding of readmission of MHCUs can lead to early intervention and early planning of care. It is envisaged that psycho education, home visits and collaboration of clinic staff with hospital staff may decrease readmission of mental health care users in this unit.

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APPENDICES

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

Readmission to hospital is a global phenomenon and is recognised as a problem which causes several concerns in many countries (Bolton, 2008:28). These concerns include, an adverse impact on taxpayers money, the health care provider costs, as well as the patients morale which may leave them feeling lost and confused (Minott, 2008:2). The other concern is that readmission may promote dependence and can lead to a self perpetuating cycle referred to as revolving door syndrome (Hasan, 2001:177). Frequent readmissions result in extra workload for the ward staff. This may increase their burden and result in exhaustion which in turn impacts on patient care (Chamika, 2011:1).

Readmission is also associated with the following factors namely: deinstitutionalisation (emanating from premature discharge), overloading of psychiatric services, inadequate discharge planning from psychiatric wards, the nature of diagnosis, substance abuse, inadequate family support, non-adherence to prescribed medication, adverse drug events and other medication related issues.

The researcher is of the view that deinstitutionalisation does not prepare the mental health care users (MHCUs) fully due to limited time available and insufficient resources to cater for mentally ill patients in communities. According to Sheth (2009:11-20), the intentions of deinstitutionalisation seem to be well as they are aimed to reduce stigma, reduce violation of human rights and to rehabilitate mentally ill patients. However, these aims are rarely achieved as MHCUs are still seen wandering on the streets, are still stigmatised by communities and are suffering in jails with their rights violated. The same author suggests that the problem of deinstitutionalisation could be addressed by building small sized mental health hospitals with an open ward facility, rehabilitation centre, daycare centres and halfway homes (Sheth, 2009:11-20).

Uys & Middleton (2010:12) in turn explain that in the 1970s, when deinstitutionalisation occurred, the community was not prepared for the influx of

psychiatric patients during their transfer to the community. The same authors further state that there were no alternative housing and vocational rehabilitation services in the community and a lack of skills in staff working in outpatient settings to help the patients was noted (Uys & Middleton, 2010:12).

Peterson & Lund (2011:1) explain that a lack of resources to adequately support community based services results in a revolving door phenomenon. The same authors add that primary health care providers are unable to detect and treat common mental disorders as they are non-prepared, including the deinstitutionalisation policy imperatives which are not adequately facilitated because of a shortfall of resources.

Adding to lack of resources, another problem that results in readmission is the burden of mental illness to the family members who have a duty to care for the MHCUs. Uys & Middleton (2010:88-90) support the fact that family members of MHCUs are subjected to some form of burden of caring for the MHCUs. As the level of stress increases from the family members, the only choice the family members are left with is negotiating for admission of the ill relative to relieve their stress. However, this becomes a problem when the MHCU presents violent and aggressive behaviour towards the caregivers and nurses during a relapse (Keltner, Schwecke & Bostrom, 2007:157).

A study by Smith (2005:105) reported that the patients found hospital as a support system and second home, as they experienced vocational failure at work and in family relationships. The study found that MHCUs experienced lack of support systems such as group homes to help people with chronic illnesses to cope in the community. Rejection of mentally ill patients by the community, loss of support from friends and relatives however affected the emotional health and sense of self worth of the primary caregiver.

Another factor associated with readmission is non compliance to medication. In a study by Mibei (2013:7) on noncompliance to medication in psychiatric patients, the researcher views medication non-adherence as an invisible major public health problem and a major factor in psychiatric hospitalisations. The researcher further

explained that non-compliance was found in all ethnic groups and age groups and that it is a common factor that leads to relapse and readmission of MHCUs in hospital. Some individual characteristics such as ethnicity, health belief, patients' religion, and lack of social support system were found to influence adherence.

As alluded earlier, side effects of antipsychotic medication are also associated with readmission to hospital. Schemnach, Obermeier, Meyer, Jager, Schmauss, Laux, Pfeiffer, Naber, Schmidt, Gaebel, Klosterkotter, Heurser, Maier, Lemke, Ruther, Klingberg, Gastpar, Seemuller, Moller & Rieddel (2012:5) in a study on predictors of relapse, state that side effects of medication emerged as one of the factors leading to relapse. The researchers further explained that patients who mostly relapse are those given high doses of antipsychotics with the intention to prevent relapse. These patients were reported to have developed severe side effects due to antipsychotics, thus they stopped treatment. Another reason for relapse of MHCUs as indicated by these researchers is patients who are given first generation antipsychotics during discharge from hospital.

The nature of diagnosis has been also associated with relapse and readmission to hospital. According to Chan (2011:339-340), schizophrenia was reported to be a chronic disease which can have a long duration in many people. The same researcher associated schizophrenia with lack of insight, relapse and readmission, and added that some people with schizophrenia were reported to have residual symptoms like paranoia, hallucinations and delusions, as well as impaired cognitive and social functioning. The researcher reported caring for a patient with schizophrenia as a common challenge in both developed and developing countries as it was a burden to the families. Rosca, Bauer, Grinshpoon, Khaweled, Mester & Ponizovsky (2006:62) concur that a diagnosis of schizophrenia is a factor leading to readmission of psychiatric patients, and the reason given was that schizophrenia is the most severe and incapacitating disorder of all disorders in mental illness.

In a study by Pono (2009:1, 2), on the association of length of stay and readmission rate among schizophrenic patients in Nakhon Phanom psychiatric hospital in Thailand, the researcher reported that schizophrenia affects approximately 24 million people worldwide and was the most severe form of mental illness. Slightly, schizophrenia is the main cause of these readmissions.

Substance abuse has also been associated with relapse and readmission to hospital. According to Smith (2005:102), the effects of substance abuse hampers treatment compliance and its efficacy, worsens the chronicity of the illness as it impairs recovery causing relapse and readmission. The author adds that noncompliance and use of substances can lead to psycho-pharmacological drug resistance in MHCUs.

From the information presented above, it is clear that an understanding of the factors that lead to readmission of MHCUs may help in the development of strategies to prevent or reduce readmissions. This may result in better utilisation of resources and may reduce the cost of health care thus promoting high quality patient care. The researcher examines the factors that enhance the readmission of MHCUs in East London so as to contribute to knowledge regarding the revolving door syndrome in South Africa as it is limited at the moment. As such, it is hoped that this study will make recommendations that will contribute to policy amendments related to care and admission of MHCUs.

1.2. Problem Statement

Brink (2006:59) describes the research problem as ~~an~~ an area of concern in which there is a gap or a situation in need of solution, improvement or alteration. The researcher has identified readmission of MHCUs in the unit where she works as complex and challenging not only for the staff at the hospital, but also for MHCUs, families and the community at large. This recurrent trend of admission has been present despite the multidisciplinary approach that is utilised in this unit. For example, between 2011 and 2012 there were 796 admissions of which 383 were readmissions. There are no available data to explain this phenomenon. This lack of knowledge is a source of concern as readmission of MHCUs may promote dependence (institutionalisation), impacting adversely the MHCUs morale, causing extra workload to the staff and making them feel exhausted. Understanding the causes of readmission of MHCUs may help in the prevention or reduction of their readmission. This study intends to explain the factors leading to readmission of MHCUs and to present possible solutions. The researcher decided to embark in this study because readmission of MHCUs imposes costs in terms of health care expenditure.

1.3. Definition of Concepts

1.3.1 Caregiver

A caregiver is a person who is in a continuous relationship with the client, has a primary responsibility for the care of the client (Burns & Grove 2005:143). A caregiver can also be described as an unpaid member, friend or neighbour who provides care to an individual who has an acute or chronic condition and needs assistance (Reinhard, Given, Petlick & Bemis, 2008:1). In this study, caregiver will mean a person who is looking after the MHCU and staying with him or her for at least six months.

1.3.2 Deinstitutionalisation

The term means discharging many MHCUs out of mental institutions to the community to alleviate overcrowding and reduce criticisms from society (Kneils & Trigoboff, 2009:236). In this study, deinstitutionalisation will mean discharging MHCUs from the institution to the community.

1.3.3 Health care provider

This refers to a person providing health care service (Mental Health Care Act No 17 of 2002:10). In this study, health care provider shall mean a person who provides health care services to MHCUs. Mental health care practitioners are also care providers within the multidisciplinary team.

1.3.4 Mental health care user (MHCU)

This refers to a person receiving care, treatment and rehabilitation service at a health establishment (Mental Health Care Act No.17 of 2002:10). In this study, the abbreviation MHCU will be referred to as a psychiatric patient.

1.3.5 Revolving door syndrome

This metaphor refers to people who are treated in a psychiatric hospital and who are discharged, become unwell and return to hospital again, either voluntarily or involuntarily in an ongoing cycle (Bolton, 2008). In the current study, revolving door patients are MHCUs who are discharged and readmitted again within six months.

1.3.6 Readmission

Readmission is defined as an hospitalisation that occurs shortly after a discharge (Carroll, Edwards & Lashbrook, 2011:3). In this study readmission means rehospitalisation within six months of discharge.

1.4 Significance of the Study

Recommendations from this study will benefit policy makers, MHCUs, families, communities, clinical care, education and research. These are discussed below:

1.4.1 Policy makers

Recommendations from this study may provide information to assist policy makers, programme planners and health service providers on what issues to prioritise with regards to care, admission and readmission of MHCUs, and also in terms of rendering appropriate services, making resources to be available to patients and families after discharge from mental institutions.

1.4.2 MHCUs

Factors that enhance readmission will be elicited and MHCUs may be treated accordingly as these factors may be removed.

1.4.3 Families

The burden of care may be alleviated as the MHCUs might knowingly use their treatment leading to less symptoms.

1.4.4 Community

The community may be enlightened and consequently, may treat MHCUs with understanding. There may be less stigmatisation and labelling of MHCUs and their families.

1.4.5 Clinical care

There may be less influx into mental health units as readmission rate may be reduced thus the quality of care will be given.

1.4.6 Education

A new curriculum might be instituted for betterment of mental health care and their rehabilitation may be enhanced.

1.4.7 Research

In research there may be an increase in the body of knowledge, and the knowledge gained in this research may help in improving the curriculum in nursing education.

1.5 Research Question

The research question for this study was;

- How do caregivers describe the readmission of MHCUs to a mental health unit in East London?

1.6 Aims and Objectives of the Study

1.6.1 The aim of this study was to:

- Explore and describe factors that enhance readmission of MHCUs to a mental health unit in East London as described by their caregivers.

1.6.2 The objectives of this study were to:

- Elicit the factors that enhance readmission of MHCUs in a mental health care unit in East London as described by their caregivers.
- Document recommendations and forward them to policy makers.

1.7 Research Methodology

This section presents the research methods and procedures used to collect and analyse data. Following is data on the research approach and design used in this study.

1.7.1 Research approach and design

A research design is defined as the overall plan for gathering data in a research study. The choice of design depends on the researcher's expertise, on the purpose of the study and on the researcher's desire to generalise the findings (Brink, 2006: 207, 53). In this study the design used was descriptive and explorative. Descriptive studies are studies in which phenomena are described or the relationship between phenomena is examined (Brink, 2006:201). According to Burns & Grove (2005:232) descriptive designs are designed to gain more information about the characteristics within a particular field of study. Their purpose is to provide a picture of situations as they naturally happen. Burns and Grove (2005:357) maintain that exploratory studies are not intended for generalization to large populations, but are designed to increase the knowledge of the field of the study.

The approach used was qualitative. A qualitative research is defined as a systemic, interactive, subjective approach used to describe life experiences and give them meaning (Burns & Grove, 2005 :747).

1.7.2 Research setting

The setting for qualitative research is the field (Speziale & Carpenter, 2007: 28). The research was conducted in a mental health unit which is within a general hospital in East London, in the Eastern Cape province in South Africa. The unit is 50 bedded and comprises an outpatient department, male in-patient ward and a female in-patient ward.

1.7.3 Population

Burns & Grove (2005:746) describe a population as all elements that meet the sample criteria for inclusion in a study and is sometimes referred to as a target population. The population for this study consisted of caregivers of MHCUs who were readmitted in a mental health care unit in East London and those collected their treatment supplies from the unit.

1.7.4 Sample and sampling

A sample is defined as a part or fraction of a whole, or a subset of a larger set, that is selected by the researcher to participate in a research study. Sampling in turn refers to the researcher's process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink, 2006: 124). The researcher selected the sample of caregivers of MHCUs who were readmitted between 2011 and 2012 who collected treatment in an psychiatric outpatient department in East London. The researcher used non probability sampling and the type was purposive.

1.7.5 Pilot study

Burns and Grove (2005:746) define a pilot study as a small version of a proposed study conducted to develop or refine the methodology. In this study the pilot study was used to develop and refine the data collection tool and see its appropriateness in terms of the time spent for the interviews. The pilot study was conducted in the mental health unit in East London. The tool used was the same interview guide which was used in the actual study. The researcher asked questions which focused on the factors that enhance readmission of the MHCUs to a mental health unit in East London.

There were three participants used in the pilot study and these were not used in the actual study. The pilot study helped in sharpening the skills of the researcher by allowing the researcher to practise using the tape recorder, to refine the research questions and see whether they were clear and not ambiguous.

1.7.6 Data collection

Burns and Grove (2005:733) define data collection as a precise, systemic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of the study. They maintain that the researcher as a whole is totally involved, perceiving, reacting, interacting, reflecting, attaching meaning and recording (Burns & Grove, 2005: 539).

In this study unstructured interviews were carried out using an interview guide. The interviews were done face to face and a tape recorder was used with the consent of

the participants. The participants were asked the same questions with probing where necessary.

1.7.7 Data analysis

Data analysis is conducted to reduce, organise and give meaning to data. The process of data analysis involves reading and rereading notes and transcripts, recalling observations and experiences, listening to tapes until you have become immersed in the data (Burns & Grove, 2005:733, 547). According to Brink (2006:55) qualitative analysis involves the intergration and synthesis of narrative non-numeric data that are reduced to themes and catergories with the aid of a coding procedure.

Data analysis was done concurrently with data collection. Five steps of Blanche, Durrheim & Painter (2008) were followed during the data analysis process. The transcribed data were read repeatedly, word by word and statement by statement until the data made sense and were understood by the researcher. The researcher sent the transcribed data together with the field notes to an independent coder for analysis. The researcher and the co-coder agreed on the themes, categories and subcategories that emerged from the transcribed data.

1.8 Ethical Considerations

Ethical consideration means that the rights of participants and others in the setting are protected (Burns & Grove, 2005:83). The researcher obtained ethical clearance certificate from the University of Fort Hare Research Ethics Committee. Permission to conduct the study was obtained from the Epidemiological and Research unit in Bisho, Department of Health, Eastern Cape and also from the East London Hospital Complex Ethics Committee.

Participants were allowed to voluntarily choose to participate or not to. Participants who were willing to participate were asked to sign a written informed consent. The participants were told about their rights to withdraw from the study at any time without being penalised. Permission to use the tape recorder was asked and obtained.

1.9 Trustworthiness of the Study

It is essential to ensure that the research process is authentic. In qualitative research this is referred to as trustworthiness. Speziale & Carpenter (2007:97) maintain that the researcher can ensure trustworthiness of data analysis by returning to each participant and asking if the exhaustive descriptions reflect the participants' experiences. The authors further reported that when the findings are recognised to be true by the participants, then the trustworthiness of the data is further established.

Trustworthiness is enhanced by credibility, transferability, dependability and confirmability. The researcher therefore ensured the trustworthiness of the study by observing the following:

1.9.1 Credibility

Speziale & Carpenter (2007:49) state that credibility of the findings can be confirmed through prolonged engagement with the subject matter, and by confirming whether the participants recognise the findings of the study to be true to their experiences. In this study, the researcher ensured credibility of the findings by returning back to the study participants and verifying whether the findings were those that they experienced. The researcher ensured that the data collection and analysis process were in line with those that were successfully used by other researchers.

1.9.2 Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations (Speziale & Carpenter, 2007:49). To ensure transferability the researcher maintained constant recording of the data so that it can be used by a future researcher in another setting. The researcher is of the view that similar findings can be obtained if the study can be repeated elsewhere under similar circumstances.

1.9.3 Dependability

Dependability can be achieved when the enquiry auditor or a peer follows the process and procedures used by the researcher in the study to determine whether they are acceptable (Brink, 2006:119). In this study, the supervisors checked all the steps of the research process to determine if the research process was authentic.

1.9.4 Confirmability

Brink(2006:119) maintains that confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator's interpretation and the actual evidence. Confirmability in this study was ensured by recording all the processes followed in the research.

1.10. Conceptual Framework

A framework is defined as an abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the findings to the nursing's body of knowledge. A concept in turn is a term that abstractly describes and names an object or a phenomenon providing it with a separate identity or meaning (Burns & Grove, 2005: 147). According to Burns and Grove (2005:136) in qualitative studies, the development of the framework is an outcome of the study as the identification of concepts may not be clear at the beginning of the study. In this study the application of this framework is in chapter five.

The researcher used Anderson's model of health utilisation (1995). According to this model, usage of health services is determined by three dynamics which are, predisposing factors, enabling factors and needs. These factors are explained below:

1.10.1 Predisposing factors

According to the framework, predisposing factors include demographics which are age, sex, marital status, education, race or ethnicity and occupation. Beliefs such as attitudes toward health services and knowledge about the disease and values are also predisposing factors.

1.10.2 Enabling factors

This factor involves the resources found within the family and community. The family resources include economic status (income and health insurance) and the location of the individual such as the distance an individual travels to the health facility.

Community resources involve access to health care facilities and availability of others for assistance.

1.10.3 Need factors

The need factor involves the individual's perceived and evaluated functional capacity, symptoms and the general state of health. The individual's perceived need will help the individual to be adherent to treatment. The evaluated need refers to the kind of treatment offered to a patient who visited the health facility.

1.11 Summary

In this chapter, the researcher orientated readers to the study by discussing the introduction and background, problem statement, definition of concepts, significance of the study, writing the research question, aims and objectives of the study, research methodology, data analysis, trustworthiness of the study and the conceptual framework. A review of literature will be conducted in the next chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review is defined as an organised written presentation of what has been published on a topic by scholars (Burns & Grove, 2005:93). In the current study, the researcher discussed national and international literature with regards to the factors enhancing readmission of MHCUs. As this is a qualitative study, the researcher did not begin with an extensive literature review, so as to avoid bias (Speziale & Carpenter, 2007:26). A review of literature was conducted after data analyses. This was done to prevent the researcher from leading the participants in the direction of the researcher's belief during the interview process. This chapter outlines various studies that explain factors that enhance readmission of MHCUs in hospital.

2.2 Scope of literature review

The themes that are under discussion in this chapter are as follows: substance abuse, non adherence to treatment, violence and high risk behaviour, family support, health care provider as a factor, pharmaceutical factor, diagnosis of patient, suicidality, previous admissions including involuntary admissions, length of stay in hospital and possible interventions to reduce readmissions. The next section discusses substance abuse as a factor that promotes readmissions of MHCUs.

2.2.1 Substance abuse

Use of unwanted substances is one of the patient factors that can lead to relapse and readmission to hospital (Nkangala, 2011:35). The researcher points out that substances like marijuana and alcohol contribute to readmission of MHCUs and alcohol use is associated with violence.

This is in line with a study by Mahamba (2009:27) that shows that illicit substances such as cannabis and marijuana may contribute to relapse when they are abused. In the study, relapse of schizophrenia in predisposed persons as well as aggressive symptoms are reported to be triggered by cannabis. The author reported that patients became violent and aggressive when under the influence of these

substances. The researcher opines that the use of substances becomes problematic to caregivers as it hinders them from caring for their mentally ill relatives. The researcher identified young people as another group of people that uses cannabis. The young people using cannabis are reported to have psychotic symptoms (Mahamba, 2009:27).

In a study conducted by Bimerew, Sonn & Kortebout (2007:81) on substance abuse and the risk of readmission of people with schizophrenia at Emanuel Psychiatric Hospital in Ethiopia, it was revealed that alcohol and khat (which is a psycho stimulant plant) are some of the contributing factors to re-hospitalisation of people with schizophrenia. The abused substances were reported to cause the patients to be restless, irritable, sleepless and unco-operative with treatment requirements. This led to a difficulty for family members in caring for their mentally ill relatives thus they are readmitted.

Brink, Oosthuizen, Emsley, Mbanga & Keyter (2003:7) state that patients with psychotic disorders have a high prevalence of substance abuse. Sariah (2012:12 & 53) stated that cannabis use precipitated schizophrenia and worsened symptoms of the disorder. The researcher reported that when symptoms were worsened compliance with treatment was reduced and it interfered with effects of the neuroleptics used to treat the symptoms.

2.2.2 Non adherence to treatment

Medication non adherence is said to be a common factor that leads to relapse, admission and re-admission to mental hospitals. For discharged patients to remain stable at home, medication compliance is critical.

According to the National Institute of Mental Health (2009) non adherence can occur in different forms such as failing to go for review of treatment, not taking the exact dose that is prescribed, taking other people's medication and failing to comply with treatment taking times.

It was also mentioned that although psychiatric patients had a greatest potential for recovering from drug adherence, they also had a great difficulty in following medication regimen. Patients who suffered from depression were found to fail to take treatment three months after the initiation of the therapy. A major reason for non

adherence was found to be the side effects. Patients who were on atypical antipsychotic medications were found to be medication compliant and those who are on typical antipsychotics to be noncompliant to medication(National Institute of Mental Health, 2009).

In a study conducted in Israel by Rosca et al. (2006:62) on rehospitalisation among psychiatric patients whose first admission was involuntary, it was reported that patients who are first admissions, and who are admitted involuntarily tend to stop treatment immediately after discharge from hospital. This leads to a revolving door syndrome.

In a study conducted by Smith (2005:16) on factors leading to frequent readmissions to Valkenberg hospital for patients suffering from severe mental illness in Cape Town, it was revealed that non-adherence to medication and non-response to treatment were the main reasons for rehospitalisation. Tang, Syed, Wagar & Shahzada (2008:2) also carried out a study on factors associated with non-adherence to medication among psychiatric patients at a tertiary hospital in Pakistan. The researchers discovered that those patients who were not compliant to medication were more likely to be admitted compulsorily and tend to be severely ill by the time of admission and stay longer in hospital. The researchers reported some reasons for non adherence which were viewed as side effects of medication ,cost of treatment and type of illness co-morbidity.

A study conducted by Nkangala (2011:6) reported that long term care gave a patient an opportunity to change attitudes. Patients were reported to be well when taking treatment and relapsed when they omitted or stopped taking treatment. The researcher added that the association between non compliance to medication and rehospitalisation was a major cause of relapse in schizophrenia, which led to poorer outcomes than when relapsing while taking medication.

Nkangala (2011:6) also suggested that the knowledge of drug treatment through psychoeducation could help patients to be compliant and help families to encourage their ill relatives on medication. The researcher mentioned that caregivers would be unable to understand the behaviour displayed by the patients, if the patients and caregivers are not given appropriate information about the condition of the patients.

Mphelane (2006:30) observed that psychiatric patients refused medication because they did not have enough information and when they experienced side effects from the antipsychotic medication they were discouraged to take medication. The prolonged illness enhances the non compliance thus the condition becomes worse. Patients were reported to seek traditional medications as an alternative healing system and were encouraged by their relatives who lacked knowledge about the nature of the illness.

2.2.3 Violence and high risk behaviour

In a study conducted in South Africa by Smith (2005:95) on factors leading to frequent readmission to Valkenberg hospital for patients suffering from severe mental illness, caregiving relatives gave violent behaviour as the main reason for frequent readmission. The families described the situation they found themselves in, such as when their safety is endangered due to exposure to violence, their possessions were destroyed and when there was often little source of help for their safety. The researcher also reported that the family also felt the police were unresponsive to calls when they were needed to help the caregivers. This prompted the family to arrange for readmission particularly when manifestations of relapse were identified.

2.2.4 Family support

A study conducted by Sariah (2012:44) in Tanzania on the factors that influence relapse among patients with schizophrenia, the family was revealed as a psychosocial factor affecting the clinical course, outcome and recurrence of schizophrenia. The researcher described the case of a patient who revealed that he lacked support from his family members, and that his family members criticised him which led to readmissions and longer hospital stay. The author also added that lack

of social support was a risk factor for non-adherence in schizophrenia. According to the researcher, family support was needed for the encouragement and supervision of treatment and accompanying patients for follow ups helped in the rehabilitation process. The researcher believes that caregivers who had a supportive attitude, who were non intrusive and who were more tolerant towards patients helped them to achieve a better social functioning.

Lewis, Tarrier and Drake (2005:65) reported that patients who were exposed continuously to families who criticised them became emotionally traumatised and relapsed frequently. The researchers also added that intergrated treatment by the multidisciplinary team (MDT) lessened the burden on relatives, reduced both positive and negative symptoms, shortened hospital stay and improved the quality of care.

A study of the role played by families in support of their mentally ill relatives in South Africa which was conducted by Mphelane (2006:37) revealed that the families became frustrated by their mentally ill relatives when they became inactive at home, unable to perform the household chores and just ate and slept. The researcher also expressed the frustration experienced by the caregivers as a result of lack of knowledge about the illness, treatment and the side effects. The researcher also discussed the financial part where mentally ill patients spent their money on drugs and alcohol, then demanded food from the relatives and also sold the family members' clothes and other household properties.

In the study, nurses were reported as showing no interest in assisting families of the mentally ill patients while they were admitted in the wards. Some family members revealed that it was very difficult to handle their mentally ill relatives as some of them became very aggressive and violent towards them especially those abusing substances.

Chan (2011:340-343) on global perspective of burden of family caregivers for persons with schizophrenia, caregivers' burden was observed to be a global issue.

The researcher reported that most countries were observed as failing to provide policies of financial support for the caring service of the family caregivers. The same author identified that caregivers were noted to be receiving little recognition for the valuable work they were doing. The researcher identified that caregivers ignored their own physical and emotional health as they struggled to balance work, family and caregiving roles. The burden on the family emanated from the patients' behaviour and symptoms, changes in household routine, socio demographic characteristics and physical health. Lack of knowledge and skills necessary to be responsible for their relatives were mentioned to be lacking to caregivers. Families of patients with schizophrenia were noted to experience daily stressors of unpredictable and bizarre behaviors, emotional frustration, stigma, isolation and conflict within the family.

Stigma related to mental illness was shown as the most common burden in caring for the sick relative. Stigma was associated with threatening the self esteem, employment and relationship to persons with schizophrenia.

2.2.5 The health care provider as a factor

Reinhard, Given, Petlick & Bemis (2008:4) stated that gaps in communication interface such as unclear discharge summaries hindered effective discharge planning. The researchers also revealed that caregivers felt upset about the unexpected discharge of their family members as the families were not prepared by the hospital staff regarding the technical and emotional challenges ahead of them. According to the researchers, at times family caregivers do not know how to access and utilise available resources as also do not know when there is a need for community resources. This shows lack of knowledge caused by lack of psychoeducation by mental health care providers.

Salazar (2010:20) in a study on factors related to potentially preventable readmissions within New York's Medicare Patient Population, advised that readmission can be reduced when communication with patients was improved before and after discharge, and also when coordination and communication with other health care providers was improved.

A report by Udem (2013:3) indicated that higher initial admissions and higher readmissions at times were caused by the hospital location, because patients were accessible to hospital or in places where the hospital was used more frequently as a site of care for illnesses.

2.2.6 Pharmaceutical factor

Mbatia and Jenkins (2010) revealed that unavailability of drugs from hospital pharmacy, at times forced patients to buy their treatment. The researchers mentioned that atypical antipsychotics which are expensive for patients and caregivers to buy, lead to non compliance and relapse. The cost of medication was therefore viewed as the factor which causes non adherence to medication.

2.2.7 Diagnosis of patient

A study by Romansky, Lyons, Lehner & West (2003:356) on factors related to psychiatric hospital readmission among children and adolescents in state custody, showed that in most studies readmission had been associated with certain clinical factors such as diagnosis of schizophrenia.

As mentioned earlier, deinstitutionalisation which decreases length of stay in hospital seemed to be the only option practised to save costs of treatment. However, since psychiatric illness such as schizophrenia need intensive psychiatric treatment and long term psychosocial rehabilitation, deinstitutionalisation have negative impacts on treatment.

2.2.8 Suicidality

In a study conducted by Chakraborty & Aryiku (2008:17), the researchers found that the most common immediate reason behind readmission was suicidality. Suicidality was suggested to be due to a background of social problems.

This was consistent with a study conducted by Roska et al. (2006:62) which identified suicide to be associated with being widowed and single. A suicidal person described above stayed long in the institution because of lack of support. A study by Barekataan et al. (2013:2) identified an 18 years old patient with first episode of

psychiatric disorder, history of psychiatric problems in childhood and suicide to be related factors to readmission.

Mellesdal, Mehlum, Larsen, Kroken & Jorgensen (2013:30) also found an increase in the most frequently admitted patients for suicide attempts as well as of self injurious behaviour. A high risk of general admission was also suggested to be associated with people that are receiving disability pension, living alone and being a female.

2.2.9 Previous admissions including involuntary admissions

According to Sariah (2012:10) there is an association between previous admissions, relapse and multiple psychiatric readmissions. A study by Gruneir, Dhalla, Van Walraven, Fischer, Camacho, Rochon & Anderson (2011:3) is consistent with the above results as they revealed a greater number of readmission of patients with history of previous admission.

The association between previous admission and readmission could be due to inability of health care providers to prepare MHCUs to cope in the communities (Thomas, 2010:4). The researcher reinforced the importance of preparing MHCUs for discharge.

2.2.10 Length of stay in hospital

Barekataan et al. (2013:3) is of the view that length of stay to hospital is an enhancing factor related to readmission. The same researcher observed that a lack of empty beds which forced patients to a shorter length of stay in hospital may lead to readmission of those psychiatric patients.

Bolton (2008:32) is of the view that there is a high risk of being readmitted in patients whose length of stay is greater than 60 days. The researcher indicates that staying long in hospital brings about dependence. A study by Niehaus, Koen, Galal, Dhansay, Oosthuizen, Emsley & Jordaan (2008:1) reveal that a decrease in length of stay led to longer time in the community before readmission. There seemed to be a difference of opinions regarding the effect of long hospitalisation and readmission of MHCUs.

However a study conducted by Pono (2009:33) in Thailand, in contrast is of the view that higher rates of readmission were related to shorter initial length of stay, because recovery had not occurred fully and because rehabilitation had not been conducted. Pono (2009:34) is of the view that when length of stay is short, patients improved slightly but when the stay is longer readmission was reduced.

Rosca et al. (2011:62) reported that prolonged hospital stay was caused by social isolation and lack of social support from family. The researcher also advised patients and the communities to prepare themselves to make longer-stays a priority so as to decrease readmission to hospital.

2.2.11 Possible interventions to reduce readmissions

Minimising non attendance

According to Killapsy (2006:8), non attendance can be minimised through the following:

Developing a primary care liaison which will advise on the triage referrals to secondary mental health services, and also developing a single point of entry for all referrals to secondary mental health services so that all assessments are carried out by staff. Newly referred patients should be sent an orientation statement with their first appointment and brief intervention protocols should be developed to treat patients with time limited common mental disorders. Patients need to be referred from the hospital back to primary care after treatment has been safely initiated and patients with more enduring and complex needs should be cared and managed in secondary mental health services. A missed appointment should not be automatically rescheduled but should be discussed with the patient and family.

2.3 Summary

In this chapter, a literature review was discussed on the factors influencing readmission of MHCUs as well as possible interventions as presented by other researchers. In the following chapter, methodology will be discussed.

CHAPTER 3

METHODOLOGY

3.1 Introduction

In this chapter, the study design and approach, sample, sampling technique, data collection, trustworthiness, ethical consideration, data collection and data analysis are discussed.

3.2 Study design

Kumar (2005:84) describes a research design as a plan, structure or strategy of investigation which is conceived to obtain answers to research questions or problems. In this study, the study design was descriptive and explorative.

3.2.1 Descriptive

The design was descriptive because it described the factors enhancing readmission of MHCUs to a mental health unit in East London as described by caregivers. According to Brink (2006:10) descriptive designs are used in studies where more information is required in a particular field to describe the concepts that will answer the research questions.

3.2.2 Exploratory

The study was exploratory because it explored and described the factors enhancing readmission of MHCUs in a mental health unit in East London as described by their caregivers. Exploratory study design is used when little is known about the phenomenon under study. This design helped in increasing the knowledge through probing to seek clarity when participants answered the research questions on the factors enhancing readmission of the mental health care users to a mental health unit in East London.

3.3 Qualitative Approach

The approach was qualitative. It was qualitative because it explored and described the factors enhancing readmission of MHCUs. This approach was appropriate as the

researcher wished to describe and explore the factors enhancing readmission of MHCUs to a mental health unit in East London so as to curb these factors.

According to Brink (2006:113), qualitative methods are more appropriate and effective where researchers wish to explore the meaning or describe and promote understanding of human experiences. A qualitative approach elicits information from the participants, by using its designs and the researcher builds on this.

3.4 Research Setting

The research was conducted in a mental health unit which is a designated health establishment within a general hospital in East London, in the Eastern Cape Province. This hospital is a referral facility. Universities such as Kwazulu Natal, University of Fort Hare, Walter Sisulu University and the Lilita College of Nursing use this hospital to allocate students for practicals. This is a 50 bedded unit which has both inpatient and outpatient.

It functions under the auspices of the Mental Health Care Act (Act 17 of 2002). According to the requirements of the Act, the unit provides in and outpatient services. The unit consists of a multidisciplinary team namely psychiatrists, psychiatric registrars, medical officers, psychologists, social workers, occupational therapist, psychiatric trained professional nurses, enrolled nurses and enrolled nursing assistants. There is an assistant director and operational managers who oversee nursing management.

3.5 Population

Population refers to the entire group of persons who are of interest to the researcher (Brink 2006:123). In this study, the population comprised caregivers of MHCUs who collect monthly medication in a psychiatric outpatient department in East London. Caregivers were chosen as the population because they were the ones who knew most about the required information, as they lived with the MHCUs. Once a population was identified, a sample was selected.

3.6 The sampling Method

As stated in chapter 1, the sampling method that was used in this study was the non-probability sampling and the type was purposive. This technique was relevant for this study because the researcher selected it according to the needs of the study, knowledgeable participants, that is the caregivers, who have experience regarding the factors enhancing readmission of their mentally ill relatives. Non probability sampling means that not every member of the population has an opportunity to be selected to the sample (Burns & Grove, 2005:40). It is more convenient and economical.

Purposive sampling requires the researcher to judge and select those participants who know the most about the phenomenon and who are able to articulate and explain to the researcher (Brink, 2006:131 & 132).

Qualitative researchers select information rich cases in purposive sampling, or those cases from which they can learn a great deal about the central focus of the study (Burns & Grove, 2005-352). Purposive sampling is explained as a technique which is based on the judgement of the researcher regarding subjects that are typical or representative of the study phenomenon, or who are especially knowledgeable about the question at hand. The advantage of purposive sampling is that it allows the researcher to select the sample based on knowledge of the phenomena being studied (Brink, 2006:133). In purposive sampling, the researcher deliberately chooses who to include in the study on the basis that those selected can provide the necessary data (Parahoo, 2006:268).

The sampling occurred in the psychiatric outpatient department. Selection of participants was done by identifying care givers of MHCUs who had accompanied their mentally ill relatives who had been discharged following readmission between 2011 and 2012, and who came for their monthly medication in a psychiatric outpatient department in an East London mental health unit.

With the help of the person in-charge of the unit, the researcher identified participants as they arrived in the outpatient department. The researcher ensured that the selection of study participants was fair. This was done by checking from the folders MHCUs who were readmitted between 2011 and 2012. The researcher approached the caregivers who accompanied the MHCUs and explained to the caregivers about the proposed study. Caregivers who were willing to participate were given a consent form to sign.

3.7 Sample Size

The researcher interviewed participants until data saturation occurred. Data saturation is a point at which new data no longer emerge during the data collection process (Brink, 2006:134). The total number of participants who were interviewed was 15.

The sample consisted of caregivers of MHCUs who collect treatment in a mental health unit in East London. All of them provided support to their mentally ill relatives. The participants of the study consisted of mothers, aunt, sisters, daughter in law, brother, husband and a cousin.

3.8 Inclusion and exclusion criteria

3.8.1 Inclusion criteria

Burns & Grove (2005:738) describe inclusion sampling criteria as a sampling requirement identified by the researcher that must be present for the element to be included in the sample. The researcher included the following participants for the study:

- Caregivers of MHCUs who collect their monthly treatment in a mental health unit in East London.
- Caregivers of MHCUs who had been readmitted in a mental health care unit between 2011 and 2012.
- Caregivers who were between 18 and 65 years of age.

3.8.2 Exclusion criteria

According to Burns & Grove (2005:736) exclusion sampling is a sampling requirement identified by the researcher that eliminate or exclude an element from being in a sample. Exclusion criteria are exceptions to the inclusion sampling criteria. The following caregivers were excluded from the study:

- Caregivers of MHCUs who collect treatment elsewhere.
- Caregivers of MHCUs who were admitted once.
- Caregivers who were less than 18 years of age and who were above 65 years, especially that dementia is prevailing at that age.

3.9 The Research Instrument

The researcher used a semi-structured interview guide to collect data from the participants. This guide was divided into two sections, namely, section A and section B. Section A comprised demographic data which included age, marital status, gender and employment status. Section B consisted of questions which directly addressed factors that influence the readmission of MHCUs to a mental health unit in East London.

The participants were asked the following questions, which were followed by probing where necessary depending on their responses :

- What do you think are the reasons for readmission of mental health care users?
- How can you describe the relations at home between the family and the mental health care user?
- What suggestions would you make to mental health staff with regards to prevention of relapse and readmission of mental health care users?

3.10 Data collection

According to Burns & Grove (2005: 430), data collection is the process of selecting participants and gathering data from these participants. The same authors maintain that steps of data collection are specific to each study and depend on the research design and measurement methods. Data may be collected from participants by

observing, testing, measuring, questioning or recording with the researcher actively involved in the process

3.10.1 Data collection method

Data collection was done by means of unstructured interviews. According to Speziale & Carpenter (2007: 36), "a qualitative interview is an unstructured conversation with a purpose that usually features audiotape and verbatim transcriptions of data, and use of an interview guide rather than a rigid schedule. In the unstructured interview, the researcher asks open ended questions"

Consent to participate was signed prior to participation in the interview process. Demographic data were requested and written down before the interviews started. An interview guide was used. Data were collected until saturation occurred.

3.10.2 Interview process

Burns & Grove (2005: 740) define interviews as structured or unstructured verbal communication between the researcher and participant during which information is obtained for a study. In this study, interviews were conducted in one of the psychiatric outpatient consulting rooms. The interviews were strictly between the participant and the researcher. Open-ended interviews were conducted using an interview guide. Speziale & Carpenter (2007:37) maintain that open ended interviews provide participants with the opportunity to fully describe their experience.

The researcher created an opportunity to probe where necessary so as to elicit unsaid information. Interviews were conducted face to face and a tape recorder was used with the consent of the participants and later information was transcribed verbatim. The interviews occurred smoothly and very freely like normal conversations, but with a purpose. The researcher observed changes in behaviours of participants, such as verbal and non verbal gestures and responded to them. The participants were given opportunity to fully describe their experiences. Field notes were made in a separate sheet and were summarised. The interviews were guided

by the research question which was: %What do you think are the reasons for readmission of mental health care users+?

3.11 Data analysis

The researcher began to analyse data during the data collection process (Burns and Grove, 2005:568).

3.11.1 Summary of stages of data analysis

The researcher followed 5 steps of interpretive data analysis as described by Blanche, Durrheim & Painter (2008:322-326) to analyse the data.

Step 1: Familiarisation and immersion

The researcher started by listening to the taped interviews and subsequently read the written interviews. The interviews (raw data) were transcribed verbatim. The transcribed data were read repeatedly, word by word and statement by statement until the data made sense and were understood by the researcher. Observations and experiences that occurred during the interview were recalled while the notes were read.

Step 2: Inducing themes

Themes were identified by looking in detail at the data. The data were written in a separate sheet line by line as they emerged from the interviews. Rough categories of themes that belong together were written together. Speziale & Carpenter (2007, 46-47) refer to this as the process of clustering similar data and the clustered ideas are referred to as themes.

Step 3: Coding

%Coding is a means of categorising and a code is a symbol or abbreviation used to classify words or phrases in the data% (Burns & Grove,2005:548). Coding and categorising were initiated at the beginning of data collection (Brink, 2006: 184). Different sections of data were marked with different colours of highlighters. Themes that belonged together were marked with the same colour. The body of the data were now broken into labelled meaningful pieces. The bits of highlighted material were clustered. The researcher identified categories and subcategories as they

emerged from the themes. The researcher checked the reliability of the coding by giving an independent coder the same data and they agreed on the themes that emerged (Brink, 2006: 184).

Step 4: Elaboration

The researcher now brought together views that were far away from one another. At this stage, the coding system was revised until no further significant new data emerged.

Step 5: Interpretation and checking

This is the final step in which interpretation of data was made. The researcher then discussed the interpretation of the data with the supervisor.

3.12 Authenticity and trustworthiness of the study

Trustworthiness refers to the ability of the researchers to convince themselves and participants that the findings of the inquiry are trustworthy or authentic (Babbie & Mouton, 2004:276). Trustworthiness is enhanced by credibility, transferability, dependability and conformability. The researcher took into consideration the trustworthiness of the study by observing the following:

3.12.1 Credibility

Credibility is demonstrated when participants recognise the reported research findings as their own experience (Brink, 2006: 118). The researcher confirmed the credibility of the findings by returning to the participants and verifying the authenticity of the study (Speziale & Carpenter, 2007:49). The researcher ensured that data gathering sessions and the methods of data analysis were derived from those that have been successfully utilised in previous comparable studies.

3.12.2 Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations (Speziale & Carpenter, 2007:49). The researcher enhanced transferability of the study by describing the research setting, study participants, keeping all data scripts, analysed data records as well as the independent coders' analysis.

3.12.3 Dependability

To ensure dependability, the opinion of an expert was sought. In this study, the researcher's supervisors followed the process and procedures used by the researcher in the study and determined their acceptability (Brink, 2006:119). The researcher ensured that all the processes within the study such as the research design and its implementation are reported in detail to enable future researchers to use the study in similar research.

3.12.4 Confirmability

Confirmability refers to the degree to which the findings are the product of the focus of the inquiry and not the biases of the researcher (Babbie & Mouton, 2004:278). It guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the researcher's interpretation and the actual evidence (Brink, 2006:119). The researcher ensured confirmability by stating the reasons for favouring the chosen approach instead of others.

3.13 Ethical consideration

According to Burns & Grove (2005:181), researchers have an ethical responsibility to protect and recognise the rights of participants. In this study the researcher protected the participant's rights by ensuring the following principles:

3.13.1 Ethical clearance

The researcher obtained ethical clearance certificate from the University of Fort Hare Research Ethics Committee.

3.13.2 Permission from Department of Health

Permission to conduct the study was obtained from the Epidemiological Research unit in Bisho, Department of Health, Eastern Cape, East London Hospital Complex Ethics Committee and also from the superintendent of the hospital.

3.13.3 Obtaining an informed consent

The researcher informed the participants about the proposed study by explaining to them its purpose and the expected duration of the participation. The researcher

allowed the participants to voluntarily choose to participate or not to. The participants were told about their rights to withdraw from the study at any time they felt uncomfortable, without being penalised in any way. All the participants who were approached by the researcher agreed to participate in the study. Participants who agreed to participate were consequently asked to sign a written informed consent form.

3.13.4 Right to self determination

The participants were treated with respect. The researcher did not force the participants to participate or force them to give information. Participants decided to be involved in the research on their own.

3.13.5 Right to privacy

Privacy was maintained by ensuring a private environment during the interview. The researcher ensured that only the participant and researcher are involved in the interview.

3.13.6 Right to confidentiality

Participants were ensured of confidentiality by making sure that the participants' names did not appear in the data sheet and information was put in locked cupboards after use. The researcher ensured that after the information had been collected, its source was not known.

3.13.7 Right to fair treatment

The researcher ensured that the selection of study population was fair. The participants were selected as they arrived. The researcher ensured that the participants were treated equally during the course of the study.

3.13.8 Right to protection from discomfort and harm

The researcher ensured that information was not leaked and no harm was done to participants. Participants were addressed with respect. They were given same information, asked same questions and given the same attention.

3.14 Summary

In this study, a descriptive and explorative designs were used. A qualitative approach was chosen as it is mostly preferred in situations where little is known. The sampling method was non-probability and the type was purposive. This type of sampling was appropriate for the current study as it allowed the researcher to choose the participants who stayed with the MHCUs and were expected to give relevant information about the factors that enhance readmission of MHCUs in hospital. Data collection and data analysis were done concurrently. An interview guide was used. Trustworthiness was ensured by observing dependability, confirmability, credibility and transferability. Ethical consideration was maintained throughout the study. In the following chapter, discussion of results will be conducted.

CHAPTER 4

RESULTS

4.1 Introduction

In this chapter, research findings were discussed under two sections which were the demographic presentation of the participants and the themes that emerged from data analysis.

4.2 Demographic Presentation of Participants

The total number of participants was fifteen (15), composed of thirteen(13) females and two (2) males. The ages of the participants ranged from 32 to 65 years. Most of the participants were unemployed, some were pensioners and only three were employed.

4.3 Themes

There were four main themes that emerged from data analysis which were: (1) Non - adherence to treatment, (2) Violent and aggressive behaviour, (3) Interpersonal relationships at home and (4) Suggestions from participants. Some of the themes emerged spontaneously while others were a response from interview questions. Table 1 below shows the themes, which were further grouped into categories and subcategories as they emerged from the interviews with the caregivers of MHCUs.

Table 1 Themes, categories and subcategories regarding readmission of mental health care users to a mental health unit.

THEMES	CATEGORY	SUBCATEGORY
1.Non adherence	Refusing to take treatment	<ul style="list-style-type: none"> • Throwing tablets in dust bin. • Refusing to come to hospital. • Hides treatment under the mattress. • Stopped taking treatment.
	Defaulting treatment	<ul style="list-style-type: none"> • Treatment makes him weak, stiff and lazy. • Treatment gets finished in clinic and we are sent back to hospital. • Does not want to be supervised treatment. • Do not have money to come to hospital, we had to wait for my husband to be paid from piece jobs.
	Denial	<ul style="list-style-type: none"> • Don't understand that he is mentally ill. • Does not believe he is sick.

		<ul style="list-style-type: none"> • Is healed and not sick. • Pastor prayed for her.
	Indulging in substance abuse	<ul style="list-style-type: none"> • Mixes dagga with other drugs. • Drinking too much alcohol. • Using every type of drug. • Some community members are giving him alcohol and dagga.
	Stigma	<ul style="list-style-type: none"> • People will tell community when seen in psychiatric out patient.
	Effects of the Disease	<ul style="list-style-type: none"> • Family are plotting to kill him. • Believes biological mother is a step mother • See things and hear voices. • Talk about things we do not know. • Smell things that are not there. • Voices are disturbing her. • Does not sleep at

		<p>night, move up and down.</p> <ul style="list-style-type: none">• Keeps quiet and don't want to speak for a month.• Very suspicious.• Does not trust anyone.• Ignores her letters in the postbox.• Would go to church day and night.• Wanders away from home.• Does not wash.• Say her sisters are jealous of her.
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<p>2.Violence and aggressive behaviour</p>	<p>Dangerous behaviour</p>	<ul style="list-style-type: none"> • Swears and threaten to burn house. • Threaten people. • Shouting and banging doors. • Putting child in wash basin full of water. • Throw stones at children • Is a bully and likes fighting. • Carrying dangerous weapons, axe and knife and chasing us with them. • Tried to kill himself by cutting his throat with a knife and claimed the voices odered him to do so. • Stabbed mother • Just released from prison. • Breaking things at home. • Accusing people of witchcraft. • We seek police intervention.
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<p>3. Interpersonal relationships at home</p>	<p>Responses from the family</p>	<ul style="list-style-type: none"> • Cannot live with him. • Relations are bad. • Pushes everybody away. • Quiet child. • Relations good at home. • Everything alright. • Sweet when taking treatment • Does not want to live with family. • Mother had to leave the house and stay with her sister. • Relations not good. • We ignore accusations towards us. • Bottling things to himself. • Would talk about old misunderstandings. • Ok at home. • Living alright. • Don't have problems.
	<p>Financial Impact</p>	<ul style="list-style-type: none"> • Misuses grant money • Buying alcohol with

		<p>grant.</p> <ul style="list-style-type: none"> • Giving grant money to girlfriends and strangers. • Make unnecessary loans.
	Emotional impact	<ul style="list-style-type: none"> • Don't feel safe staying with him. • Everyone is afraid of him. • Are stressful • Very difficult • Are terrible • Living in fear
	Support system from family members	<ul style="list-style-type: none"> • Had to quit job and look after her. • Alright and supporting. • Show love and support. • Arranged for brother to stay with her. • Children understand the illness.
4. Suggestions from participants	Views	<ul style="list-style-type: none"> • To change tablets and give injection. • Staff to visit homes at times. • Staff to help.

		<ul style="list-style-type: none"> • Nurses to give education about illness. • Doctors and nurses to help encouraging patient to take treatment everyday. • Advise to take medication. • Hospital staff to phone when he does not come. • To be kept to hospital for a long time. • Hospital to talk to community about dangers of giving mentally ill patients dagga and alcohol. • Advise patients to stop using alcohol. • Staff to send treatment to clinic. • Doctors to talk to him to stop abusing grant money.
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4.3.1 Non adherence to treatment

The responses of participants with regards to non adherence with treatment were mostly different with some few commonalities. The most common responses was defaulting treatment and indulging in substance abuse. Other reasons for non-

adherence of MHCUs to treatment were: refusing to take treatment, are in denial, were afraid of being stigmatised by community members, and lastly caregivers associated non adherence to treatment with the effects of the disease.

4.3.1.1 Refusing to take treatment

Participants revealed that the MHCUs refused to take treatment and this was evidenced when the participants reported that the MHCU was found throwing tablets in the dustbin while another was hiding treatment under the mattress. It also emerged from the interviews with caregivers of MHCUs, that some MHCUs refused to go to hospital for follow ups. Participants reported that some MHCUs just stopped taking treatment. The following are some of the responses from the participants:

%She was refusing to come to hospital”.

“She stopped taking treatment”

%At times he would go to the clinic for check up but on the way back home he throws all the treatment away or hides tablets under the mattress

“ I once caught her throwing treatment in the dustbin”

4.3.1.2 Defaulting treatment

Most participants indicated that the MHCUs defaulted treatment. The participants reported that the reasons for MHCUs to default treatment was that MHCUs complained that the treatment made them weak, stiff and lazy. Some participants revealed that the treatment gets finished in the clinics. One participant indicated that the MHCU did not want to be supervised on treatment as she claimed that she is old enough to be supervised. Another participant said that they could not come to hospital as they did not have money for transport, as they had to wait for the husband to be called for piece jobs. These are the participants' responses:

“ She refuses to eat treatment, she does not want to be supervised on treatment as she claims that she is old enough”.

“ When we are referred to the clinic at times we don't get his medication, we are told that it is finished and we had to come to hospital”.

“She refuses to eat tablets at home, as she claims they make her stiff, weak and lazy” .

“When we don’t have money to come for check up,we wait until my husband is called from his piece jobs as all of us depend on his piece jobs”.

4.3.1.3 Denial

It emerged from the interviews that some of the MHCUs did not understand that they are mentally ill and did not believe that they are sick. One participant revealed that the MHCU believed that she was healed from the pastor’s prayer and was not sick. Participant’s responses:

“I think the problem is that many times he does not understand that he is mentally ill”

“At times he would refuse to come for check up and claim that he is not sick”.

“He really does not believe that he is sick”.

“She would refuse her tablets and claims she is healed. I think the church is having an input in this. She would claim that there is no need to take tablets as her pastor prayed for her”.

4.3.1.4 Indulging in substance abuse

Most participants reported that MHCUs were abusing drugs. The participants reported that the MHCUs drank alcohol excessively, mixed dagga with other drugs and other MHCUs were reported to use every type of drugs. The following are some of the extracts from the interviews:

“He is smoking dagga and mixing it with other drugs”.

“He smokes dagga and drinks too much alcohol”

“%o don’t understand other people because they know he is mentally disturbed but they give him alcohol and dagga to smoke, then he becomes sick”.

“He is using every type of drug he comes across with”.

4.3.1.5 Stigma

One participant revealed that the MHCU refused to come to hospital as he feared that if she is seen by community members in the psychiatric outpatient department, others in the community will know that she is mentally ill. This is what the participants said:

%She was refusing to come to hospital as she claims that when people see her in the outpatient they will say she is mentally ill and will tell others in the community”.

4.3.1.6 Effects of the disease

It also emerged from the interviews that the effects of the disease also contributed to the relapse and readmission of MHCUs. Participants reported that the MHCUs believed that their families were plotting against them, planning to kill them, saw, heard and smelled things that were not there, talked about things others did not know, and that the MHCUs did not sleep at night. Another participant said that his son believed that she is a stepmother whereas she is the biological mother.

One participant revealed that the MHCU kept quiet for the whole month, ignored letters from the post, was very suspicious, did not trust anyone and wandered away from home. Another participant reported that the MHCU would go to church day and night, did not wash. One MHCU was reported to sing, dance and believed that her sisters are jealous of her. The following are the extracts from the interviews:

%Just think of it when your child refuses food and treatment because he thinks you want to kill him. He believes that I am his stepmother whereas I am his biological mother”

“She believes we are plotting to kill her by poisoning her food”.

“At times she hears, sees and smells things that are not there. The voices are disturbing her”.

“He moves up and down at night, sings dances and speak the whole night”.

“Yho! Sister, just imagine staying with someone who does not talk with you for the whole month. She also ignores her letters in the post. Does not trust anyone”.

“She believes that her sisters are jealous of her”.

“She is always in church, goes to her church day and night and does not wash herself”

4.3.2 Violence and aggressive behaviour

During the interviews it emerged from the participants that the MHCUs were a danger to themselves and others as the MHCUs displayed violent and aggressive behaviour towards their families, children and community at large.

4.3.2.1 Dangerous behaviour

There were strong emotions when participants expressed the trauma they experienced when the MHCUs displayed violence and aggressive behaviour towards them. MHCUs were reported to swear, shout, banged doors, broke things at home and accused neighbours of witchcraft.

One participant reported that the MHCU threw stones at children, carried dangerous weapons like an axe and knife and was a bully and liked fighting. Another participant reported that the MHCU put a child in a wash bowl full of water and was claiming that she is baptising the child and another reported that the MHCU was just released from prison as he stabbed his mother. It also emerged from the interviews that one MHCU tried to kill himself by cutting his throat with a knife. Participants mentioned that they had to seek help from the police officers, to take the MHCUs to hospital. Caregivers reflected the following:

“He tried to kill himself by cutting his throat with a knife. He said the voices from his ears ordered him to kill himself. He is always complaining of not getting a job and it worries him, I think this added to the reason for him to try to kill himself”.

“She is very aggressive towards his father and me, swears at us and threatens to burn the house, we cannot live with her when she is like this, she need to be admitted”.

“We quickly ask help from the police, as we cannot manage to take her to hospital on our own”.

“Yho! sister, you can just imagine staying with someone who is threatening you! We are living in fear. He is very aggressive towards us at home, shouting and banging doors. Is carrying dangerous weapons like axe and knives and chasing children with stones. He is accusing neighbours of bewitching him”.

“He is just released from prison as he stabbed our mother with a knife. He is a bully and likes to fight”.

“I found her putting a child in a wash bowl full of water, claiming she is baptising the child”.

4.3.3 Interpersonal relationships at home

There were different responses from participants with regards to the relationships between the MHCUs and their families at home. Some participants revealed that the financial and emotional impact were associated with the relapse of MHCUs.

4.3.3.1 Responses from family

Relationships between the MHCUs and their families at home were described as being bad, good, sweet and alright. Some participants revealed that they could not live with their MHCUs, didn't feel safe staying with them, and some reported that the MHCUs pushed their families away and refused to live with family members. One participant reported that the MHCU was bottling things, would talk about old misunderstandings and other participants reported that they just ignored accusations made by MHCUs towards them. One participant revealed that their mother had to live the house and stay with her sister because she feared the MHCU.

4.3.3.2 Financial impact

During the interviews it emerged that relapse of MHCUs had a financial impact. Participants reported that the MHCUs misused their disability grant money as the MHCUs bought alcohol, gave money to friends and strangers and made unnecessary loans. These are some of the responses from the participants:

“She is misusing her disability grant money, as she borrows money from cash loans making unnecessary loans”.

“The problem is that she manages her grant money by herself. When her money is finished, she demands money from me and her father. When we refuse to give her money, she starts shouting at us and banging doors and becomes violent”.

“He is giving his grant money to girlfriends and strangers and buy alcohol with the money”.

4.3.3.3 Emotional impact

The participants verbalised the emotional impact that is caused by the relapse of the MHCUs. Some participants revealed the fear, stress, difficulty and feeling unsafe with staying with the MHCUs as everyone was afraid of the MHCU. These are some of the extracts from participants:

“We really don't feel safe staying with him”.

“Everyone is afraid of him, yho sister! We are living in fear”.

“Its very stressful at home”.

“Yhu, it's very difficult”.

“If I can tell you the truth, things are terrible”

4.3.3.4 Support system from family members

The findings showed that most of the participants supported their MHCUs. Participants reported that they showed love and support to the MHCUs. One participant reflected that she had to quit her job so as to look after the MHCU and that she had to arrange for her brother also to help look after the MHCU. It also

emerged from the interviews that some children understood that the MHCUs are ill. Participants ignored accusations from the MHCUs as they understood that they are mentally ill.

A few number of participants were not keen to support the MHCUs as they reported that it is very difficult and stressful to live with the MHCU and they did not feel safe staying with them. Participants also revealed that when the MHCUs relapsed they would talk about old things that were resolved and that worries the participants a lot. These were the responses from participants:

“We try by all means to show love and support to her”.

“I had to quit my job sothat I can look after her”.

“I had to arrange for our brother to stay with her at home as she chased me away.”

“The children understand that he is mentally ill”.

“We cannot live with him”.

“He would talk about old misunderstandings, and this bothers us”.

“We ignore accusations towards us, we understand that he is ill”.

4.3.4 Suggestions from participants

Participants gave suggestions which they believed would help in the reduction or prevention of relapse and readmission of MHCUs to hospital. The most common suggestion which was raised by the participants was home visit by nurses. Participants suggested that visits by nurses to their homes would help as they believed that the MHCUs listened to the nurses when they are admitted in hospital. The participants also believed that the MHCUs would take the treatment when they knew that the nurse would visit their home. It also emerged from the participants that a telephone call from hospital to remind MHCUs who defaulted treatment would help the MHCUs to adhere to treatment.

Participants also suggested that nurses should educate caregivers and MHCUs about the mental illness and the treatment so that they can understand it. Participants also suggested that the nurses should educate the community about the dangers of giving MHCUs alcohol and dagga.

It also emerged from the participants that the hospital should ensure the availability of the MHCUs treatment in the clinics when the MHCUs are referred to the clinics. Some participants suggested that it would be better if their MHCUs are given injections instead of tablets. One participant suggested that the MHCU should be kept in hospital for a long time. The following are the suggestions which emerged from interviews:

“It would be better if she is given an injection instead of tablets, as she is refusing treatment”.

“I wish there could be someone from the staff to visit at times, because he listens to the staff when he is in hospital”.

“Sometimes it is better when he hears the illness and the signs of illness from the staff so that he can accept that he is ill”.

“The staff can also help in ensuring that the treatment is available at the clinic”.

“If possible, I think the hospital can arrange for the staff to talk to our community members to stop giving the patients alcohol and dagga as they make their sickness worse”.

“It would be better if he will be kept in hospital for a long time”.

4.4 Summary

This chapter discussed the themes, categories and subcategories as they emerged from the interviews of the caregivers of MHCUs. The next chapter will discuss the findings, conceptual framework, implications, limitations, conclusions and recommendations of the current study.

CHAPTER 5

DISCUSSION

5.1 Introduction

This chapter discusses the findings in relation to earlier studies, conceptual framework, implications, limitations of study, conclusions and recommendations.

5.2 Discussion

According to Brink (2006:193) there are elements which need to be covered when discussing the findings and these elements are as follows: (1) Interpretation and a summary of the findings, (2) Conclusions related to the questions raised in the introduction, (3) Limitations identified in the study and (4) Suggestions and recommendations.

The demographic representation of this study illustrated that most people who care for the mentally ill patients are females. The reason for more female caregivers could be that the caregivers were housewives, unemployed or left their jobs because of the caregiving responsibilities. On the other side it could be that male relatives were at work or the traditional belief that caregiving responsibilities are for females. These findings are consistent with the study by Chan (2011:340-343), who observed that caregivers were women who were either wives, mothers or daughters of the mentally ill patients.

With regards to readmission various factors were suggested by caregivers as influencing readmission of MHCUs to a mental health unit in East London. These were:

5.2.1 Non adherence to treatment

Non adherence to treatment emerged from the findings of this study as a leading factor which influenced relapse and readmission of MHCUs to hospital. The findings of this study revealed that MHCUs refused to take treatment, defaulted treatment, denied mental illness, indulged in substance abuse, feared stigma of mental illness and the effects of the disease were associated with nonadherence to treatment.

Participants reported that the MHCUs refused to take treatment as that was evidenced when MHCUs were found in different acts like throwing the tablets in the dustbin, hid treatment under the mattress, refused to go to hospital and stopped taking treatment. The statement above showed the unwillingness of the MHCUs to adhere to the psychiatric medication which was prescribed for them.

These factors made it very difficult for the caregivers to ensure that the MHCUs were stable, as it is a problem when the MHCU is refusing to go to hospital and throwing the tablets away. One participant also revealed that the MHCU refused to be supervised on treatment and wanted to take the treatment on her own. This made it difficult for caregivers to monitor if the MHCU is taking treatment or not. This notion was supported by Mibei (2013:7), that nonadherence is a common factor which is an invisible major public health problem which may lead to readmission of MHCUs.

5.2.2 Side Effects

Participants reported that MHCUs defaulted treatment due to the side effects of the psychiatric drugs. These side effects include: weakness, stiffness and laziness. It is common for patients to refuse treatment because of side effects. Even patients who are not mentally ill stop treatment if they experience side effects. This becomes a problem as treatment default delays recovery. Side effects also add a burden to the caregivers of MHCUs as some MHCUs had to be helped with the basic things like bathing, dressing and eating when MHCUs could not perform the above due to side effects. MHCUs and their caregivers were at times shocked by the appearance of the side effects if they were not told ahead that the treatment might cause some side effects, and at times they view the side effects as the worsening of the illness.

Side effects can hinder the MHCUs to perform the usual tasks that they used to perform. The side effects can affect the MHCUs at work, home and community. At work the MHCU will be seen as someone who is lazy and unproductive. At home the family might also not understand that the MHCU is experiencing side effects and the MHCU may be labelled as being lazy. Some community members make fun of the MHCU, laughing and teasing them when they notice the side effects such as stiffness and drooling saliva. This can eventually lead to some MHCUs prefer to endure the symptoms of mental illness than the side effects of the psychiatric treatment.

Default of treatment due to side effects can be prevented or controlled. There is a need to develop ways to address the problem of treatment default, considering the fact that relapse and readmission to hospital is associated with high costs, affects patient morale, puts a burden on caregivers.

In light of the information above, psychoeducation for MHCUs and their caregivers about the side effects of the psychiatric treatment is very important to prevent treatment default. MHCUs and their families need to be aware that there is an option of changing treatment when the MHCU is presenting with side effects. This is in line with a study by Mphelane (2006:30) who observed that MHCUs stopped treatment because of side effects and because of their conditions which are chronic.

5.2.3 Unavailability of treatment from clinics

Participants also indicated that the treatment gets finished in the clinics. When treatment is not available in clinics, MHCUs are denied their right to treatment. The problem of unavailability of treatment in hospital has capacity to make MHCUs and their caregivers to lose hope in the health department and staff. This may lead to relapses and eventually readmission to hospital. Hospitals and the clinics should work in collaboration to avoid MHCUs being turned away without treatment. This can be done by informing the clinics about the names and treatment of MHCUs when the MHCUs are referred to the local clinics. Local clinics should devise a way of informing the hospital or MHCUs through telephone call, if their treatment is out of stock so that a plan can be made in advance. This is in line with a statement by Botha, Koen, Oosthuizen, Joska & Stellenboch (2008:274), that ~~in~~ South Africa, not all medications are readily available in the public sector and some medications may not be available at community clinics.

5.2.4 Lack of money

It also emerged from the interviews that the MHCUs and the caregivers could not go to hospital because they did not have money for transport. Accessibility need to be ensured to MHCUs by using mobile clinics as a vehicle of dispensing psychiatric treatment to MHCUs staying in places that are far from clinics and hospitals. Alternatively, transport should be made available for MHCUs coming from far places.

This also means that social workers should be involved so that they look at the social circumstances of the MHCU and determine MHCUs who qualify for disability grant. Caregivers and MHCUs need to be asked suitable dates for appointments so that they can schedule their appointments and be given a return date suitable for them, when they have money. It should be ensured that the MHCUs get enough treatment in such cases. This is supported by Botha et al (2008:274) who state that patients need to be helped for transport as fewer patients afford regular visits.

5.2.5 Denial

It also emerged from the findings of the study that denial led to non adherence to treatment. Participants reported that MHCUs did not understand that they were mentally ill and some did not believe that they were sick and they believed that prayers and pastors can heal them. Lack of insight by MHCUs result to nonadherence to treatment. The MHCU will not see the reason to take treatment when they believe that they are not sick and that they are healed. Psycho-education is necessary for both MHCUs and their families to help MHCUs understand the nature of their illness.

This is in line with a study by Smith (2005:99) who states that in some MHCUs there is impairment in insight and judgement which causes difficulty to know and accept the illness.

5.2.6 Religion

One of the participants reported that one MHCU refused treatment because of the belief that she was healed through prayers by her pastor. In some churches mental illness is associated with evil spirits and people believe that the psychotic symptoms are caused by the evil spirit. This affects the medical treatment as the MHCU will believe that only prayers will help, leading to refusal to take medical treatment.

Religion can have both positive and negative impact on the MHCUs. The positive aspect is understood when Christians support their ill member, giving spiritual support by visiting the ill member when in hospital and pray for the ill member. The support helps in the speedy recovery of the MHCUs. The negative aspect is when the ill member refuses treatment due to the belief that he/she is healed from the disease through prayers, while the member is still sick. It is important to carry out on-going education about the disease and treatment to the MHCUs and families so that

they understand the disease, its symptoms and side effects better. Education in churches about mental illness will help the church members to understand mental illness and encourage the ill member to adhere to treatment. This will help to prevent treatment default and will encourage treatment adherence.

Sariah (2012:48) supports the notion that religion may impact negatively on the outcome of mental disorders especially when medical treatment is replaced or delayed by it. According to the researcher, some MHCUs may refuse psychiatric care because of religious belief and influence by spiritual leaders.

A study by Mibei (2013:7) also reveals that individual characteristics such as ethnicity, health belief, patients' religion, and social support system were found to influence adherence. Nkangala (2011:34) however noted that there was no relationship between religion and mental illness in her study.

5.2.7 Substance Abuse

Uys and Middleton (2010:443) define the misuse of drugs as using in excess or using in a different way from the prescribed or intended use. In this research substance abuse also emerged as a factor that is associated with non-adherence to treatment. Common drugs which were identified by participants were dagga and excessive use of alcohol. Participants reported that the MHCUs drank too much alcohol, mixed dagga with other drugs and that they used every type of drugs. During interviews, one of the participants complained that community members were giving the MHCUs alcohol and dagga.

It is important to note that the medication will not be effective if taken with substances. Additionally, substance abuse alone affects the mental health of an individual. The situation is worsened when the person who abuses drugs or alcohol has a mental illness. Substance abuse therefore prolongs the time of recovery and that of inpatient treatment. Substance abuse can hinder the caregivers from caring for their mentally ill relatives. Generally, people who are abusing substances don't have time for treatment. They spend most of the time away from their homes with their friends.

Some people who are addicted to drugs steal money and other people's belongings and sell them when they are craving for drugs. Some MHCUs become involved in

criminal activities due to substance use and they become jailed. Some MHCUs become aggressive when under the influence of drugs.

This is supported by Smith (2005:102) who explains that substance abuse hampers treatment compliance and causes relapse and readmission. This study is in line with Bimerew, Sonn & Kortebout (2007:78) that revealed that many communities were reported to provide mentally ill people with alcohol and marijuana instead of helping them.

Uys and Middleton (2010:443-448) state that rates of poly substance abuse remain high, with the North West province and Northern Cape being 29% and Eastern Cape, where more than one substance is abused at 44%. The authors reported that, use of drugs was an escape from reality, for the euphoric and pleasurable effect and for the relief of tension and anxiety. Overdosage of dagga was reported to cause hallucinations. Alcohol and substance abuse were regarded as a huge problem which caused prevention and treatment more problematic. The same authors mentioned that, when a substance became an essential part of the individual's life such that it became difficult for the person to function without it, it is called substance dependence. Chronic use of substances were reported to cause lowered sensory threshold, euphoria, anxiety, enhanced self confidence and fragmented thoughts. It was therefore urged that nurses should play a most important role to fight against substance use disorder (Uys & Middleton 2010:448).

5.2.8 Stigma

Uys & Middleton (2010 :84) define stigma as "something that brands a person in a negative way in the eyes of society". The findings of the study associate stigma with non adherence to treatment as one MHCU refused to go to the psychiatric outpatient department because of fear of being seen in the clinic. Stigma therefore can contribute to treatment default and can cause social isolation. Some people are afraid of MHCUs and don't want to involve themselves with them. Due to fear of social isolation MHCUs prefer to default treatment so that they can be accepted and belong to the communities.

Not only MHCUs are stigmatised by communities, but also at their workplace. Colleagues at work at times may judge their colleague who is mentally ill and even

errors made by MHCUs may be associated with mental illness. Sometimes MHCUs are required by their employers to come with proof from their doctors that they are fit to work. Even when MHCUs are applying for employment they fear to reveal that they are mentally ill as they are afraid that they will be denied work because of their mental state. Caregivers are also stigmatised in communities because of caring for people with mental illness and this causes some caregivers to deny or hide that their relatives are mentally ill because they are afraid that they will be stigmatised. Some caregivers may leave the MHCUs or refuse to be associated with someone who is mentally ill. This suggests that more education need to be carried out in communities sothat the community can accept people with mental illness.

This notion is supported by Smith (2005:100) that the stigma attached to mental illness made MHCUs to resist to take psychiatric treatment. Peterson & Lund (2011:7) also support the view that stigma and discrimination contribute to treatment default and social isolation.

Nkangala (2011:37) however argues that stigma is not associated with readmission, but instead caused feeling of being rejected, not understood, and denied basic needs. The researcher also revealed that some people felt uncomfortable around the MHCUs and that led to individuals to lose contact with family or friends, develop low self esteem and feel ashamed.

Mahamba (2009:22) adds that stigma does not affect the MHCUs only, but also affects their families. This is in line with Uys & Middleton (2010 :84) who explained that mental illness is a frightening and hostile experience a person can endure, and the stigma attached to it made the experience more difficult. People with mental disorders are regarded by society as being dangerous, acting strange, unpredictable and make people uncomfortable. Lack of knowledge, not understanding what mental illness is and how it is treated are reported to be the reasons for the above perceptions.

5.2.9 Effects of the disease

In this study, the researcher found that MHCUs experienced symptoms such as: belief that people are plotting to kill him, hear, see and smell things not there, talk about things not known, not sleeping at night, suspiciousness, mistrust and

wandering away from home. Participants associated these symptoms with non adherence to treatment. These symptoms made it difficult for caregivers to provide care for the MHCUs as the psychosis prevents the MHCUs from taking treatment. The content of the delusion or hallucination determines the type of the behaviour the MHCU will display. If the MHCU believes that the caregiver is trying to poison him/her, then the MHCU will refuse everything given to him/her by the caregiver including treatment.

One participant reported that the MHCU believed that his mother is not his biological parent and this became very devastating to the mother. This false belief hindered the mother-son relationship, causing the son to mistrust the mother. The son refused food, treatment given by the mother as he believed that the mother was someone hired to look after him or was a stepmother. This led to readmission of the MHCU.

From the above information, it is clear that some symptoms of mental illness cause difficulty for caregivers to contain MHCUs at home. The hallucinations may be negative such as commanding the MHCUs to kill or harm themselves. MHCUs may have delusions such as believing that there are people plotting to kill them or caregivers want to poison them. Some MHCUs believe that their caregivers are jealous of them. This makes it very difficult for the caregivers to stay with their caregivers at home, leading to readmission to hospital.

5.2.10 Violence and aggressive behaviour

During the interviews caregivers of MHCUs indicated that violence and aggressive behaviour was a factor that influenced relapse and readmission of MHCUs to hospital. The participants also expressed that the MHCUs became violent, aggressive and destructive at home. It also emerged from the participants that some MHCUs threatened to burn the house, carried dangerous weapons such as knives and axes. One of the participants also reported that the MHCU stabbed his mother and the MHCU had to be jailed.

Violence apparently was not directed to adults only, but children were affected by the violent behaviours. For example, one MHCU who was found putting a child in a washbasin full of water claiming she was baptising the child, and another MHCU reportedly threw stones at children.

The participants also reflected how they feared as the MHCUs were a danger to themselves, family and community at large. At times community members were accused of witchcraft and everyone felt threatened by the MHCU. Some of the participants linked the violence with substance abuse. This suggested an association between substance abuse and violence.

Aggression and violence have a negative influence on the well being of the people affected by it and may cause emotions such as anger and burnout. Caregivers need ongoing support as violence and aggressive behaviour may affect them physically and emotionally. Referral of caregivers to psychologist may help them to ventilate their feelings. Caregivers need to be empowered on how to manage aggression.

Participants reported that they had to seek help from police to take the MHCUs to the hospital as the participants were unable to manage the MHCUs at home. According to participants they had to restrain the violent MHCUs before the police arrive, as police ordered the caregivers to do so. Participants expressed the difficulty they experience when restraining the MHCUs as they are afraid of the MHCUs and they had to ask for support from the community. Police officers need to be trained about how to handle an aggressive patient

The above notion is supported by Mibei (2013:10) who states that MHCUs at times became violent and aggressive and had to be brought to the psychiatric emergency department with mechanical or chemical restraints to manage the acting out behaviour.

5.2.11 Suicide

In this study, suicidal ideation, is associated with admission to hospital. One participant reported that the MHCU was found trying to kill himself by cutting his throat with a knife and the MHCU claimed he was responding to the voices who told him to do so. MHCUs with suicidal ideations are admitted in mental health units so that they can be provided with treatment, counselling and referral to psychologist. This is in line with a study by Chakraborty & Arkiyu (2008:17) that states that the most common immediate reason for readmission is suicide and was due to a background of problems.

Mellesdal, Mehlum, Larsen, Kroken & Jorgensen (2010:5) support the notion that suicide was associated with admission. The researchers also indicate that patients attempt suicide so that they can get help, when they don't have enough coping strategies or as a way of communicating and ventilating feelings.

5.2.12 Financial impact

Participants revealed that the MHCUs' relapse had a negative effect financially. Misuse of disability grant was suggested as another factor associated with relapse and admission. The participants explained that the MHCUs misused the disability grant and when the money was finished the MHCUs demanded money from the caregivers and became violent if they did not get the money. This becomes a burden to caregivers of MHCUs as some of the caregivers are unemployed and depend on the MHCUs disability grant for food, transport to hospital and clothing.

It is noted that some MHCUs refuse to take treatment on an empty stomach, so when there is no food MHCUs are likely to relapse. Social workers need to intervene in cases where there is misuse of disability grant money. This is because MHCUs may involve themselves in criminal activities such as stealing, because of financial difficulties. This is in accordance with a study by Thomas (2010:3) which associates unemployment and being on a disability grant with a risk of increased readmission.

5.2.13 Relations at home

There were different views with regards to relations at home. The participants reported that the relations at home between MHCUs and their caregivers were bad, stressful, very difficult and that MHCUs pushed everybody away and did not want to live with family. For example, one participant said that their mother had to leave her house and stayed with her sister because she was stabbed by her son. The participant reported that they do not feel safe staying with the mentally ill relative as he is a bully who likes to fight. Not only adults are exposed to the danger of MHCUs, but children also. Caregivers cannot be blamed for not giving support to their ill relatives if staying with the MHCUs put their lives in danger.

In contrast, some participants said the relations between the MHCUs and family were good, everything was alright, MHCUs were sweet when taking treatment, family ignored accusations towards them. This suggested that the participants understood

the signs and symptoms of the mental illness and knew how to manage their mentally ill relatives. The researcher is of the view that those who receive support and are understood by the caregivers are those who are likely to behave well.

5.2.14 Suggestions from participants

Participants suggested the following strategies to reduce relapse: home visits, psychoeducation, injection instead of oral tablets, collaboration with clinics and that MHCUs should be admitted for long term. Discussion of these strategies are as follows:

- **Home visits**

Participants suggested that home visits by nurses would help in preventing the relapse of MHCUs. Home visit will also help in identifying signs of relapse early and provide support to the MHCUs and their caregivers. Extrapyramidal side effects will be detected early and managed early to prevent treatment default. Additionally through home visits, caregivers will have time to ventilate all their fears and ask questions they are unable to ask from hospital. Home visits also help in educating the family and MHCUs about the mental illness. It is important to note that not all MHCUs are entitled to home visits, but only those identified as high risk for relapse and those who are defaulting treatment are to be visited by psychiatric nurses.

This study is in accordance with Uys & Middleton (2010:307) who report that the aim of the home visit is to gain understanding of the client and the caregivers. The focus of home visits is health education to promote the adoption of health-promoting behaviours.

- **Education**

Education of MHCUs together with their caregivers was suggested by the participants. Participants believed that if the MHCUs are given education about their mental illness, it will help the MHCUs to understand their illness and they will see the importance of taking treatment.

In other words, psychoeducation increases and improves the insight of the MHCUs and increase treatment compliance thereby decreasing relapse. Nurses need to be encouraged to continue the pschoeducation programme as it improves the patients

and the caregivers's understanding of the condition. Nurses need to be encouraged to continue with the education that they do in outpatient department while the patients are waiting for the doctors. This will increase the cooperation between the caregiver, MHCUs and families and decrease the blame caused by relapse of MHCUs. This will also alleviate the burden of the caregivers and promote independence as the caregivers will know how to detect signs of relapse early and know how to manage the MHCUs at home.

Education encourages the caregivers to support their mentally ill relatives and caregivers will in turn get support from the staff. Psychoeducation also helps the MHCUs to understand that their illness is chronic and that they need to take treatment even if they feel well. Caregivers and MHCUs will have knowledge about the side effects and how to manage them. This will prevent the MHCUs from stopping treatment or refusing treatment because of side effects.

Educating the community about substance abuse would benefit the caregivers and MHCUs as the participants reported that the community are giving the MHCUs alcohol and dagga. Nurses need to strengthen the outreach programmes and go to communities, schools and churches to educate about the mental illness. This is in line with Uys & Middleton (2010:258) who state that educating patients and their families increases their ability to cope with mental illness and prevent relapse.

- **Collaboration between clinic and hospital**

Participants also suggested that there should be collaboration between hospital staff and clinic staff. Collaboration emerged as a call following the unavailability of treatment of MHCUs in clinics. According to participants, this caused relapse in MHCUs as they stay at home without treatment when it is not available in the clinics. Some participants reported that they stayed away from the hospital, that is, in rural areas, so they do not always have money for transport. So if treatment is not available from clinics it becomes a big problem for them.

In the light of this problem, pharmacists need to be encouraged to do down referrals to clinics so that patients who are referred to nearest clinics could receive their treatment in time. Hospital staff need to enquire the availability of treatment from clinics before referring patients to clinics and the clinic staff need to be made aware

when there is a patient referred to them by the hospital. This is in line with a study by Thomas (2010:4) that readmission can be reduced through improved communication with primary care practitioners.

It also emerged from the interviews that participants preferred long acting injectable antipsychotics than oral antipsychotics with the hope of preventing or decreasing relapse, as it was reported that MHCUs refused to take oral medication. Injection would also benefit the MHCUs in the waiting time as the MHCUs will not need to go to the pharmacy to wait for treatment to be dispensed, but they will go to the outpatient and injection will be given by nurses.

Giving MHCUs injections will provide the staff with reliable information as the nurse will attach signature after the patient has been injected and doctors will not need to ask compliance from the caregiver. MHCUs who are non adherent will be easily detected and followed up. It would be cost effective to give an injection than giving different types of oral antipsychotics. Side effects will be decreased as the patients will not be subjected to polypharmacy.

It also emerged from the interviews that a call from the hospital to remind follow up when the patients does not come for check up will help.

5.3 Conceptual framework

The researcher used Anderson's model of health utilisation (1995) to support the findings of this study. This framework was relevant for this study as it has a theory for thinking about the reasons for patients to be frequently readmitted and it also focuses on the usage of health services. According to this model, usage of health services is determined by three dynamics which are: (1) predisposing factors, (2) enabling factors and (3) needs.

5.3.1 Predisposing factors

According to this model the individual predisposing factors include the demographic characteristics such as age, sex, marital status, education, occupation, ethnicity and mental factors such as attitudes, values, knowledge related to health and health services.

The predisposing factors which were associated with readmission of MHCUs as they emerged from the findings of this study were religion. Religion was associated with relapse of MHCUs as it was identified that some MHCUs refused to take treatment as they believed that they are healed by the pastors prayers.

5.3.2 Enabling factors

According to Anderson, enabling factors entail income/ financial situation, family and community support, means of transportation, waiting time for health care and availability of medical services.

This study suggested that having no source/little income is associated with relapse. One participant reported that they could not come for check up as they did not have money for transport, as such they had to wait until the participant's husband was paid from his job. In that case, the MHCU had to live without treatment until they had the money to go to hospital.

Another financial factor which emerged from the interviews was the misuse of disability grant money. Participants revealed that MHCUs misused the grant money by buying alcohol, giving money to friends and making unnecessary loans. After the money was finished the MHCUs become aggressive, demanded money from relatives and relapsed when they did not get the money from the relatives.

Accessibility as it emerged from the interviews was associated with relapse of MHCUs. Caregivers reported that MHCUs were turned back without treatment by the clinic staff, when there was no treatment at the clinic. This led to relapse and readmission of MHCUs in hospital.

Although family provided support to the MHCUs, it emerged from the data that some MHCUs due to psychotic symptoms, refused the support given to them by their caregivers. Some MHCUs chased caregivers away from home, threatening them and one MHCU stabbed his mother. This causes the caregivers to be afraid to stay with the MHCUs and lead to the MHCUs to relapse and admitted to hospital as there was no one to supervise in treatment.

5.3.3 Need factors

According to the framework, the need factor entails how people view and experience their own health and illness symptoms. In this study, lack of insight emerged as a factor that hinders adherence to treatment and this led to relapse and readmission of MHCUs. The findings of the study suggested that lack of insight, denial and stigma associated to mental illness contribute to relapse.

Participants revealed that psychiatric symptoms such as delusions, hallucinations hindered the MHCUs from taking their treatment. This was evident when the participants reported that the MHCUs refused to take treatment from their caregivers, as the MHCUs believed that their caregivers wanted to kill them.

5.4 Implications

Implications are meanings of conclusions for the body of knowledge, theory and practice (Burns & Grove, 2005:582). This study provides an understanding of the reasons for readmission of MHCUs in the mental health unit in East London. Understanding the factors which enhance readmission of MHCUs may help to improve the MHCUs quality of life, alleviate the family burden and reduce readmissions. This may subsequently reduce costs associated with readmission.

The results of this study if taken into consideration can help to manage better the readmission of MHCUs in the mental health unit in East London. These results may also help the doctors, nurses and hospital at large in planning care and may lead in better understanding of early intervention of relapse and readmission.

5.5 Limitations of the study

This study was conducted in one mental health unit which is within a designated hospital, the findings may have limited generalisability because of the limited data from one hospital. As this is a qualitative study, the sample size was small and the results of this study can not be generalised.

5.6 Conclusions

This study examined factors that influence readmission of mental health care users to a mental health unit in East London as described by their caregivers. The findings of this study revealed several factors that enhance the readmission of MHCUs in a mental health unit in East London. These factors were non adherence to treatment, refusing to take treatment, defaulting treatment, denial, indulging in substance abuse, stigma, effects of the disease and violence and aggressive behaviour.

The above findings helped the researcher to formulate recommendations which may help to decrease or prevent relapse and readmission of MHCUs to the mental health unit in East London. Therefore, the research question was answered and the aim of this research was achieved.

5.7 Recommendations

Based on the findings of this study the researcher recommended the following:

- Measures should be taken to improve compliance through psychoeducation of MHCUs and their caregivers.
- Psychiatric nurses should conduct home visits to mental health care users with a history of missed appointments, nonadherence to psychiatric medication and those who are at risk of relapse.
- Psychaitric nurses should be allowed to make telephone calls for MHCUs who defaulted treatment and those who are at risk of relapse.
- Psychiatrists should consider giving injections instead of tablets if possible to reduce relapse.
- An outreach programme should be designed with an objective of increasing community awareness on the dangerous effects of substance abuse on mentally ill people.
- Collaboration between hospital staff and clinic staff should be emphasised.
- Anti-stigma campaigns to be conducted to make the public aware of the effects of stigmatising the MHCUs.

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Annexure A: Ethical approval from University of Fort Hare

Annexure A: Ethical approval from University of Fort Hare



University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number: MAG03 1SMAH01

Project title: **A study on the factors leading to readmission of mental health care users to a mental health unit in East London as described by caregivers.**

Nature of Project: Masters

Principal Researcher: Nozizwe Patricia Mahashe

Supervisor: Mrs N Magadla

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

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

25 July 2013

Annexure B: Approval from the Eastern Cape Department of Health

From:

To: 0437082544

22/08/2013 15:33

#203 P.001/001



Eastern Cape Department of Health

Enquiries: Zonwabele Merle

Tel No: 040 608 0630

Date: 22nd August 2013

Fax No: 043 642 1409

e-mail address: zonwabele.merle@impilo.ecprov.gov.za

Dear Ms NP Mahashe

Re: A study on the factors leading to readmission of mental health unit in East London as described by caregivers

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

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

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT



Ikama eliasqambhinyo!

Annexure C: Permission from East London Hospital Complex ethics committee

Annexure C: Permission from East London Hospital Complex ethics committee

<i>Ethics Committee: E. L HOSPITAL COMPLEX</i>	
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

27th September 2013

Mrs N P Mahashe
East London Hospital Complex
Amalinda
East London
5200

Dear

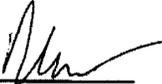
RE: Factors leading to readmission of Mental Health care users to Mental health Unit in East London as described by caregivers.

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 D: Permission from Superintendent



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@impilo.ecprov.gov.za

TO: MRS N. P. MAHASHE
FROM: DR GALO: MANAGER – MEDICAL SERVICES
SUBJECT: RE: PERMISSION TO CONDUCT RESEARCH
DATE: 04 FEBRUARY 2014

Dear Mrs Mahashe

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. You are requested fill in and submit the Indemnity form to the office before conducting the research.

Regards


DR L. GALO
DATE *07/02/14*
MANAGER: MEDICAL SERVICES
CECILIA MAKIWANE HOSPITAL
EAST LONDON HOSPITAL COMPLEX

MEDICAL SUPERINTENDENT
CECILIA MAKIWANE HOSPITAL
PRIVATE BAG X 9047 EAST LONDON 5200
DR LUNTU GALO



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Website: www.ecdoh.gov.za



Annexure E: Consent form

WRITTEN INFORMED CONSENT FOR RESEARCH PROJECT

Title of the study: Factors enhancing readmission of the mental health care users to a mental health unit as described by their caregivers

You are invited to participate in a research study conducted by Mrs.N.P.Mahashe, from the University of Fort Hare (Department of Health Sciences). I wish to learn and understand the factors enhancing readmission of mental health care users to a mental health unit in East London. The aim of the study is to explore and describe factors enhancing readmission of mental health care users to a mental health unit in East London as described by their caregivers and make recommendations to policy makers.

You were selected as a possible participant in this study because you are a relative/caregiver of a mental health care user who has been admitted more than once in the above mentioned unit. Your participation is voluntary. You have a right to withdraw from the study at any time without any penalty. Any information that is obtained in connection with this study will not adversely affect you or the user. If you agree for a tape recorder to be used, your name will not be mentioned in the tape and the recorded information will be destroyed after it has been used. The information that will be gathered for this study will not be misused and will not be shared with others, but it will only be for the research purpose
If you have any questions regarding the study feel free to contact me at this number (083 5926 855) or my supervisor Mrs Magadla at 043 7224 372. Your signature indicates that you have read and understand the information given above and that you willingly agree to participate .

Interviewee

Date

Annexure F: Interview guide

- 1.what do you think are the reasons for readmission of the mental health care user?
- 2.How can you describe the relationships at home between the family and the mental health care user?
- 3.What suggestions would you make to the mental health staff with regards to prevention of relapse and readmission of mental health care users?

Annexure G: Proof of co-coding of analysed data

DEPARTMENT OF NURSING SCIENCES

P.O. Box 1054
East London 5200
Tel: +27 (043) 7047574 Fax: +27 (0866282021)



REGARDING: Co-coding of analyzed data.

This is to confirm that I co-coded analyzed data for MCur Student Nozizwe Patricia Mahashe. Student No: 201206425.

The processes that I embarked on are as follows:

I read her proposal and methodology chapter to understand the approach and the design of choice for the study so as to understand the objectives and the questions the participants had to answer.

I thereafter read how she delineated the meaning units from the data transcripts.

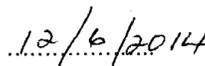
I examined the analyzed data to understand how segments of meaning units were clustered. I then made suggestions with regard to how she and her supervisors could modify categorization of some information so as to come up with the final themes, categories and sub-categories where applicable.

I do have experience in qualitative data analysis and have been utilized by Nursing Science Department to co-code analyzed qualitative data for several studies.

D.Murray



Signature



Date

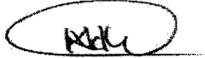
Annexure H: Editors declaration

EDITOR'S DECLARATION

I Dr Ketiwe Ndhlovu (Department of Linguistics UNISA) confirm that I edited Masters Nozizwe Patricia Mahashe (201206425)'s MA dissertation entitled:

A study of factors that enhance readmission of mental health care users to a mental health in East London: A care giver perspective

During the process of editing, the following changes were recommended; grammatical, sentence construction and paragraphing and structural among others. It is up to the candidate to effect these changes as she is the author of this research and thus remains in control of the writing process.



9/06/2014

.....
Editor's Signature

.....
Date

M. Mahashe

12/06/2014

Candidate's Signature

Date