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MENTAL HEALTH CARE USERS’ PERCEPTIONS AND EXPERIENCES OF COMMUNITY RE-INTEGRATION IN THE DIKGATLONG SUB-DISTRICT

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ABSTRACT

Community re-integration is regarded as one of the most significant outcomes of community-based rehabilitation of mental health care users (MHCUs). Without community-based rehabilitation MHCUs experience difficulties with re-integration into communities, resulting in high readmission risks and defaulting on clinic visits and medication. The study aimed to explore and describe the experiences and perceptions of MHCUs community re-integration in the Dikgatlong sub-district. A key objective of the study was to report on the facilitating factors and support needs of MHCUs after their discharge from hospital. The research setting was the Dikgatlong sub-district in the Northern Cape. A qualitative research approach and an exploratory descriptive research design was utilised. Data collection included semi-structured interviews with two key informants and eight MHCUs located in the Dikgatlong sub-district. Interviews were audio-taped, transcribed verbatim and thematically analysed. Measures of trustworthiness were included and ethical clearance for the study was obtained. Four themes were generated from the data analysis process namely; experiences of being a MHCU, facilitators of re-integration, re-integration struggles and it gets easier. The first theme describes participants' experiences of the effects of mental illness and how caring for MHCUs were perceived as a burden by family members and caregivers. Theme two reports on the facilitating factors of community re-integration. The third theme provides insights into the financial struggles and lack of employment opportunities participants experienced and the effects of stigma. The final theme describes how religious faith was a source of strength and a coping mechanism enlisted that enable MHCUs to complete daily tasks and counter relapse. Recommendations include the implementation of community-based groups to address the challenging aspects of community re-integration; establishing family support structures; and advocacy for supported employment opportunities in the Dikgatlong sub-district.

KEY WORDS

Community Re-integration

Occupational Therapy

Rural Communities

Mental Health Care Users

Qualitative Research

Experiences

Perceptions

DECLARATION

I, Nawaal Arendse declare that this thesis: *Mental Health Care Users' perceptions and experiences of community re-integration in the Dikgatlong sub-district;* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Name: **Nawaal Arendse**

Date: **August 2022**

Signed:

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ABBREVIATIONS AND ACCRONYMS

NMHP	National Mental Health Policy
MHCU	Mental Health Care User
MHCUs	Mental Health Care Users
WHO	World Health Organisation
PHC	Primary Health Care
SAFMH	South African Federation of Mental Health
OTASA	Occupational Therapy Association of South Africa
PEO	Person-Environment-Occupation Model
RDP	Reconstruction and Development Programme better known as government subsidy housing
SASSA	South African Social Security Agency

LIST OF DEFINITIONS

Community re-integration: refers to mental health care users moving out of patient roles towards independence and normal adult roles in a community setting (Bond et al., 2004).

Mental Health Care Users: persons receiving care, treatment and rehabilitation services or using a health service at a health establishment. These services are aimed at enhancing their mental health status. Where a mental health care user is a person below the age of 18 year or is incapable of taking decision and in certain circumstance, the definition may include:

(i) a prospective user;

(ii) the person's next of kin;

(iii) a person authorised by any other law or court order to act on that person's behalf;

(iv) an administrator appointed in terms of this Act; and

(v) an executor of that deceased person's estate and "user" has a corresponding meaning; (*Mental Health Care Act 17 of 2002*, 2014).

Mental illness or mental disorder: A confirmed diagnosis of a mental health related illness in terms of diagnostic criteria which is made by an authorized mental health care practitioner (Department of Health, 2013)

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CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

According to the National Mental Health Policy (NMHP) Framework and Strategic Plan 2013 – 2020, neuropsychiatric disorders rank as the third highest disease burdening South Africa, after HIV/AIDS and other infectious diseases such as TB and malaria (Department of Health, 2013). In a national study completed in 2009, 16.5% of adults reported experiencing a mood, anxiety or substance use disorder in South Africa (Department of Health, 2013). Based on these figures, Gerber (2020) notes that mental illness left unaddressed will cost South Africa more than the provision of mental healthcare (Gerber, 2020).

The Mental Health Care Act no. 17 of 2002, defines the term mental health care user (MHCU) as "a person receiving care, treatment and rehabilitation services or using health services at a health establishment aimed at enhancing the mental health status of a user" (Parliament of South Africa, 2014, p.6). Successful community re-integration is regarded as one of the most significant outcomes in the community-based rehabilitation of mental health care users (MHCUs). Community re-integration plays a positive role in reducing the relapse and re-admission of MHCUs (Lund et al., 2012). Community re-integration refers to the ability of a person with a serious mental disorder to live, work and enjoy their free time and day-to-day activities within a community setting as part of the recovery journey (Gamaldien et al., 2021). Community re-integration has therefore been validated as a significant predictor of the quality of life for MHCUs (Stumbo & Ross, 2015) as it contributes to their empowerment and social inclusion (Read, 2009).

When discussing the concept of community re-integration, community needs are understood in relation to the physical boundaries that describe where a person resides and, furthermore, linked to the common rituals and traditions of the community (Stumbo & Ross, 2015). The community is also understood as the immediate environment where the MHCU finds themselves. This environment is constantly changing and has an enabling or constraining effect on a person (Law et al., 2003).

The term recovery is conceptualised as occurring through constant interactions between a person and their world (Sutton et al., 2012). Recovery can be understood as a journey taken by the MHCU. This journey can be unique, uninterrupted and involves the person having active choice, becoming empowered, hopeful and involved in a search for personal meaning (Kelly et al., 2010). When these factors are considered, the impact of the environment is therefore significant and can affect the MHCU's experiences of the community re-integration process.

According to Benjamin et al (2021), the World Health Organisation (WHO) has described that a good state of health exists when individuals can realize their abilities, cope with the normal stresses of life, work productively and contribute to their communities. Community contribution involves the full participation and integration into a community. Social isolation is regarded as a factor that negatively impacts on the caregiving for MHCUs. Other negative factors that impact on caregiving include a limited understanding of mental illness, food insecurity, harsh environments and substance abuse (Sibeko et al., 2016).

The discipline of occupational therapy has been identified as significantly contributing to the rehabilitation and community re-integration of MHCUs (Urlic & Williamson, 2012). A systematic review of the effectiveness of occupational therapy supporting the re-integration into the community and the integration of normative life roles for MCHUs, demonstrated that occupational therapists play a vital role in mental health care service delivery. Moreover, occupational therapy is effective in promoting social participation and facilitating instrumental activities of daily living (IADL), work and education (Urlic & Williamson, 2012).

1.2 PROBLEM STATEMENT

This study emerged through the researcher's identification of a specific need for the development of community-based occupational therapy services for MHCUs in the Dikgatlong sub-district of the Frances Baard District in the Northern Cape, South Africa. The researcher is an occupational therapist who completed her community service year at Prof ZK Matthews Hospital in the Northern Cape in 2013 and was subsequently permanently employed for a period of seven years. During this time, she observed that in cases of relapse, MHCUs would be admitted for a 72hour period of observation at Prof ZK Matthews District Hospital before they were transferred to the specialised psychiatric hospital. It was further observed that MHCUs received mostly pharmacological treatment from primary health care (PHC) facilities and was not referred for any rehabilitative services. In the case of occupational therapy, MHCUs were not referred for any community-based rehabilitation or psychosocial rehabilitation services to assist with community reintegration post their discharge from hospital.

In their review of mental health services in South Africa, Lund et al. (2012) noted that there were limited psychosocial rehabilitation services offered at the PHC level. Another review of mental health service delivery between 2000 and 2010, reported that while much effort was placed on improving policies, these were not matched by an equivalent improvement of service delivery at the PHC level (Petersen & Lund, 2011). Lund et al. (2012), highlight that without availability of community-based rehabilitation services, MHCUs are likely to find it difficult to reintegrate into their communities, thus causing high risks of readmission and defaulting on clinic visits and medication. These views from literature resonate with observations and the opinion of the researcher.

According to the national mental health policy (NMHP) Framework, mental health is positioned as part of the core package of district health and rehabilitation services, which includes the provision of occupational therapy services (Department of Health, 2013). The NMHP Framework proposes a shift toward the servicing of mental healthcare at the PHC level. Much research seems to focus on the perceptions of health practitioners and/or service providers as stakeholders who are actively being involved in mental health service delivery and on caregivers of MHCUs (Schierenbeck et al., 2013 & Sibeko et al., 2016). However, there is little research that places focus on the perspectives of MHCUs about their transition and integration into the lived spaces of their communities.

Accessible and relevant community-based rehabilitation services, including occupational therapy, are important in supporting and facilitating the community re-integration of MHCUs. Research conducted by Gamaldien et al. (2021) investigated the perceptions of MHCUs regarding community re-integration following a residential-based rehabilitation programme in the Western Cape. The study’s findings highlighted the continued limited information about the contribution of such programmes to community re-integration. However, such a residential-based rehabilitation service is currently unavailable in the Northern Cape. Commenting on the availability of resources in rural areas, Benjamin et al., (2021) note that awareness, availability and structural resources for mental health services remain sparse.

While a plethora of research has investigated the provision, availability and effectiveness of mental healthcare services, there is a paucity of research that considers the efficiency of such services from the MHCUs' perspective. The consequences of unsuccessful community re-integration for MHCUs are high; they risk readmission and defaulting on clinic visits and medication (Lund et al., 2012). For occupational therapy services to be relevant in the context of community re-integration, such services should be developed and implemented to address the specific needs of clients. However, limited research and literature have considered the experiences of community re-integration from the perspectives of MHCUs in rural contexts of South Africa. Specifically, MHCUs' perceptions and experiences of community re-integration in the Dikgatlong sub-district are unknown. In the South African context, integrating MHCUs into their communities is highlighted as a provision of mental healthcare services at PHC level. However, no community-based occupational therapy services are available to MHCUs in the Dikgatlong sub-district. The impetus for the current study was therefore premised on a need to understand MHCUs perceptions and experiences regarding their community re-integration after being discharged from hospital, with the objective of generating knowledge that could be utilised towards developing and implementing relevant community-based occupational therapy services in the Dikgatlong sub-district.

1.3 RESEARCH QUESTION

The research question addressed in this study is: *What are the perceptions and experiences of MHCU's in the Dikgatlong sub-district regarding community re-integration post discharge from hospital?*

1.4 RESEARCH AIM AND OBJECTIVES

The aim of the study was to explore and describe MHCUs' experiences and perceptions of community re-integration in the Dikgatlong sub-district.

The objectives were:

i. To explore and describe MHCUs' experiences and perceptions of the challenges they encountered after discharge from hospital.

ii. To explore and describe MHCUs' experiences and perceptions of factors that facilitated community re-integration after discharge from hospital.

iii. To explore and describe MHCUs' experiences and perceptions regarding support needed post discharge from hospital.

1.5 STUDY PURPOSE AND SIGNIFICANCE

The purpose of the study was to explore and describe MHCUs' experiences and perceptions of community re-integration in the Dikgatlong sub-district after discharge from hospital. The findings of the study will enhance occupational therapists' and other healthcare practitioners' understanding of what MHCUs experience of re-integration into the community is in the Dikgatlong sub-district. Service providers will be able to use this understanding to consider possible intervention strategies most suitable to support community re-integration and reduce relapse.

1.6 OUTLINE OF THE THESIS

This thesis is comprised of the following chapters:

CHAPTER 1: Presents the background to the research study, introduces the problem statement, research aims and objectives and the research question. The purpose and significance of the study are also described.

CHAPTER 2: Presents the literature review with reference to the study's conceptual and theoretical framework; literature highlighting mental health services in South Africa, the community re-integration of MHCUs and the role of occupational therapy services in this regard is presented.

CHAPTER 3: Describes the research methodology utilized in the study; the research setting, approach and design as well as the participant selection process is described.

CHAPTER 4: Presents a short profile of the participants and key informants and reports on the findings of the study namely the themes and sub-themes which emerged from the thematic analysis of the data.

CHAPTER 5: Presents a discussion of the research findings by integrating relevant literature.

CHAPTER 6: Provides the main conclusions, offers recommendations informed by the findings and lists the limitations of the study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the literature associated with the research question will be reviewed. Literature pertaining to mental health services in South Africa, community re-integration of MHCUs and the role of occupational therapy services in community re-integration will be reviewed. Lastly, the theoretical framework of the study, which incorporates psychosocial rehabilitation framework and the person-environment-occupation model, are synthesised.

2.2 MENTAL HEALTH CARE SERVICES IN SOUTH AFRICA

Mental illness can affect anyone irrespective of their racial, gender or cultural group, and is defined as a positive diagnosis based on diagnostic criteria made by a mental health care practitioner authorized to make such a diagnosis (Department of Health, 2013). The WHO recognizes that mental illness contributes significantly to the burden of disease and loss of quality of life, resulting in substantial impacts on the economic and social costs of societies (WHO, 2012). A South African study (Herman et al., 2011) provided data on the 12-month and lifetime prevalence of mental illnesses, the results indicate that socioeconomic variations do result in different mental health risks. It was identified that inidividuals with a high-average income had a higher risk to mental illness compared to low-average income individuals. The 12-month prevalence findings show that of the 4351 participants, 42.7% had mild mental illnesses, 26.2% serious mental illness and 31.1% moderate mental illness (Herman et al., 2011). Participants in this study included MHCUs living in households and hostels but did not include prisoners, inpatients or military citizens (Herman et al., 2011).

A 2015 report by the South African Federation of Mental Health (SAFMH) reported that the geographic distribution of MHCUs in South Africa were 28% rural, 35% peri-urban and 37% urban (South African Federation for Mental Health, 2015). A study conducted by Benjamin et al. (2021) explored mental health services in rural South Africa, by focusing on two communities, namely Lamberts-Bay in the Western Cape and Calvinia in the Northern Cape. Pariticipants in this study were comprised of parents of MHCUs and other stakeholders in these communities. The findings highlighted a lack of structural and mental health care resources and services in these rural communities (Benjamin et al., 2021).

Mental health care services in South Africa are mainly offered as in-patient services at facilities classified as psychiatric inpatient units, community residential facilities, psychiatric hospitals and forensic inpatient units. Recently, the need for integrating mental health services into PHC were identified in the Mental Health Care Act 17 of 2002 (Parliament of South Africa, 2014). According to Gerber (2020) the cost of providing mental health care in South Africa is high, however due to limiting factors, failure to treat mental illness will increase costs significantly. According to Petersen and Lund (2011) significant strides were made with respect to the implementation of government policy aimed at deinstitutionalising MHCUs and integrating mental health care service into PHC in the post-apartheid period. The systematic review of all mental health care service research between January 2000 and October 2010 conducted by Petersen and Lund (2011), indicated that the South African government failed to devote the same effort into establishing PHC settings for MHCUs as they had during the deinstitutionalisation process. The same lack of integration of mental health care services into PHC was highlighted by Gerber (2020). Gerber (2020) questioned 95 healthcare practitioners, in the West Rand of the Gauteng Province regarding their opinions of MHCU integration services in PHC settings. It was reported that 65.25% of healthcare practitioners did not believe integration was working due to resistance from practitioners to manage MHCUs, limited knowledge and skills, feelings of uncertainty and incompetence, difficulties with follow-ups due to lack of specialized staff as referral sources for MHCUs and the inaccessibility of clinical files or scripts. The study also noted that almost half (49.5%) of the healthcare practitioners stated they did not support the integration of MHCUs into PHC services. This was due to them experiencing difficulty in managing MHCUs with the increased workload, MHCUs not wanting to wait in queues, MHCUs attachment to specific healthcare practitioners and the increased risk of frustrations and incidents of MHCUs.

2.2.1 BARRIERS TO MHCU ACCESSING AND RECEIVING MENTAL HEALTH SERVICES

Research addressing the topic of the integration of MHCUs in South Africa, tend to focus on comparing mental health care services available at PHC level and those at tertiary or specialized hospitals. This research, however, does not explore the effects of community living. Gerber (2020) argued that health care practitioners noted several challenges experienced at the PHC service level, namely; limited knowledge and skills, increased work load, limited child psychiatric resources, resistance from MHCUs, inaccessibility of patient files, challenges with follow up reviews of medication scripts and inadequate training and support. Gerber’s study investigated the perceptions of healthcare practitioners regarding the integration of mental health care services into PHC but did not focus on community re-integration. Schierenbeck et al. (2013) reported on the access and provision of mental health services at the PHC level in the Eastern Cape. This study also explored the perspectives of health care professionals. The Availability, Accessibility, Acceptability and Quality framework used in this study identified 11 barriers to MHCU accessing and receiving mental health care service (Schierenbeck et al., 2013). These barriers included the inadequate provisions of facilities, transport, and information, the lack of physician or psychiatrists, properly trained mental health staff, limited organizational capacity and community services and preventative care; stigmatization, barriers created by traditional cultural beliefs of community and staff and limited cross-cultural understanding among staff (Schierenbeck et al., 2013).

2.3 MENTAL HEALTH CARE USERS AND COMMUNITY RE-INTEGRATION

Community re-integration refers to the concept of helping MHCUs to move out of patient roles and enabling them to move towards independence and normal adult roles within a community setting and in so doing improve their overall health (Bond et al., 2004). An individual who achieves overall health is seen to be in a state whereby they can realize their abilities, cope with the normal stressors of life, work productively and contribute to their communities (Bejamin et al., 2021). McColl et al. (1988) state that community re-integration combines three concepts; 1) relationship with others, 2) independence in living situations and 3) activities to fill one's time (In Stumbo & Ross, 2015). Stumbo and Ross (2015) furthermore, define community re-integration by drawing attention to the definition of community as the physical boundaries that describe where a person resides and which is inclusive of the social institutions, rituals, and traditions of that community group.

The period of transition from hospital to the community and the rehabilitation of MHCUs is acknowledged as challenging (Cherner et al., 2014). Cherner et. al 2014 reached this conclusion after they researched the transition into community for a group of forensic patients in Ontario using a housing pilot project, despite the creation of a structure to support the participants of the study by providing housing and skills training within a recovery-oriented psychosocial rehabilitation approach. According to Stumbo and Ross (2015) barriers that affect the' community re-integration of MHCUs are limited financial resources, employment resources, and vocational adjustment. Additionally, insufficient social supports and relationships also act as further impediments to community re-integration (Stumbo & Ross, 2015). Further factors identified as influencing the process of successful community re-integration of MHCUs are insufficient skills development in the areas of communication, transportation, time management, problem solving and money management (Stumbo & Ross, 2015). Numerous studies have evaluated the effects of specific programmes aimed at facilitating the transition period of community re-integration (Cherner et al., 2014 & Scanlan et al., 2017 & Gamaldien et al., 2021 & Tirupati et al., 2021).

Scanlan et al. (2017) evaluated the effects of a hospital-to-home programme in Australia. Inpatient staff of a mental hospital identified individuals who were perceived as needing extra support during this transition period. Staff of the hospital-to-home programme consisted of workers who all had their own personal lived experiences of mental illness. Workers were assigned one MHCU to provide practical and emotional support during the transitional period as well as linking the MHCU to community-based supports. Scanlan et al. (2017) identified that the hospital-to-home programme resulted in positive outcomes for the participants in their functional and clinical recovery. Participants also found the lived experiences of programme workers assisted them to ignite their hope for the future and delivered helpful social contacts (Scanlan et al., 2017).

Similarly, Cherner et al. (2014) evaluated the effects of a transitional rehabilitation housing project for forensic MHCUs in two cities in Ontario, Canada. The housing project created a step-down facility in the form of shared residences for MHCUs. The study evaluated the effects of these housing projects on the incidences of re-offending and re-hospitalisation of forensic MHCUs during the post discharge phase. The findings reported that despite some incidences of offences and re-hospitalizations, participants experienced increase levels of independence, developed new skills and acquired social skills. It was furthermore evident from the evaluation of the housing project that post-discharge support played a vital and necessary role and that support should foster independence within the context of supervision (Cherner et al., 2014). The participants in the Cherner et al (2014) study noted that factors which improved function were their new found independence and the ability to do things like cooking and shopping by themselves. They also found that regaining social contacts and being involved in community activities such as sports also improved their function. It was furthermore noted in the findings of the study that the program encouraged healthy lifestyle choices and allowed for self-reflection as factors which improved participants' recovery (Cherner et al., 2014).

Gamaldien et al. (2021) conducted a qualitative descriptive study to determine the perceptions of five male MHCUs following a residential-based rehabilitation programme in the Western Cape. Residential-based programmes were introduced in the Western Cape in 2008 to relieve the burden of long-term hospitalization. The findings of the study highlighted various challenges that MHCUs encountered when integrating into the community. Some of these challenges included following the residential-based programmes which was not flexible to promote personal recovery, stigma and not being serviced by the same health care providers throughout the clinical recovery journey. Participants felt that the programme was inflexible, for example, participants had to decline prospective job offers while they were enrolled in the programme (Gamaldien et al., 2021).

A European based study that focused on six countries, explored how psychiatric rehospitalisation can be avoided and which factors assisted MHCUs to remain in the community (Ådnanes et al., 2020). Focus groups with a total of 55 participants were conducted in these six European countries. The findings of the study demonstrated the importance of planning and preparing for discharge which assisted in creating outlines of treatment options, avoided lack of structure and helped to prevent loneliness. The findings also suggested that medication education, sufficient follow-up sessions with mental health services and being part of a social community were beneficial. All participants mentioned the importance of and benefits derived from having ‘something to do’ after being discharged (Ådnanes et al., 2020).

2.4 OCCUPATIONAL THERAPY AND THE COMMUNITY RE-INTEGRATION OF MHCUs

Occupational therapy fundamentally focuses on occupations. Krupa et al. (2009) assert that occupation is a determinant of health and wellbeing. According to the WHO (2013), health is defined as a state of complete physical, mental, and social wellbeing, not simply the absence of illness or disease. A state of health allows an individual to realize their abilities, cope with life’s stressors, productively engage in work and contribute to the community (Benjamin et al., 2021). The ability to cope with life’s stressors is important, as it enables an individual to balance the occupations of daily life and ensure successful community re-integration. Kelly et al. (2010) noted that limited research has addressed the topic of recovery and occupation. Similarly, limited evidence exists in the literature highlighting the effectiveness of occupational therapy interventions with respect to engagement in community re-integration (Murphy & Shield, 2021).

The American Occupational Therapy Association states that occupational therapy assists people with mental illness with their community re-integration processes and helps them to meet their role responsibilities (Gibson et al., 2011). Occupational therapists are able to assist people who are mentally ill through a process of evaluation and intervention. When working with MHCUs, occupational therapists assess the individual, their environment, and interactions (Gibson et al., 2011). The role of occupational therapy in the context of psychiatric rehabilitation and mental health recovery has been suggested by Krupa et al. (2009) as an important one. Their review highlights how MHCUs may experience "occupational disruptions" (Krupa et al., 2009, p.157). These disruptions include being unable to balance their occupations, and being unable to gain meaningful engagement due to their mental illness or social and cultural exclusions (Krupa et al., 2009). Krupa et al. (2009) argue that occupational disruptions should be intervened by occupational therapy practice to provide assistance at an individual, environmental and community level (Krupa et al., 2009).

A study based in the Limpopo Province assessed the mental health services in a rural setting. It was noted that the primary aim of mental healthcare was the improvement of the wellbeing of MHCUs and their families, through the provision of preventative, psychosocial and rehabilitative services that targeted all levels of service delivery with a multi-disciplinary team (Matsea et al., 2018). However, the Matsea et al. (2018) study reported that not only did other health professionals display limited knowledge about the work of occupational therapists, the services rendered by these therapists were thus underutilised in the field of mental illness (Matsea et al., 2018). Krupa et al., (2009) assert that despite the underutilization, occupational therapy services play a key role in addressing the issue of mental health. The position statement of the Occupational Therapy Association of South Africa's (OTASA) on therapeutic group work in occupational therapy affirms this position (OTASA, 2014). Emphasis is placed on the use of occupation-focused group work as an aspect of occupational therapy. Two studies have highlighted the contribution of occupational therapy towards recovery (Kelly et al., 2010 & Sutton et al., 2012). Recovery from mental illness is described as a process involving personal growth that involves the individual and their ongoing interactions with their environment (Sutton et al., 2012). The concept of recovery and community re-integration has some similarities, as they both highlight the importance of the MHCU's entry and engagement in their community as a meaningful participant.

In a New Zealand-based study, 13 participants were interviewed about their understanding of occupational engagement during their recovery process (Sutton et al., 2012). The study established that the recovery process was not linear (Sutton et al., 2012). Another study that explored the experiences of five participants who were involved in a GROW mental health support group programme in Ireland, found that occupational engagement was a key need during the recovery process (Kelly et al., 2010) These findings support those of the Sutton et al. (2012) study based in New Zealand, and suggest that the concept of recovery occurred as a journey rather than in a linear or chronological fashion. (Kelly et al., 2010).

2.5 THEORETICAL FRAMEWORK

The theoretical framework that underpins this study includes the psychosocial rehabilitation framework (Pillay & Kramers-Olen, 2013) and the person-environment-occupation (PEO) model (Law et al., 2003).

2.5.1 PSYCHOSOCIAL REHABILITATION

Psychosocial rehabilitation refers to a combination of occupational, social, educational, behavioural and cognitive interventions aimed at increasing the quality of life of MHCUs who have serious and persistent mental illness (Pillay & Kramers-Olen, 2013). The terms psychiatric rehabilitation and psychosocial rehabilitation are often used interchangeably, as they capture a similar set of core principles relating to values and attitudes (Kramers-Olen, 2014). According to Anthony and Furlong-Norman (2011) psychiatric rehabilitation was initially understood as the process whereby persons with long term psychiatric disabilities were "assisted to increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention" (p. 1). Psychiatric rehabilitation is currently understood as a rehabilitation strategy that promotes recovery, full community re-integration, and improved quality of life for MHCUs (Anthony & Furlong-Norman, 2011). The operationalization of eight key points associated with the concept of mental health recovery was presented by Anthony (1993) in Kelly et al., 2010). Two of these points state that recovery can occur without professional intervention and that recovery from mental illness occurs in the company of people who trust and support the MHCU in need of recovery (Kelly et al., 2010).

According to the NMHP Framework, the focus of psychosocial rehabilitation is recovery, empowerment, competency, and assisting MHCUs to become more independent and confident to function in their communities (Department of Health, 2013). Within psychosocial rehabilitation, recovery is described as a "symptom reduction, vocational functioning, independent living, and peer relationships" framework (Pillay & Kramers-Olen, 2013, p.277). The NMHP Framework advocates for recovery that is more than the cure or absence of illness but involves healing from the devastating effects of mental illness, allowing an individual to reach their full potential and live a meaningful life (Department of Health, 2013). Rehabilitative efforts should thus focus on social and psychological aspects alongside medical factors.

Psychosocial rehabilitation includes skills training, community support and intervention, which includes occupational, social, educational, behavioural, and cognitive factors aimed at improving quality of life (Pillay & Kramers-Olen, 2013) and reducing the amount of professional intervention and involvement (Department of Health, 2013). Effective psychosocial rehabilitation interventions reflect recovery principles that are person-orientated. Health personnel should provide assistance to the MHCU for as long as they require it and practitioners should be cognisant of the intrinsic ability of the individual to learn new skills and recover (Pillay & Kramers-Olen, 2013). Psychosocial rehabilitation intends to include the active participation of MHCUs in the process of goal setting and treatment planning with the least amount of professional intervention (Kramers-Olen, 2014). As Gamaldien et al., (2021, p.66) argue, “There is no one size fits all” when reporting on the needs of MHCUs in a step-down programme highlighting their recommendations for personalised and flexible programmes.

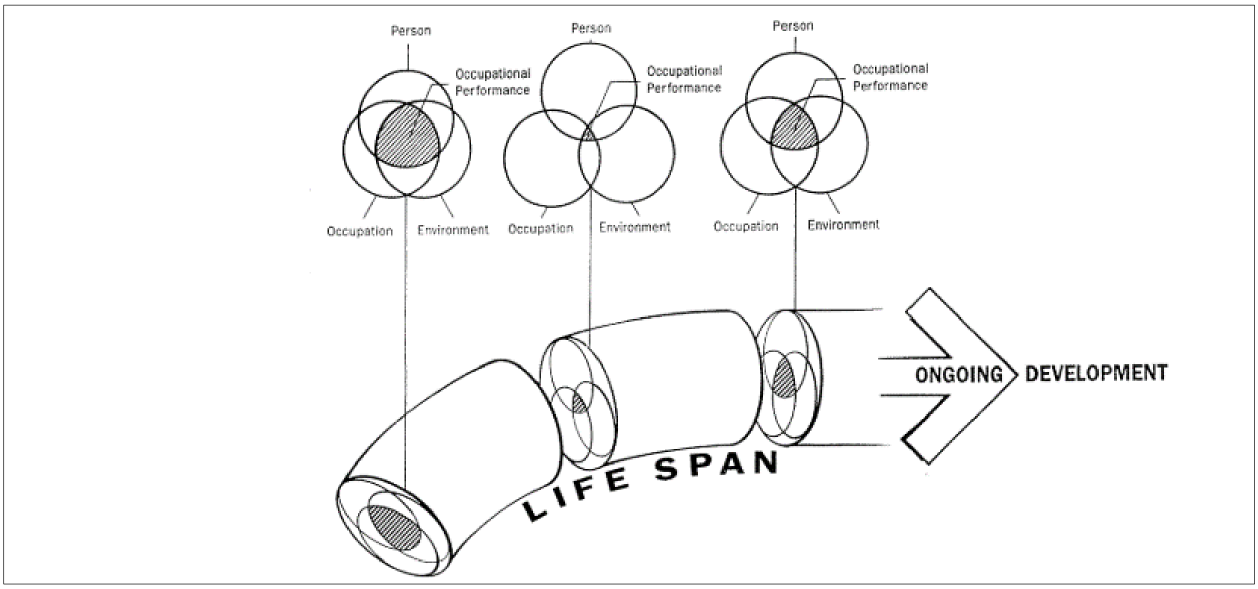
The values which the NMHP framework advocates for are the integration of mental health into general healthcare as well as community-based care and human rights promotion and protection (Department of Health, 2013).. The NMHP framework thus supports mental health services based on recovery models by facilitating the participation of MHCU in determining their chosen roles in communities with an emphasis on psychosocial rehabilitation at community levels (Pillay & Kramers-Olen, 2013). However, observations of the practical realities experienced with implementing the NMHP framework note that, specifically that in rural areas, mental health care services are inadequate. Furthermore, there is scarcity of health professionals employed to cater for mental health services. Additionally, these professionals are under skilled, and there are structural and infrastructure limitations, such as inadequate private rooms for consultation.(Matsea et al., 2018)

2.5.2 THE PERSON-ENVIRONMENT-OCCUPATION (PEO) MODEL

The person-environment-occupation (PEO) model was developed by Strong et al. (1999). It focuses on the complex and dynamic relationships between people, their occupations and their environments (Strong et al., 1999). The model endeavours to facilitate an understanding of the ongoing dynamic nature of occupational performance (Law et al., 2003). Occupational performance is described as the transactional relationship between three interrelating spheres namely, the person, the environment and occupation. These interrelating spheres are always changing and influencing each other therefore causing the occupational performance to change as well. The occupational performance or the occupational outcome is based on what the person experiences with regards to their satisfaction and functioning of occupations within the environment (Strong et al., 1999). When applied to this study, the model is able to account for the MHCUs experiences of their community re-integration and evaluate levels of satisfaction and functioning in occupations within the new environment. Occupational performance can also be understood as the person-environment-occupation ‘fit’ (Strong et al., 1999, p.126)

There are three components of the PEO model, namely the person, environment and their occupations which are represented in spheres as shown in Figure 1. Firstly, the person relates to an individual, a group or an organization. The environment comprises of the cultural, institutional, physical and social factors affecting the occupational performance. Lastly occupations relate to clusters of activities and tasks the person engages in while engaging in various roles (Strong et al., 1999). There are three underlying assumptions to the PEO model. The first assumption is that the person is dynamic, ever developing and interacts within the environment. The MHCU population fits into this assumption and reinforced by Benjamin et al. (2021) which states that mental health is an integral part of one's overall health. Secondly, the environment is constantly changing and has an enabling or constraining effect on the person. The last assumption is that occupations are complex and meet a person's intrinsic need for self-maintenance.

Figure 1: The Person-Environment-Occupation (PEO) Model



(Srong et al., 1999)

The relationships among the three spheres are transactional and difficult to separate. Therefore, the outcome of this transactional relationship is the occupational performance. Additionally, a relationship between the person-occupation, person-environment and environment-occupation also exists and is synthesized within this ongoing transactional relationship. The PEO model can be used in hospitals, community, academic and research settings. It has been proved to be useful in a qualitative study determining the experiences of a group of youth transitioning into adulthood (Strong et al., 1999)

2.6 SUMMARY

The literature review sheds light on the realities of mental health services in South Africa and levels of accessibility for MHCUs. The literature review highlighted the importance of occupational therapy for MHCUs while noting the limited information on the community re-integration. The literature discussed the aspects of integrating the mental healthcare services from tertiary institutions to the PHC level. The theoretical frameworks of psychosocial rehabilitation and the person-environment-occupation model were also described and applied to the current research study.

CHAPTER 3: METHODOLOGY

3.1 INTRODUCTION

The research methodology utilised in this study is presented in this chapter. Firstly, the research setting, approach and design will be described followed by participant selection, the methods of data collection and data analysis will be described. Lastly, trustworthiness and the ethics pertaining to the study will be described.

3.2 RESEARCH SETTING

The research setting for this study was the Dikgatlong sub-district in the Northern Cape Province. The Dikgatlong sub-district covers an area of 7 315 km^2 and is the largest of four sub-districts in the Frances Baard District in the greater Northern Cape. Figure 2 is a geographical representation of the four sub-districts which form the Frances Baard District.

Figure 2: Four Sub-Districts forming Frances Baard Local Municipality

(Municipalities of South Africa, 2020)

The Dikgatlong sub-district has one district hospital, namely, Prof ZK Matthews Hospital. The hospital is a 45 bed facility with 11 supporting PHC facilities. There are five fixed PHC facilities, four satellite clinics, and two non-functional mobile clinics. The residential areas serviced by the non-functional mobile clinics are rendered as outreach services or patients travel to operating clinics. MHCUs in the Dikgatlong sub-district access the PHC services and obtain their monthly repeats for prescribed medication.

The specialised psychiatric hospital, New Mental Health Hospital, is located in Sol Plaatje sub-district and was opened in September 2019. The hospital is 31kms away from the Dikgatlong sub-district while the previous psychiatric hospital, West End Hospital was 34kms away. At the time of data collection the West End Hospital was operational. Six of the eight participants were previously admitted at West End Hospital and only two were admitted to other hospitals as they were living in different provinces at the time of admission.

There are three occupational therapists based at Prof ZK Matthews Hospital, two are permanently appointed and one is a community service therapist. Therapists conduct outreach to one fixed PHC facility. Other surrounding clinics refer patients to Prof ZK Matthews Hospital for occupational therapy services as space at the local PHC facilities is for outreach services. Clinics can also refer clients who cannot travel with home visit requests. Currently, there are no community-based support groups or residential-based programmes facilitated or operational in the area. MHCUs are treated at the district hospital for 72-hour observations and referred to the specialized hospital for further management if necessary or discharged to the care of their family members at home.

Residential suburbs in the Dikgatlong sub-district are owned by the municipality, the community or individual farmers. This results in the inconsistent management of suburbs and basic service delivery. The housing structures in many of the residential areas in the Dikgatlong sub-district range from brick houses to more informal structures built with zinc. While several houses have access to running water or electricity many do not, and typically communal taps are used. The Dikgatlong sub-district population, according to 2016 figures, comprises 48 473 people. 30.5% of this population is under 15years, 61.7% between 15—64 years and 7.8% over 65 years. The last documented rate of unemployment (in 2011) was 39.7%. Educational achievement figures suggest 10.5% of the population have no formal schooling, 22.7% obtained a matric certificate while only 3.4% have higher education qualification. Municipalities of South Africa, 2020)

3.3 RESEARCH APPROACH

The study utilised a qualitative research approach. Austin and Sutton (2014) state that qualitative research involves asking participants about their experiences of a phenomenon in the context of their lives. This enables researchers to gain insights into what it feels like as another person experiences it. The qualitative research approach permits the researcher to examine peoples' experiences in an in depth way by utilizing specific research methods. It foregrounds the identification of issues from the perspectives of the study participants and thus enables understanding of the meaning and interpretation given to those behaviours, events or objects (Hennink et al., 2020).

3.4 RESEARCH DESIGN

The researcher chose a research design that aligned with the aims of the study (Hunter et al., 2019). The current study adopted an explorative descriptive qualitative research design in order to explore and describe MHCUs perceptions and experiences of community re-integration from their own perspectives. Hunter et al. (2019) synthesized the work of Stebbins (2001) and Sandelowski (2000 & 2010) to offer a description of the explorative descriptive qualitative design. As a qualitative research design, explorative descriptive approaches grants the researcher an opportunity to explore a topic which has had limited empirical attention (in Hunter et al., 2019). The experiences and perceptions of MHCUs of community re-integration in Dikgatlong sub-district, has attracted limited empirical research attention. Furthermore, Hunter et al. (2019) states that explorative descriptive research approaches allow the study participants to contribute to the investigation topic. In this manner, explorative descriptive research is able to generate a picture of the world from the research participants' perspectives (Hunter et al., 2019). Explorative descriptive research also aims to explore and describe the experience of participants in relation to the phenomena under study (Hunter et al., 2019). Hence, the phenomenon explored in the study is that of community re-integration from the perspective of the MHCUs.

3.5 PARTICIPANT SELECTION AND RECRUITMENT

Purposive sampling was employed to select participants in this study. This sampling method aims to obtain suitable participants which capitalizes on the representation of a certain population in order to gather essential information to address the aims of the study (Hunter et al., 2019). Additionally, the sample selected allowed the researcher to capture and describe the phenomena (Hunter et al., 2019). MHCUs who attended local district clinics represented the population of MHCUs in the Dikgatlong sub-district. The inclusion criteria provide the main characteristics of the sample, while the exclusion criteria defines factors that exclude unsuitable participants due to the possibility of interference with the success of the study (Patino & Ferreira, 2018). The criteria used for the study are listed below:

Inclusion Criteria:

- Participants 18years and older.
- Participants formally diagnosed with a mental health condition.
- Participants discharged from hospital for a minimum period of 6 months.
- Male and female participants
- Participants able to speak English, Afrikaans and/or Setswana

Exclusion Criteria:

- Participants experiencing an actively psychotic episode.
- Participants awaiting hospital re-admission.

The PHC facility nursing managers were approached by the researcher and asked to identify one possible MHCU who used their PHC service and met the inclusion and exclusion criteria. Each prospective MHCU was provided with the information leaflet (see Appendix 1: Information Sheet - English) about the study. These leaflets were also available in Afrikaans and Setswana (see Appendix 2: Information Sheets – Afrikaans and Setswana). The leaflet described the aims and objectives of the study and was further explained by the PHC nurse. The MHCUs were then contacted via the PHC nurse and invited to participate in the study. Once the information sheet was shared with participants and verbal consent received the researcher arranged an interview at a time and place convenient for the participant. Participants mainly chose venues at Prof ZK Matthews Hospital or their local clinics on days of their regular appointments as these facilities. The researcher secured a private, quiet and suitable venue with chairs and at least a small table. Prior to commencing the interviews the researcher explained the research study and ensured that the participant had received the information leaflet. Issues of anonymity were also discussed and participants were asked to sign the consent form prior to commencing the interview (see Appendix 3: Consent Form - English and Appendix 4: Consent Forms – Afrikaans and Setswana).

Additionally, two family members of the selected participants were invited to participate in the study as key informants. The rationale of the inclusion of these key informants was an interest in obtaining the views of those directly exposed to the phenomena (Fink, 2003) of community re-integration of MHCUs. The selected participants were asked to identify a family member who was then approached to participate in the study as key informant. The criteria for selection as key informant was family members who were male and female and who lived with the participants. Those family members who did not live with participants after their hospital discharge were excluded as key informants. The identified family members were contacted via the participant and their participation in the study requested.

3.6 DATA COLLECTION METHOD: SEMI-STRUCTURED INTERVIEWS

Semi structured interviews are a method of data collection typically used in qualitative research where the experiences and beliefs of individuals on a certain topic are explored (Gill et al., 2008). Semi-structured interviews use various key questions but also make allowance for the interviewer to shift away from these prepared questions or explore other ideas or topics that might emerge in the interview process (Gill et al., 2008). Semi–structured interviews were conducted with the key informants as well as the participants.

3.6.1 KEY INFORMANT SEMI STRUCTURED INTERVIEWS

Semi-structured interviews were conducted with two key informants who were family members of the MHCU participants. The aim of these interviews were to assist the researcher to obtain a holistic and in-depth understanding of how family members experienced the community re-integration process. In the case of this study, family members were selected as key informants because they were able to provide particular knowledge (Fink, 2003) related to the family's encounters with the participants after they were discharged from hospital.

Interviews commenced after written consent was received and the key informants' questions regarding the study were answered. An interview guide (see Appendix 5: Interview Guide – Key Informants) was utilised and addressed specific questions related to how the key informant experienced their family members' re-integration into both the family and community after they were discharged from hospital. The duration of the interviews were approximately 45-60 minutes long. They were conducted at a local clinic that was convenient for the key informant and was scheduled to coincide with the interview of their family member. The interviews were audio-recorded and a verbatim transcript was produced for data analysis.

3.6.2 PARTICIPANT SEMI STRUCTURED INTERVIEWS

Eight (8) individual semi-structured, face-to-face interviews were conducted with MHCUs at an arranged venue. According to Hunter et al. (2019) interviews should be arranged at a time and place convenient to participants to decrease any power imbalance which may exist. Each participant was contacted telephonically and an interview appointment that best suited them was arranged. The interviews commenced with a few open-ended questions, which allowed the researcher to adapt questions and thereby encouraged a more natural conversation (Austin & Sutton, 2014). The interview guide (see Appendix 6: Interview Guide – MHCU participants) was used to direct the interview towards questions that explored the participants experiences and perceptions of their community re-integration, a key objective of the study.

Written consent was obtained from each participant and the participants full understanding of the information presented on the information leaflet was attained before the interviews commenced. The natural conversation was created during the interviews, and this allowed participants to feel comfortable. Data saturation was achieved after eight interviews when responses from participants yielded no significantly new information in response to the questions posed (Guest et al., 2020). The duration of the interviews were approximately 45-60 minutes and were conducted at either the participant's local clinic or at the Prof ZK Matthews Hospital. Private venues with minimal distractions were used and all interviews were audio-recorded and then transcribed verbatim for the data analysis process.

3.7 DATA ANALYSIS

All transcribed interview data from the eight participants and two key informants were analysed using thematic analysis. Thematic analysis is described as a descriptive method that reduces, classifies and organises data according to key themes, concepts and emerging themes (Castleberry & Nolen, 2018). The six phases of data analysis suggested by Braun and Clarke (2006) were followed. The first step is associated with the familiarisation of the raw data and immersion completely in the data by reading and re-reading and listing recurrent themes.

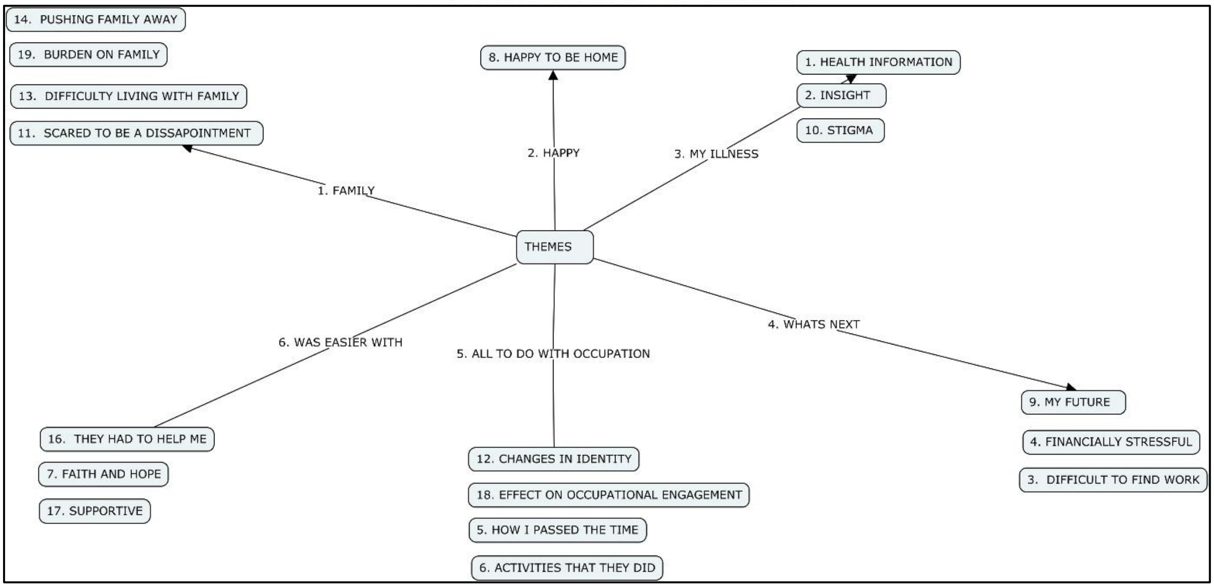
Secondly, the identification of key issues through the coding of data items and the collation of the codes was undertaken. The third phase involved searching through codes, the identification of data similarities and then categorising them into themes and sub-themes. Thereafter, the researcher reviewed the themes and established whether a complete story was generated from the raw data. The processes of reviewing, reconnecting, collapsing and defining the theme encompassed the fourth phase of data analysis. In the fifth phase the themes were written up and the essence of each theme established. The themes should also be defined in relation to the overall story the research aims to tell. The final phase consisted of writing up themes in relation to the existing literature (Braun & Clarke, 2006).

A manual process of data analysis using the Braun and Clark (2006) approach was employed. Once the verbatim transcripts were received, the researcher reviewed each interview to gain familiarity with the data while attempting to close gaps in the documents. Interviews that had a mixture of languages were translated into English. Each interview transcript was read and re-read to identify key issues and coded into a separate excel document. Each code was given a unique number so the researcher could trace the code back to a specific interview. Once all the interviews were coded, the excel documents were printed and each numbered code was cut out separately. All participant interviews were printed on white cardboard and the key informant interviews were printed on coloured cardboard.

Using separate colour envelopes, the researcher then analysed the uniquely numbered codes and grouped codes with similar meaning or significance together. These colour envelopes with groups of numbered codes then formed the possible sub-themes. Storing the sub-themes in this manner made it easier to manage the raw data. Each envelope was given a heading with the corresponding codes related to this label inside. The separately enveloped codes were then re-entered into an Excel spreadsheet using their uniquely numbered codes. This process enabled the researcher to review, reconnect, collapse and define the coding process to generate themes and sub-themes. An inductive process allows meaning to develop from the data analysis (Castleberry & Nolen, 2018). Once the essence of participants' accounts were established, a meeting with the research supervisors was scheduled to discuss the findings.

A mind map of sub-themes was created using the C-map programme. This was peer reviewed by the research supervisors. The mind map of the draft sub-themes and themes are presented below in Figure 3. As a result of the peer review process themes were collapsed and reconfigured to ensure a comprehensive and holistic account of the data was evident before the final themes and sub-themes were formulated.

Figure 3: First Draft of Themes and Sub-themes Mind Map



3.8 TRUSTWORTHINESS

According to Krefting (1991) Guba's Model of Trustworthiness, helps to ensure the trustworthiness of a qualitative research study. Trustworthiness consists of credibility, transferability, dependability and confirmability of the research findings (Krefting, 1991). Credibility (check proposal, add audit trail) refers to the adequate representation of multiple realities (Krefting, 1991). In the current study credibility was ensured through reflexivity, member checking and triangulation. Reflexivity was done by keeping a reflexive journal throughout the research process. The journal served as a means to debrief after each interview and also to record important aspects linked to the data collection process. Peer review was done when meeting regularly with research supervisors to discuss aspects of data collection and data analysis. Triangulation was achieved through the use of multiple data sources, such as conducting eight semi-structured interviews with MHCUs and the two key informant interviews with family members. An audit trail was also maintained through diligent record keeping of all audio recordings, transcriptions and interviews.

Transferability refers to the ability of the research findings to be applied outside of the study context (Krefting, 1991). Transferability was ensured through detailed descriptions of each of the participants and the study setting. Dependability refers to the ability of the researcher to create boundaries between the experience or phenomenon (Krefting, 1991). This was achieved through researcher reflexivity and debriefing sessions with the research supervisors. An in-depth description of the research process was also provided. Confirmability can be achieved when using an audit trail (Krefting, 1991). Hence a record of the research process and data analysis was kept throughout the study.

3.9 ETHICS CONSIDERATIONS

Ethics clearance was obtained from the Biomedical Science Research Ethics Committee of the University of the Western Cape (UWC) Research Ethics Committee (see Appendix 7: Ethics Approval – UWC). Thereafter, permission to conduct the study was also requested from the Northern Cape Provincial Health Ethics Committee and the respective health managers (see Appendix 8: Ethical Approval – Northern Cape). The purpose of the research was thoroughly and carefully explained to all participants in their preferred language. Participants were also provided with an information sheet (see for example Appendix 1 & 2) in their preferred language of English, Afrikaans or Setswana. Participants were ensured that their participation was voluntary and that they could withdraw from the study at any time without experiencing any negative personal consequences. Signed written consent forms (see Appendix 3 & 4) were completed by all participants. These forms and the identities of participants were only accessible to the researcher and the research supervisors. The prescriptions of the POPIA Act were upheld. Confidentiality of all participants was maintained through the process of anonymization and the secure storage of all data collected during the study in a password protected digital folder and only shared with the research supervisors. Anonymity was upheld by creating pseudonyms for participants using numbers that could not be attributed to any specific participant. Hard copies of information were stored in a lockable folder only accessible to the researcher. All study data will be stored in an anonymized state on the UWC research repository, to which only the research supervisors will have access and will be destroyed after a five-year period. Some forms of risks are always possible when humans interact or share experiences and perceptions. Safety measures were taken to ensure the minimization of such risk. A psychologist was available for participant referrals, although none of the participants in this study requested this service, suggesting they did not suffer any adverse effects due to being interviewed.

3.10 SUMMARY

The research setting, research design and qualitative approach adopted by this study was described in this chapter. Inclusion and exclusion criteria used to select participants were also discussed. The data collection methods used and the data analysis process employed were also explained. Approaches used to ensure the trustworthiness of the findings and the ethical principles applied during the research undertaking were outlined. In the following chapter the research findings are presented. .

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

In this chapter, the findings of the study are presented as the themes and sub-themes that was generated from the thematic analysis of the data. Firstly, a short profile of the participants and key informants of the study are provided, followed by a tabulated display of the themes and sub-themes. Thereafter, each theme and their related sub-themes are presented with supporting codes from the interview data.

4.2 PARTICIPANT PROFILES

The participants consisted of eight MHCUs as well as two key informants who are family members of two of the participants. In Table 1 below, a short demographic representation of the participants' gender, age and residing area within the Dikgatlong sub-district is presented. Subsequently, each participant will be described separately and their psychiatric diagnosis, background information, context of where they live and who they lived with, work circumstances, financial background and history of hospital admissions. The key informant descriptions are also provided with information about their age, relation to participant and the area where they live.

Table 1: Demographic Description of Participants

Participant	Age	Gender	Residing Area In Sub-District	Psychiatric Diagnosis
Participant One	52	Female	Gong Gong	Depression
Participant Two	26	Female	Delportshoop	Major depressive disorder, bipolar disorder, personality disorder, borderline personality disorder
Participant Three	37	Male	Longlands	Bipolar disorder
Participant Four	42	Male	Mataleng	Schizo-affective disorder
Participant Five	44	Female	De Beershoogte	Depression & anxiety
Participant Six	48	Female	Holpan	Substance induces schizophrenia
Participant Seven	35	Male	Windsorton	Schizophrenia
Participant Eight	43	Female	Windsorton	Schizophrenia
Key Informant One	60	Male	Gong Gong	Not Applicable
Key Informant Two	32	Female	Windsorton	Not Applicable

4.2.1. PARTICIPANT 1

Participant 1 is a 52-year-old female living in the Gong Gong location and was diagnosed with chronic depression. Participant 1 has had multiple suicide attempts and multiple hospital admissions in the Northern Cape and Gauteng Province. Gong Gong location is a poor socio-economic area with mostly informal and clay housing structures. The Gong Gong location has a clinic which is operational twice a week from 8am-4pm and is approximately 11 kms away from the 24-hour district hospital in Barkly West. There is no electricity in the houses and water is accessible from the nearby river. Most families rely on fish caught in the river as a food source. Participant 1 is unemployed and relies solely on social grants.

4.2.2. PARTICIPANT 2

Participant 2 is a 26-year-old female currently living in the Delportshoop area. She was diagnosed with multiple psychiatric disorders, namely; major depressive disorder, bipolar, personality disorder, and borderline disorder. Additionally, she also has epilepsy and struggles with anger management, alcohol and substance abuse and stress. Participant 2 has had multiple hospital admissions where she was admitted on four occasions; twice for three months, once for one week and her last admission was for six weeks. The Delportshoop community is a large community with both affluent and underprivileged families. The Delportshoop area has a fixed PHC facility in the community that is open daily between 8am - 4pm and the 24-hour district hospital, in Barkly West, is 30 kms away. Participant 2 currently lives with her aunt in a brick house with running water and electricity. She is currently unemployed and receives a social grant, however, assists her aunt in selling goods.

4.2.3. PARTICIPANT 3

Participant 3 is a 37-year-old male who has been living in a safe house in the Longlands area and is diagnosed with bipolar. He has only had one admission to hospital and was in a rehabilitation centre afterward. The Longlands area has mostly Reconstruction and Development Programme (RDP) houses with available running water and electricity. The Longlands area has a fixed PHC clinic in the community that is open daily between 8am - 4pm. The 24-hour district hospital in Barkly West is approximately 21 kms away. Participant 3 was placed in the safe house by the Department of Social Development after an assault in which all his belongings were stolen. The participant was previously employed but was unable to secure work and currently receives a social grant.

4.2.4 PARTICIPANT 4

Participant 4 is a 42-year-old male who resides in the Mataleng location. He was diagnosed with schizo-affective disorder and has had numerous hospital admissions. The area of Mataleng has a fixed PHC facility in the community that is open daily between 8am - 4pm and about 3 kms away from the 24-hour district hospital. Mataleng is a mixed socio-economic location with RDP housing structures and informal structures. Some homes have running water and electricity while others only have water or share an outside communal tap. Participant 4 lives with his brother, sister-in law and their two children in an RDP house. The house has running water and electricity. Currently he has a casual job at a shop but also receives a government social grant.

4.2.5 PARTICIPANT 5

Participant 5 is a 44-year-old female residing in De Beershoogte. She was diagnosed with depression and anxiety with only one hospital admission. De Beershoogte is the residential area close to the main town of Barkly West. The residential area has a higher social-economic status, most houses are built with bricks and have water and electricity. There are RDP houses and a few informal structures. The PHC facility in De Beershoogte is approximately 1 km away from the 24-hour district hospital and is operational daily from 8am - 4pm. She is unemployed and relies on social grants and financial support from her family.

4.2.6 PARTICIPANT 6

Participant 6 is a 48-year-old female living in the Holpan area, which is a farming town where many community members work on the neighbouring farms. The area has a low socio-economic status, with mostly informal housing structures with shared communal taps and outside toilets. The Holpan area has a clinic which is operational twice a week from 8am-4pm, which is roughly 28 km away from the 24-hour district hospital in Barkly West. Participant 6 was diagnosed with substance induced schizophrenia and has had two hospital admission. She is unemployed and receives a social grant.

4.2.7 PARTICIPANT 7

Participant 7 is a 35-year-old male residing in the Windsorton area. Windsorton is a mixed socio-economic area with both formal and informal houses. There is a fixed PHC facility which is operational daily between 8am - 4pm and is roughly 32 km away from the 24-hour district hospital in Barkly West. Participant 7 was diagnosed with schizophrenia and has had two hospital admissions. Participant 7 is unemployed and receives a disability grant.

4.2.8 PARTICIPANT 8

Participant 8 is a 43-year-old female also lives in Windsorton. Participant 8 was admitted for three months, for schizophrenia. At the time of admission, he was employed however after admission did not return to her place of employment and is therefore currently receiving a disability grant.

4.2.9 KEY INFORMANT 1

Key informant 1 is a 60-year-old male who is married to Participant 1. The couple has has two children and reside in the Gong Gong location. Key informant 1 receives an old aged pension.

4.2.10 KEY INFORMANT 2

Key informant 2 is a 32-year-old female who is the biological sister of Participant 7. She is currently unemployed and has one child.

4.3 THEMES AND SUB-THEMES

Table 2 below provides an overview of the themes and sub-themes that was generated from the thematic analysis of the data. Following the table each theme with related sub-themes will be presented.

Table 2: Themes and Sub-themes

THEMES	SUB-THEMES
1. How it is being a MHCU	The illness and its effects
	Effect on the family
	Utilizing health services
2. Facilitators of re-integration	Happy to be home
	Availability of support
	Occupational engagement
3. The re-integration struggle	Financial struggles
	Stigma
	'Now you really don't know who you are'
4. It gets easier	Spirituality, hope and faith
	Ongoing assistance from caregiver

4.3.1 THEME ONE: HOW IT IS BEING A MHCU

Theme One captures participants' experiences of being a MHCU and how they are affected by their illness bio-medically. The influence of their psychiatric condition on participants, their caregivers and family members are highlighted, as are perceptions of the health system and its impact on the participants. The theme is illustrated through three sub-themes namely: the illness and its effects, effect on the family and utilizing health services as presented in Table 3 below.

Table 3: Theme One and Sub-themes

THEME	SUB-THEMES
How it is being a MHCU	The illness and its effects
	Effect on the family
	Utilizing health services

4.3.1.1 The illness and its effects.

When identifying the illness, some participants linked their understanding of the diagnosis to information received about their diagnosis from health professionals.

> *I was actually, in the late 80s, I was called erm chronically depressed. Then in the early 90's they said that I'm manic depressive. And with a bit of schizophrenia and then now, at the beginning of 2000, they say I'm bipolar also with schizophrenic tendencies (Participant 1)*

However, other participants were unable to name their psychiatric diagnosis. When the researcher asked one participant what their diagnosis was, she replied:

> *"Ooh hene (laugh) I don't know" (Participant 6)*

Even though the diagnosis was not known to all participants, they described symptoms associated with their illness and how this affected their thoughts. A participant noted his thoughts were not always clear or 'right'.

> *Yes because my thought were not so right (Participant 4)*

Another participant indicated how the diagnosis made her feel disorientated and uncertain of what was going to happen to her.

> *Ja, I hated not knowing what is going to happen. (Participant 2)*

Another participant also noted experiencing confusion and implied that their psychiatric illness affected their capacity to control their thoughts and actions.

> *Because I walked around confused down the white road up then she walks all after me. Ai then I say my mother I really give you work but I can't help it (laughing) I just come, those thoughts just come and let me walk this direction and that direction then I walk* (Participant 6)

Participant 8 explained how difficult it was to cope with responsibilities such as child care and doing her washing because the medication prescribed for her mental illness caused fatigue.

> *Ek moet my klere self was. Die pille maak my moeg. Ek moet my pille drink. Ek moet my kind versorg. Dit is teveel vir my. Ek kan dit nie handle nie."* [I must wash my clothes myself. The tablets make me tired. I must drink my tablets. I must take care of my child. It is too much for me. I cannot handle it.] *(Participant 8)*

The mental illness affected a participant's ability to achieve their dreams and complete her education as she wished.

> *I would have finished my school. I mean I wanted to become a doctor, but no – a forensic pathologist, that I wanted to become. I would really – that is my dream. But it did not work out that way. (Participant 2)*

In the extract below a participant comments on her uncertainty about the future;

> *That is my thing and where am I going to go? Where am I going to start from the beginning, how am I going to do it? (Participant 2)*

Their illness also influenced participants' ability to cope with and manage their diagnosis. One participant recounted being disoriented and unaware of the drastic effects of their psychiatric illness

> *Well you do feel like an idiot when you eventually wake up and you find out five days are gone. (Participant 1)*

When discussing being diagnosed with a psychiatric illness and its effects, one participant communicated her fear of relapse and how it would upset those she loved. She reflected;

> *I always say to please gentle Jesus never again, because it's not something I want to do again." (Participant 1)*

This participant felt that her psychiatric episodes was her fault and that she should be able control or prevent a relapse from occuring.

> *I just never want to do something like this again to them (Participant 1)*

The participant also expressed feelings of shame associated with a possible relapse which could signal her inability to cope.

> *I was always so ashamed of myself, always so ashamed of what I was doing and everything (Participant 1)*

One participant suggested that suffering a relapse was a result of not being able to cope with her illness. She thus expected to relapse because her family care responsibilities meant she was neglecting herself. She recounted how she hardly took care of herself, saying "*I wouldn't be able to look after myself*". While she understood what she needed to do to take care of herself, she could not do this successfully and therefore felt she would become susceptible to relapsing, as she mentions;

> *I did anticipate that I would become my old self again. My husband, my people. I wouldn't be able to look after myself, it will just always be about them (Participant 5)*

4.3.1.2 Effect on the family

This category highlights the effect of the participants' mental illnesses on the family. A key informant indicated that family members were required to be constantly alert, and they felt less important because of their loved one had a mental illness.

> *So we got to. The children got to be quiet, everybody has got to be on their toes and you understand? We got to always be the least. (Key Informant 1)*

The key informant further emphasised that as a family member he received little information about his wife's diagnosis.

> *Nobody at the hospital, nobody spoke to me (Key Informant 1)*

This lack of information prompted the family to read-up on the diagnosis, its side effects and conducted their own investigation into the illness.

> *There's a lot of side effects. The thing is any book I'll get that and it talk about depression and all, I'll read about it. I'll read and I'll see what that says. This people don't do a lot of them don't do…I have educated myself a lot (Key Informant 1)*

The burden of taking care of participants, however, rests with one or more family members. In the extract, the interviewee comments that even though the participant has a big family that offered support, he has a clear preference for one family member.

> *…if he (the participant) is mad (has a psychiatric episode) he like only me, he like only me (Key Informant 2)*

One participant perceived her loved ones would reject her as a result of her illness, and expressed how she pushed her family members away. The participant stated:

> *I've always expected rejection and I've always received love, but the rejection part is always there and because of that, when I got home I started the rejection process (Participant 1)*

Another participant also avoided being emotionally open with her family members, despite knowing that it would be beneficial to her.

> *Emotions, I did not want to open them up to anything, and then I think if I did it, it would have helped. (Participant 2)*

Some participants experienced difficulties living with their family members. One participant noted how he struggles with his sister-in-law when there are money problems.

> *They (the family) are nice but sometimes if I giving a problems of money and it is my brother's wife (Participant 4)*

The illness affected not only the primary caregiver but also everyone in the household. Family members took turns in caring for participants with the consequence that sometimes they were unable to undertake certain activities or even missed school.

> *Tomorrow the children don't go to school to watch her (pause) then I must go to work (Key Informant 1)*

A key informant described feelings of being 'stuck' and how the illness caused the family suffering and disrupted their normal activities, like sleep.

> *You won't believe me how many times, how many nights I had to sit up…We the one's (suffering) (pause) she's not suffering, she's just got it (the mental illness) (Key Informant 1)*

4.3.1.3 Utilising health services

This category captures participants' experiences of being a MHCU utilizing the health services at the PHC level. Perceptions of using the PHC facilities and expressions of concern and gratitude are also noted. Certain participants indicated how it is beneficial to have easy access or live close to a clinic. One participant mentioned her gratitude, stating:

> *Yes we are happy to have a clinic. And it's also not far to walk." (Participant 6)*

Participants grew accustomed to their PHC facilities and some have their medication delivered to their homes, instead of collecting it at the clinic.

> *If I don't come fetch my medication if I like don't feel lekker that day then she (nurse from PHC facility) sends it to me. (Participant 6)*

Some participants commented on the levels of support they received from the Department of Health. A key informant mentioned his wife preferred to go to a PHC facility further from their home because of poor services received at the PHC facility closest to her.

> *She rather goes there (another PHC) and gets the medication there, because she used to come here (nearest PHC), they (staff of clinic) when there isn't medication, no medication they say "ooh sign here sign here" then she must sign for the medication that she never got" (Key Informant 1)*

4.3.2 THEME TWO: FACILITATORS OF RE-INTEGRATION

This theme highlights the facilitating factors that assisted participants to cope with the initial re-integration into the community immediately after their hospital discharge. These factors convey the sense of happiness when the participant returned home and also the support received from their family members. Some participants noted that their engagement in their occupations facilitated the process of their re-integration. This theme has three associated sub-themes namely: happy to be home; availability of family support and occupational engagement (see Table 4 below).

Table 4: Theme Two and Sub-themes

Facilitators of re-integration	Happy to be home
	Availability of support
	Occupational engagement

4.3.2.1 Happy to be home

Underscored in this category is the general expression of happiness after being discharged from hospital and being reunited with their home and family. Feelings of happiness emerged as a facilitating factor that contributed to the participant's community re-integration. These perceptions of happiness were mutually expressed by family members and loved ones. The extracts below give voice to these feelings:

> *Dit was baie mooi, want ek het, ek het huis toe gekom, het die mense geverlang"* [It was very nice, because I had, I came home, missed the people] *(Participant 7)*

> *But I was happy when I came out there. ...A happy time to come home because I was there for five months already. (Participant 6)*

Another participant indicated how the family and neighbours welcomed her when she returned home. The joy conveyed towards the participant made her feel accepted and had a positive impact on her initial experience of the community re-integration process.

> *Ha ah everyone was just happy, that I am back home. That same day that I came back from the hospital my neighbours and the rest of the friends came to welcome me that I am back at home. (Participant 6)*

Another participant who while affirming her happiness also expressed her desire to not return to hospital.

> *Ek was bly en ek het gesê ek wil nooit weer teruggaan nie* [I was happy and I said I will never again go back there] *(Participant 8)*

4.3.2.2 Availability of support

An additional factor that facilitated the participants' re-integration was the support they received particularly, from family. Some participants noted how family members were willing to be at their side and care for them:

> *Yes the family helped me a lot and my daughter stood by me till now she still stands by me. (Participant 6)*

> *…want my familie was bly, ek wou net by my tannie wees, want sy het mooi agter my kyk. Ek het my kind verlang. Hy het ook vir my verlang"* [because my family was happy, I just wanted to be by my aunt, because she looked nicely after me. I missed my child. He also missed me*] (Participant 8)*

Another participant commented on the type of support she received from her family, attributing her recovery to this support.

> *Ja, my familie het my baie ondersteun"* [Yes, my family did support me a lot]*…At least I got better so quickly because I had the (family) support (Participant 8)*

However, some participants reported that they did not receive family support. Commenting on this a participant said;

> *"Uhm, my aunt that was supposed to – said she was too old. My peetma* [godmother]*, she said she was too old. So no, I did not have any family support." (Participant 2)*

When family members were unable to provide the necessary support, some participants relied on support groups or friends. Such support structures were welcomed and played an important role in the re-integration process. As one participant commented:

> *I didn't know one of these people and uhm once every second week we used to go to Rosebank for a cup of coffee and we talk and somehow or the other I eventually started talking and opening up. It was the longest time I wasn't depressed (Participant 2)*

Another participant mentioned the support he received at the local clinic. He reported how he was able to visit the clinic daily to greet staff, help with minor tasks or complete favours for clinic staff in exchange for a small fee. The participant expressed his enjoyment at being able to engage in these activities at the local clinic as noted in the extract below:

> *Ja, ek like by die kliniek kom. Ek help hulle, as hulle water kort hierso, gaan skep ek hulle water in die ou gebied, hulle ou my rand dat ek my sigarettes koop* [Yes, I like coming to the clinic. I help them, if they short water here, I fetch water in the old area, they give me a rand that I can buy my cigarettes] *(Participant 7)*

4.3.2.3 Occupational engagement

This category highlights participants' engagement in occupations and the enjoyment they derived from these activities, which was regarded as a facilitating factor contributing towards their community re-integration. Some participants with free time engaged in leisure activities, which ensured their time was used constructively. The comment below illustrates this point.

> *Otherwise I am at home, busy at home. Cleaning, basic stuff and then time goes. I did crochet me a blanket. (Participant 2)*

One participant noted that after her discharge, she reassumed various hobbies she enjoyed before her hospital admission. She found these activities beneficial to her community re-integration. She expressed this point as follows:

> *But when I came home. My plants I started talking to my plants started looking after them again. Started doing things and started to do needle work again… then I clean the yard it is nice for me. I walk and sing when I am in the yard (Participant 5)*

These occupational engagements allowed most participants to experience independence and facilitated their community re-integration as they could undertake activities that encouraged self-achievement and gave order to their daily lives.

> *Hmm no I did, it wasn't difficult to wash myself look like I said I did everything for myself and so they said no you must help yourself. (Participant 6)*

The instrumental activities of daily living such as cleaning was also mentioned by another participant as an occupation they participated in systematically.

> *I can work the entire time from the morning till the night. 10 'o clock, 11 'o clock but I knew. I told myself 'Rome was not built in a day' so I will do a room each day (Participant 5)*

4.3.3 THEME THREE: THE RE-INTEGRATION STRUGGLE

In Theme Three factors that hinder participants' experiences of community re-integration are highlighted. Participants noted difficulties in finding and sustaining employment. With limited employment opportunities, the majority of the participants struggled to support themselves and their families financially. Other challenges participants encountered during community re-integration included stigmatization received from the community and difficulties associated with living with their families. Another factor that hindered the re-integration process was the extent to which participants' mental illness changed aspects of their personality. These multiple factors hampered the process of re-integrating for participants. The theme is underpinned by three sub-themes namely: financial struggles, stigma and 'now you really don't know who you are' (see Table 5).

Table 5: Theme Three and Sub-themes

The re-integration struggle	Financial struggles
	Stigma
	'Now you really don't know who you are'

4.3.3.1 Financial struggles

All the participants mentioned that they experienced financial stressors and strains when re-integrating back home.

> *…ek net niemand wat kon vir my gewerk het. My seun hy was mos nog klein. As iemand kon gewerk het, want finansieël gaan dit maar swaar* [I had nobody that could work for me. My son he was still small… financially it is hard] *(Participant 8)*

A primary reason for their financial difficulties was the challenge associated with securing employment as related by one participants who spoke about difficulties encountered with finding work.

> *Baie moeiliker vir 'n psigiatriese pasiënt om werk te kry as wat dit vir 'n normale mens is* [Much more difficult for a psychiatric patient to get work compared to how it is for a normal person] *(Participant 3)*

The same participant also mentioned how demanding it was maintaining employment and how stressful some work situations were for him.

> *"Sy het vir my daai werk gekry, maar ek het net 'n jaar daar gewerk, toe raak die werksdruk te veel vir my."* [She got me that work, but I only worked there for a year, so the work pressure got too much for me] *(Participant 3)*

Other participants found it hard to work mainly due to their psychiatric illness and the symptoms they experienced, as the extracts below illustrates:

> *But still I cannot work, because my mental health problems (Participant 2)*

> *Ek sal nooit kan gaan werk het met die stemmetjies (voices in her head) nie.* [I will never have been able to work with these voices (voices in her head)] *(Participant 8)*

Another participant also described how MHCUs were perceived in society, indicating they were viewed as weaker than others. He notes this perception as a key reason why he struggled to find employment after being discharged from hospital.

> *Want hulle sien, erm, (pause)'n psigiatriese pasiënt sien hulle as 'n swakkeling in die samelewing.* [Because they see, erm, (pause)a psychiatric patient as a weakling in society] *(Participant 3)*

The lack of employment and financial income put strain on the participants' re-integration into the community and had a negative impact on their experiences and perceptions of the transition from hospital to home. The extract below illustrates financial difficulties that resulted from being unemployed.

> *Because if I do not work who is going to give me money. Where am I going to eat? Then I must go to the ground and get money. (Participant 4)*

Similarly, another participant spoke about the difficulties associated with not working or having an income.

> *It is not very easy. Believe me it is not very easy, especially when you do not have anything (money) (Participant 2)*

All the participants received financial assistance through a government social grant, as their mental illness was classified a disability. In the extract below, a participant recounts how he gave his grant money to his sister so that it would pay for this living costs and other expenses.

> *Ja sy hou dit by haar, dan betaal sy die insurance, dan betaal sy die dan die kerk se goete.* [Yes she keeps it with her, then she pays the insurance, then she pays this the church's things] *(Participant 7)*

Another participant reported he gave his brother the social grant money and then received a portion as pocket money that he could use as he liked.

> *The people at my house, when I pay (receive grant), then it's so and so. Money, they don't give me anymore R500. They just give me so R50 (pocket money.) (Participant 4)*

This financial situation however, created pressure for the participant. In the extract below he expressed the stress induced by not having the amount of money he was accustomed to previously.

> *Yes, I come right. But now, the thing is they used to give me every month R500 and that R500 I used to buy me clothes now and then, but now I stress" (Participant 4)*

4.3.3.2 Stigma

Stigma was highlighted as a further factor that hindered most participants' ability to re-integrate back into the community. While participants lived in different areas within the sub-district, they all shared a common experience of community stigma. Most of the participants felt they received little or no support from the community. They felt that community members saw themselves as 'better than us' and as MHCUs, they were thus assigned a lesser status within the community.

> *those people that feel they are better than us. Because they think they think too little of us (Participant 5)*

One participant recounted the embarrassment she felt in relation to the rest of the community, and perceived herself as an 'idiot'.

> *Yes please, so they wouldn't realise what an idiot I was…Nothing, besides having a bag over my head (Participant 1)*

A key informant confirmed this perception and noted that MHCUs only received support from their families and not their communities. In the codes below, the key informant identifies stigma as a factor of struggle for participants.

> *Uhm, with the community, they'll just say Ag man, hulle (MHCUs) is bedonerd of hulle is b-f (crazy)* [Uhm, with the community, they'll just say. Ag man, they are mad or they are crazy] *(Key Informant 1)*

A source of community stigma appears to reside in the misperception that the symptoms experienced by MHCUs, especially during psychiatric episodes, were not real. Community members also did not fully appreciate or understand the extent of their illness and the problems they experienced as a result

> *The outside people they do not understand our problems. It isn't that we are being on purpose (Participant 5)*

Participants were also subject to stigma from their own family members. One participant reported that she felt she did not fit in and how she was unable speak to anyone.

> *…And coming home I felt I didn't fit in …I wouldn't go anywhere and I wouldn't speak to anyone on the phone or my children I wouldn't speak to them (Participant 1)*

4.3.3.3 'Now you really don't know who you are'

Their psychiatric impairment itself appeared to act as a hindering factor to some participants' re-integration. A few participants noted that their psychiatric diagnosis changed their personalities and resulting in a decrease in their self-esteem. Two participants explained how their personalities changed.

> *I came back I wasn't shy for people anymore* (Participant 5)

> *I was a total extrovert (Participant 1)*

These personality changes created difficulties for some participants as they experienced self-doubt and lost confidence in their abilities. These feelings were captured by the participant below who also mentioned the influencing role of alcohol use.

> *…you're already not confident of yourself, you understand? You're already not too sure or exactly who you are. Alcohol plays with your brain, now you really don't know who you are (Participant 1)*

Both key informants mentioned, noticing how participants reacted differently to their mental health condition. Some of these behaviours included being unable to eat or sleeping too much or not at all.

> *She'll sleep it off (Key Informant 1)*

> *He walks around in the field and his too confused now. Then he eats nothing the food if you give he throws it away (Key Informant 2)*

Another participant expressed how she changed because the stress affected her so badly.

> *It (the stress) affected me so badly. The problems affected me so bad. I couldn't eat, I only survived day and night on tea and I started to smoke a lot and it was for me I was really I couldn't eat (Participant 5)*

4.3.4 THEME FOUR: IT GETS EASIER

In the last theme entitled, "It gets easier"; participants' perceptions and experiences about the support factors that made the process of community re-integration sustainable and easier are discussed. This theme (see Table 6 for an overview) comprises of two sub-themes which emerged in the data analysis. The first category addresses participants' experiences and perceptions of spirituality, faith and hope, and the second describes ongoing assistance received from caregivers.

Table 6: Theme Four and Sub-themes

THEME	SUB-THEMES
It gets easier	Spirituality, faith and hope
	Ongoing assistance from caregiver

4.3.4.1 Spirituality, hope and faith

All the participants identified as Christian and shared a common perception that there is a higher power which helped them to gain strength and to get them through the day. Most of the participants reported they relied on their faith and belief in spirituality and religion. This reliance on faith helped create a positive mind-set when dealing with community re-integration. Two participants expressed how their faith in God gave them strength and daily sustenance:

> *Because you cannot be without God, He helps you, He gives you the strength for the day forward. (Participant 6)*

> *And I decided now I am not going to sit alone with my problems. I feel we have a God and I ask Him to help me. Me and Him. So I feel the Lord will bring me through (Participant 5)*

Their faith and belief in God furthermore helped most participants to perceive things differently. A participant expressed how her depression created a darkness but that her belief in faith helped this to change.

> *"I'm in the space that it totally dark, it's so black that the only way out is to try and kill myself but now slowly but surely that darkness is receding it's receding. The more my faith grows, the less the darkness is there" (Participant 1)*

The participant continued, commenting that she believed that her belief in God would guard against a possible relapse as she also did not want to burden her family due to being readmitted to hospital.

> *"And by the grace of God I am not going to put my family through this again" (Participant 1)*

Other participants highlighted how a sense of hope for the future and visions of possibility helped to sustain them during their re-integration. A participant observed the importance of completing her matric and gaining employment. She saw these as achievements that demonstrated her independence and helped her to imagine and plan a future for herself.

> *Working, living uhm, doing stuff for myself…I will do it now, since I have got my pension everything, I am clear, my head is clear, because when I was married, I mean I did not really want to study, I mean really. But now I will. I will – I really want to get my matric. Participant 2)*

4.3.4.2 Ongoing assistance from caregiver

When discussing their re-integration experiences, some participants spoke about the continued assistance they received from their caregivers. The continued assistance from caregivers, who were mostly family members, was essential for many participants who were unable to manage their daily lives independently. In the extracts below, participants recount the level of assistance they received from their primary caregivers.

> *As my kop bietjie uithaak, dan sê ek – die goete praat in my kop in, dan versorg sy vir my. Sy gee vir my kos in die oggende, sy sit vir my water op. Sy sê vat die skottelgoed met water en sy bring vir my skoon klere. Ek was vir my.* [If my head goes off a bit, then I say – the things are talking in my head, then she cares for me. She gives me food in the morning, she puts my water on. She takes the dishes and brings me clean water] *(Participant 8)*

> *My husband would cook all the things I love, he'd basically be all around me" (Participant 1)*

A key informant mentioned how she cleans her brothers' room on a daily basis, stating

> *His (the participant) shack, his room always stays right. I make it right every day (Key Informant 2)*

Participants regarded the type of ongoing help they received from caregivers as a primary means through which family members expressed their love and care. One participant expressed this feeling as follows:

> *my familie is baie lief vir my. As ek so siek is, hulle is bekommerd. Hulle loop kyk my in die nag in, hulle kom soek my waar ek is. Hulle is baie baie lief vir my* [My family loves me a lot. If I am so sick, they are worried. They come and look after me in the night, they come look where I am. They love me a lot] *(Participant 8)*

This need for consistent caregiver assistance was emphasized by a key informant in the following quote:

> *They need the support, they need someone to protect them, to give them food anything they want and people they went people that stay with them. They look after them buy each and everything they need. (Key Informant 2)*

Additionally, the caregivers assisted with medication compliance. A key informant said that he ensured his wife took her medication.

> *Ya, I'll make sure she take her medication every day. Morning and night. (Key Informant 1)*

Another participant noted that his sister made daily inquiries about whether he took his medication.

> *When I forgot my sister tell me 'Do you drink your pills?' I will say 'No, I did not drink my pills just give me, I want the porridge to eat now' (Participant 7)*

4.4 SUMMARY

In summary, this chapter reported the findings of the study as presented through four main themes. Brief introductions of the eight participants and two key informants were provided. Thereafter, the emerging themes and sub-themes were presented. Each theme and its relevant sub-themes were presented with supporting codes. Theme One highlighted participants' perceptions and experiences of being MHCUs. Theme Two provided insight into the factors that facilitated re-integration. Theme Three described the struggles associated with re-integration. Finally, Theme Four explained the factors that made participants' experiences of re-integration easier. In the next chapter, the findings will be discussed in relation to the literature.

CHAPTER 5: DISCUSSION

5.1 INTRODUCTION

In this chapter, the findings of the study will be discussed and supported by relevant literature. The findings will be compared to policies and practices to identify the implications of the research findings.

5.2 CHALLENGES ENCOUNTERED BY MHCUs AFTER DISCHARGE

Evidence presented in the findings of the study demonstrate that participants encountered numerous challenges after their hospital discharge. This is significant to the first objective of the study i.e. to explore and describe MHCU experiences and perceptions of challenges they encountered after discharge from hospital. Challenges which participants encountered included, financial stress, difficulties associated with finding employment, occupational engagement and living with mental illness, the negative effects of social stigma and the lack of social interaction.

5.2.1 FINANCIAL STRESSORS

The major challenge experienced by all participants was the financial stress that resulted primarily from being unemployed and the concomitant financial insecurity this created. The participants all received a disability grant from the South African Social Security Agency (SASSA) as mental illness is classified as a disability. The disability grant allowance, when the study was conducted, amounted to R1600 per month. The disability grant was the only form of income for many participants. Only two of the eight participants were employed as casual workers and earned a minimal wage to supplement their monthly grant allowance. The combination of their unemployment status and the financial insecurity that resulted, placed enormous pressure on participants as they scrambled to make ends-meet and pay for their basic living costs, such as food and transport, and the servicing of loans or insurance costs. This finding is confirmed by Wright (2015), who investigating how disability grant monies were used in the Mpumalanga Province, reported that the allowance was mostly utilized to buy food, clothes, pay for basic services like water, electricity and school fees, and funeral cover premiums. Some households were however, forced to rely on loans to pay for their regular monthly expenses (Wright, 2015). An ethnographic study conducted by MacGregor (2006), based at a psychiatric clinic in Khayelitsha, reported that there is an expectation that MHCUs should receive a disability grant. Officially the purpose of the disability grant is to provide financial support to adults who are unable to work due to their disability (MacGregor, 2006).

The findings of the Wright (2015) study furthermore noted that in some households the grant recipient was the only household member able to contribute to the family finances and the grant thus became the sole form of income. The grant allowance was not seen as a personal allowance, but was instead primarily used to support the whole household and provide basic necessities such as food (Wright, 2015). Similar findings are evident in this study that shows how participants' grant allowance was used to contribute to their family or household income. One participant described the expectation that he hand-over his disability grant money to his primary caregiver, his brother, and only received a small allowance for his own personal use. This was a source of unhappiness. Sibeko et al. (2016) assert that socioeconomic issues can influence the relationship between the caregiver and the MHCU. Brooke-Sumner et al. (2014) make similar claims and they argue that despite receiving social grants MHCUs still experience hardships and poverty. They therefore advocate for psychosocial rehabilitation aimed at increasing productive activity which includes employment, thus enabling the MCHU to better cope with stressors such as those caused by financial insecurity, which might ultimately, promote recovery (Brooke-Sumner et al., 2014). Nhunzvi et al. (2019) also report that other non-biomedical factors play a crucial role in sustaining the health and wellbeing of MHCUs.

The importance of linking MHCUs with community-based programmes in parallel to or prior to discharge is well documented (Janse Van Rensburg, 2005). Psychosocial rehabilitation forms a key aspect of community-based programmes and emphasize that MHCUs should have more control in determining their roles of choice within their communities. Such approaches are aligned with policy frameworks (Kramers-Olen, 2014). For example, the National Mental Health Policy Framework and Strategic Plan 2013-2020 promotes the adoption of the integration of mental health into general healthcare, while asserting that such integration will help to improve the mental health status of South Africans (Department of Health, 2013).

5.2.2 FINDING EMPLOYMENT

Another key challenge to community re-integration which emerged from the findings of the study relates to the occupation of work. Work is an important occupation during adulthood and is essential for financial security and functions as a main factor that signals participating in society. Participants experienced difficulties securing and maintaining employment and the occupation of work was therefore a major challenge to the community re-integration process. Many participants perceived a correlation between their improved mental health and access to work, which was also seen as a vital means to increase their integration into society. In support of the position that work positively contributes towards improved mental health, Soeker et al. (2021) argues that work is one of the foremost performance areas contributing to a vital aspect in the life of MHCUs. Work functions to provide financial stability for the individual and thus is an important component of survival in contemporary society (Soeker et al., 2021). In the

Soeker et al. (2021) study that explored the value of occupational therapy programs in forensic mental health, the findings demonstrated participants' desire to work and to be regarded as part of society. The findings discussed in this study are therefore consistent with those reported by Soeker et al. (2021). Work fulfils a major function in the lives of most individuals and contributes towards their financial security, thus demonstrating their contribution towards the communities in which they live (Smith et al., 2014). Additionally, Smith et al. (2014) emphasized that engagement in work or work-related tasks has a positive impact on the improvement of mental health. While few of the participants in this study were employed, their perceptions about the significance of work, are supportive of the arguments made in the literature referred to here.

In the Dikgatlong Municipality the unemployment rate, when it was last reported in 2011, was 39.7% (Municipalities of South Africa, 2020). There were little indications at the time of this study that the employment rate had increased significantly. It was therefore unsurprising that only two participants in this study reported being employed, albeit in casual positions, and that others expressed feelings of frustration at being unable to secure or maintain employment. The reasons participants advanced for being unable to find employment corresponded to those reported in the Soeker et al. (2021) study. The researchers argue that the economic situation in South Africa poses a key barrier to finding work for all citizens but more so for individuals who suffer from mental illness (Soeker et al., 2021).

The participants also reported their experiences and perceptions of being treated differently because of their mental illness, particularly in the open labour market. According to Engelbrecht and Kasiram (2012) the high unemployment rate in South Africa, means that a person with a mental illness faces more obstacles in finding employment as they are competing in a shrinking pool of available positions. (Engelbrecht & Kasiram, 2012). The findings show that participants perceived that if they disclosed their mental illness to employers it would decrease their chances of being successful in securing a job. Matsea et al. (2018) argue that the influence of stigma is a strong negative factor in all social relationships and denies MHCUs unbiased prospects including employment (Matsea et al., 2018). Furthermore as Yotsidi and Kounenou (2018) note, despite the insufficiencies associated with the process of deinstitutionalisation, MHCUs still indicated that access to empowering opportunities such as employment are beneficial.

Hanisch et al. (2017) also assert that work plays a fundamental role in mental health recovery as it creates a personal sense of achievement and decreases psychiatric symptoms. Given its essential role in recovery, work should be included in the rehabilitation of MHCUs as a means of providing routine, enabling socialization and improving access to basic necessities (Soeker et al., 2021). Soeker et al. (2021) contends that occupational therapists are trained to develop MHCUs' work skills. They further argue that as MHCUs progress towards the point of discharge, they should be given more responsibility and be prepared for community re-integration as well as enskilled to find employment (Soeker et al., 2021). In the Dikgatlong sub-district, this kind of rehabilitation offered as part of the PHC service package would be beneficial for the study population. It would contribute to the improvement of vocational skills which would assist in reducing the burden of financial stress frequently reported by MHCUs. As previously stated, occupational therapists are ideally skilled to facilitate such groups, and indicative of the findings of this study, community-based occupational therapy at a PHC level in the Dikgatlong sub-district is strongly indicated.

5.2.3 OCCUPATIONAL ENGAGEMENT

According to Krupa et al. (2009) occupation is a broad concept that captures the manner in which people do daily life (Krupa et al., 2009). Participants in this study, on their return home after their hospital discharge, encountered multiple challenges in their daily life as they started to engage independently in activities of daily living (ADL's). They experienced the inability to manage all the activities they needed to complete and also performed activities at a slower pace than they had previously. Benjamin et al. (2021) notes that mental health is an integral part of overall health and has a relationship with occupational engagement. Therefore engagement in occupations has an impact on an individual's mental health (Benjamin et al., 2021). Smith et al. (2014) explored the readmission factors of MHCUs diagnosed with schizophrenia. Reasons for readmission reported included poor personal management skills. The study also noted that long term MHCUs were less likely to perform self-care or health promotion activities (Smith et al., 2014). Echoing the importance of occupational engagement, the findings from this current study highlighted that many participants were dependent on family members to complete or assist with their personal management activities. Occupational disruptions as related to mental health was reported by Krupa et al (2009) such as when MHCUs experience occupational imbalance due to the constrained time use for a variety of occupations (Krupa et al., 2009). When an occupational imbalance occurs, MHCUs experience it as an imbalanced time use pattern. For example, taking a very long to complete a task and not managing to have enough time for a subsequent task. Such constrained time use patterns were evident in the findings and it was also shown to limit an individual's capacity to meet a variety of occupations thus resulting in occupational imbalances, similar to those reported by Krupa et al. (2009).

Occupational imbalance is a useful concept as it is able to aid the understanding of the occupational disruption participants experienced during their re-integration into the community and when they needed to start independently engaging in occupations. Thus, it can be argued that occupational imbalance was experienced as a challenge in the community re-integration of the participants. This therefore highlights the importance of PHC services that focus on the occupational needs of MHCUs in the Dikgatlong sub-district. However, community-based services have not assigned a high priority to the occupational needs of MHCUs even though the engagement in occupation is a significant contributor toward stable mental health (Krupa et al., 2009). This further adds support for the crucial need for the development of community-based occupational therapy services in the Dikgatlong sub-district. Primarily because occupational therapists are skilled at addressing occupational disruption and its underlying causes that influence peoples' patterns of participation.

5.2.4 LIVING WITH MENTAL ILLNESS

The participants reported the challenges they experienced of living with a mental illness. Symptoms experienced when they returned home included loss of control of their thoughts, personality changes and the alteration of their actions and behaviours. Gamaldien et al. (2021) observe that a MHCU typically associates their mental illness as the main identifier of themselves and how they are perceived and viewed by others. However, a sense of personal control is essential to the MHCU's successful community re-integration (Gamaldien et al., 2021). The study's findings illustrate that participants experienced confusion and disorientation due to the inability to control their thoughts. This resulted in a sense of uncertainty about events and happenings. Mental health issues are related to challenges linked to controlling feelings, thoughts and behaviours (Kamat & Vajaratkar, 2020). The participants reported that the medication they were prescribed often made them tired and unable to engage in expected activities. They also experienced impairment in task activities when compared to their previous levels of functionality. Common side effects associated with anti-psychotic medication range from agitation, restlessness and anxiety to impaired concentration, blurred vision and dizziness (Morrison et al., 2014). Additionally, Chapleau (2012) reported that people with schizophrenia experience certain challenges associated with engagement in ADL's due to clinical symptoms and drug side effects.

The participants also mentioned how living with a mental illness changed their personalities. One participant mentioned that before the onset of her illness she was a shy person, yet after returning home, she found she was no long that timid. Another participant also reported an almost complete change in her personality shifting from someone who displayed extrovert qualities yet became more withdrawn or introverted.

Comparing psychosocial rehabilitation with approaches that rely solely on pharmaco therapy, Dogu et al. (2021) argue that psychosocial rehabilitation in combination with pharmacotherapy, results in better engagement in ADL's, less psychiatric symptoms and improved social functioning. This is an important factor to consider when interpreting the findings of this study, primarily as the study participants only received monthly medication follow ups with no combined psychosocial rehabilitation. This gap in service delivery appears to have amplified the difficulties which participants reported regarding their experiences of community re-integration. This includes not only having impacted their levels of occupational engagement but also on their overall functioning. These findings are consistent with those reported in a Turkish study (Dogu et al., 2021). The researchers observed that MHCUs who attended only social skills training showed improvement in basic conversation and problem solving but lacked the ability to apply those skills in the real world (Dogu et al., 2021), hence strengthening the case for psychosocial rehabilitation.

5.2.5 STIGMA

Stigma was another challenge that participants experienced when re-integrating into the community. There were two main sources of stigma that they experienced, namely the community and their family members. These sources of stigma match those observed by previous research, namely public and self-stigma (Matsea, 2017). Yotsidi and Kounenou (2018) also suggest that self and public stigma are experienced simultaneously and reduce MHCUs levels of empowerment. While participants did not report experiencing self-stigma, they did voice feelings of guilt and shame about their mental illness.

The outward expression of the negative consequences of community stigma was often evident when participants commented that they preferred staying at home or did not want to socialise or mix with people outside of their homes. Often when attending the clinic, participants recounted being on the receiving end of harsh comments or slurs directed towards them by other community members. Participants described community members as offering little support or showing limited interest in participants and their welfare, instead any contact between participants and community members were primarily transactional, i.e. when community members needed something from a participant. Matsea (2017) defines stigma as a negative connotation attached to an individual causing a negative perception of the group or person. The study's key informants attributed stigma to lack of knowledge among their relatives and the community. These findings are accord with a recent study that explored how people in two rural areas in South Africa, understood mental health (Benjamin et al., 2021). The study observed that stigma is linked to a lack of mental health awareness and understanding and misconceptions regarding mental illness (Benjamin et al., 2021). Additionally, Cremers et al. (2014) noted that MHCUs living in rural areas have a decreased amount of privacy. The lack of awareness and understanding of mental health has a direct link to the help-seeking behaviour of MHCUs (Benjamin et al., 2021). Benjamin et al. (2021) also found that the parents of MHCUs had misconceptions of mental health and similarly lacked a comprehensive understanding of mental illness. Such insights were also echoed by the key informants in this current study who stated that they had to read up and educate themselves to offset their initial lack of information.

According to Engelbrecht and Kasiram (2012) planned services able to meet the needs of MHCUs and their families should be community-based and consist of interventions that are culturally relevant to those being serviced. The literature furthermore notes the imperative to include families in such service planning. Thus Stumbo and Ross (2015) argue that interventions incorporating caregivers is an essential part of service planning and such programmes then deliver a more effective service approach. The implication of these insights suggests that psychosocial rehabilitation should be directed at both participants and their family which in turn will have greater impact on the community re-integration. With increased levels of understanding and awareness of mental illness, the reduction of stigma would be possible, which might lessen the burden experienced by the caregivers.

5.2.6 LACK OF SOCIAL INTERACTION

Returning home to live with family members was experienced by many participants as challenging. Participants frequently reported difficulty with expressing themselves and communicating with their family members, despite recognising that their family were supportive and would probably understand their feelings or experiences. They also acknowledged their withdrawal and non-communication might be perceived as signs that they were rejecting their family. A recent study reported similar findings, highlighting that MHCUs do display uncooperative behaviours and refuse care offered by family members (Modise et al., 2021). Such behaviours have the consequences of leading to stressful relationships between caregivers and MHCUs. Participants in this current study recounted their perceptions of feeling misunderstood and not accepted by their families. They believed their families expected them to better control their mental illnesses. A study conducted by Yotsidi and Kounenou (2018) that investigate the experiences of MHCUs living with their family members in Athens, maintained that while MHCUs found such living arrangements were substantially helpful, it was also a source of discord in the MHCU's social interactions. Research by Marimbe et al. (2016) also reported that caregivers at times also experienced rejection from their extended family members. Furthermore they struggled to attend social gathering as they were unable to find others willing to take over their caretaking responsibilities with the MHCU (Marimbe et al., 2016).

These results emphasise the importance of creating opportunities for social interaction. According to Nhunzvi et al. (2019) social inclusion, defined as a multidimensional technique aimed at supporting full and active participation in all characteristics of life, functions to improve mental health. One participant highlighted her delight when her neighbours celebrated her return home. When community-based rehabilitation services are considered, ways of stimulating and creating social inclusion should be a crucial component as the findings indicate the detrimental effects lack of social interaction has on the participants and their caregivers. The participants would benefit from the opportunities for healthy and meaningful occupational engagement. For groups living with stigmatisation the provision of relevant resources and opportunities should be implemented at the macro level (Nhunzvi et al., 2019). Such resource provisions and opportunities should include those that promote social interaction and improve levels of the occupational engagement through disability advocacy campaigns.

5.3 FACTORS THAT FACILITATE COMMUNITY RE-INTEGRATION

The second objective of the study sought to explore and describe MHCU experiences and perceptions of factors that facilitated community re-integration after discharge from hospital. The facilitating factors identified in the findings are: the meaning of occupational engagement and spirituality, hope and faith.

5.3.1 THE MEANING OF OCCUPATIONAL ENGAGEMENT

Participants' sense of their general mental health improved as they started to engage in occupations. Examples of such occupations included taking an interest in hobbies, such as gardening, crocheting and reading. Kelly et al. (2010, p.130) defined occupation as "the doing of any activity whereby the execution of the task impacts ones culture purposefully". Occupations have the beneficial effect of re-establishing routine, acquiring skills, improving competence and productivity, normalisation, and establishing feelings of meaning, cohesion and creating a sense of social support (Kelly et al., 2010). Participants also reported increased levels of self-pride, when they were able to complete activities such as household chores and engaging in hobbies. These findings confirm those by Sutton et al. (2012) who claim that engagement in occupations created meaning and interaction for MHCUs even as they might shift between low and high levels of engagement. The Sutton et al. (2012) study, conducted in New Zealand, provides additional evidence of the range of occupational engagement levels from complete disengagement to full engagement. Across the different levels of engagement, participants in their study reported feelings of connectedness, self-doubt, purpose and worth.

As levels of occupational engagement increased, participants' levels of satisfaction, acceptance and capacity to manage daily demands also increased (Sutton et al., 2012).

The Ramafikeng et al. (2020) study investigated the experiences of MHCUs accessing a psychosocial rehabilitation day centre. The day centre provided recreational activities, arts and crafts, board games and outings. The day centre also allowed participants to have a specific role in the centre such as serving tea, assisting with cooking or filling the urn (Ramafikeng et al., 2020). The researchers reported that programme activities provided participants with a sense of belonging, while catering for their occupational needs. Ramafikeng et al. (2020) state that some of the benefits of participating in programme activity included improved cognitive functioning, problem solving, attention, learning and decision making. The findings highlighted by the literature (see for example Bond et al., 2004 & Ramafikeng et al., 2020 & Benjamin et al., 2021) suggests that if applied to MHCUs in the Dikgatlong sub-district, the inclusion of such occupational engagement through reactional activities would prove beneficial to the mental health of participants.

5.3.2 SPIRITUALITY, HOPE AND FAITH

The concepts of spirituality, faith and hope were interlinked and gave expression to participants' strong belief in God. God was identified as responsible for assisting participants as they encountered the many challenges associated with their mental illness. The belief in God was regarded as a source of strength and a positive influence in their lives. Participants' association with a church community and being aware that either the pastor/priest or religious community would pray for them, acted as a source of encouragement and helped with their re-integration into their communities. Participants also expressed hope for a more positive future and were able to identify future goals they hoped to achieve such as building a home, finding a job or becoming more independent. They also mentioned moving to a new town, going back to school or returning to their previous town. A positive correlation was previously reported between expressions of hope and self-efficacy, self-esteem, empowerment, spirituality, quality of life and social support (Schrank et al., 2012). Moreover Brooke-Sumner et al. (2014), suggested strategies around the integration of spirituality into psychosocial rehabilitation and occupational therapy programmes.

A study by Sullivan (1993) also reported that 48% of participants viewed their spiritual belief as central to their success. Similarly, Mthembu et al. (2017) noted the significant role of spirituality in community development which appears to promote social change within the community. Additionally, Basset et al. (2008) acknowledged the potential impact on health provided by spirituality. Mental health practitioners are therefore encouraged to recognise the impact of spirituality and harness its potential as a source of strength for MHCUs and their caregivers (Bassett et al., 2008). Religion has long been recognised as a coping mechanism. Psychosocial rehabilitation groups have been encouraged to more suitably incorporate a better understanding of the role of religion and spirituality in the support provisions for MHCUs, rather than dismissing it as a result of psychopathology (Brooke-Sumner et al., 2014). Basset et al. (2008) argue that in the assessment phase of psychosocial rehabilitation, it is necessary to take a holistic approach which includes a consideration of the role of spirituality. By understanding cultural backgrounds and spiritual beliefs, the practitioner will have a better conceptualisation of how spirituality affects health behaviours (Bassett et al., 2008).

As illustrated by the findings of this current study, spirituality provides comfort and can instigate a journey of recovery for MHCUs (Bassett et al., 2008). The findings in this study demonstrate how spirituality, hope and faith was a significant and positive factor that contributed towards community re-integration. It also played a vital role in promoting the health and wellbeing of participants. The inclusion of spirituality in the assessment of MHCUs will be of benefit to the Dikgatlong population. Practitioners will thereby be empowered with a deeper and more holistic understanding of MHCUs' needs which could in turn inform service development. Currently no psychosocial rehabilitation services are offered in the Dikgatlong sub-district, however, it could be initiated at PHC level in which facility staff could include spirituality in the assessment phase. Healthcare practitioners should create interdepartmental collaborations with community-based faith groups and can encourage MHCUs to access them as a means of improving their health.

5.4 ONGOING SUPPORT NEEDS POST DISCHARGE

The final objective of the study required the exploration and description of the MHCU's experiences and perceptions regarding support needed post discharge from hospital. Participants in the current study expressed a need for ongoing support from family and the health service.

5.4.1 ONGOING FAMILY SUPPORT

When participants initially returned home, many relied on family members for assistance with instrumental activities of daily living (IADLs) and ADLs, such as, cleaning up their rooms, helping to cook and person care. This is a finding with concurs with trends evident in low –to-middle income countries where the burden of care for MHCUs commonly becomes the responsibility of the family members and communities where they live (Marimbe et al., 2016). Families and caregivers of those with mental illness, such as schizophrenia, report a sustained burden and experience psychological effects (Mizuno et al., 2012). Family members experience the effects of caregiving with Krupa et al. (2009) stating that the occupational problems experienced by MHCUs can for example, carry over to family members and not only those living with a mental illness. A reason for this can be located in the sense of accountability and care taking responsibility felt by families which extends to activities such as engaging in other occupations and assisting with financial resources (Krupa et al., 2009).

The findings of this study are supportive of other research, especially when key informants mentioned that they had to give up their sleep, provide food and take care of cleaning tasks. Family members also engaged in other occupations such as sharing caring responsibilities for participants at the expense of attending work or school. Research findings also note that because of these caregiving responsibilities, they often have to forgo economic opportunities, like employment, which then exacerbates the levels of poverty in the household (Marimbe et al., 2016).

The support from family members typically continue for an extended period, frequently after the period of initial community re-integration. For example, a participant mentioned that her daughter first supported her when she was discharged, and continued to do so. Palli et al. (2021) confirm that such levels of continuous support and assistance is typical for individuals who suffer from severe mental illness who have to rely on assistance from their families to manage their symptoms, functional impairment and treatment. Additionally, in a survey conducted with 415 MHCU caregivers in Nigeria, it was found that nearly half of the caregivers (49%) experienced psychological distress (Udoh et al., 2021).

Two of the eight participants were mothers and had children they needed to care for, which caused additional strain as they mentioned they were unable to cope with all the responsibilities associated with childcare. This finding of the research thus confirms results reported elsewhere about the additional strain caused by parental responsibilities and activities for parent with mental illnesses (Perera et al., 2014 & Hine et al., 2018). A study by Perera et al. 2014, with eight mothers and 11 staff members at a psychiatric facility, highlighted some of the main challenges associated with motherhood. These included the extra stress and feelings of incompetence and guilt felt by the mothers. The study also reported the need for positive support and assistance with childcare required from spouses and families (Perera et al., 2014).

These findings emphasize the importance of family support in facilitating the participants' community re-integration. Family support would be another aspect which healthcare practitioners should assess when preparing a network of social resources for supporting community re-integration (Mizuno et al., 2012). It can thus be argued, that during admission mental healthcare practitioners at tertiary, secondary or district level hospitals should establish family support for the MHCU. Family support can be provided through educating family members and identifying a main caregiver. Such activities should be part of discharge planning which and would help to facilitate MHCUs' initial community re-integration.

5.4.2 HEALTH SERVICES

The findings of the study reported participants' experiences and perceptions regarding the role of the PHC facility in addressing their needs to achieve successful community re-integration. Participants mentioned how they appreciated having a clinic within walking distance, thus confirming similar insights reported by research conducted in the Mashahane rural area of Limpopo (Matsea et al., 2018). The Matsea et al. (2018) study argued that the accessibility of services was considered an advantage by health care providers. The participants also mentioned how they became attached to a specific PHC facility and healthcare provider, which helped to foster an alliance to the clinic as a support structure. Similar insights were noted by Gamaldien et al. (2021) who identified that the MHCUs require frequent guidance to maintain their mental wellness during recovery and that a key necessity identified by participants was receiving such support from the same healthcare providers throughout their recovery journey.

Participants typically received their monthly medication at the PHC facility, confirming that such local facilities were available to all. Miles and Morley (2013) state that a mental health patient is less likely to be screened for common physical health ailments even though they belong to a group with higher incidents of heart disease, stroke and hypertension. Matsea et al. (2018) reported that available health services were accessible because mental health services are integrated at the PHC level. However, in the Limpopo Province researchers found that there are insufficient services at PHC facilities thus creating levels of unavailability to access to a complete multi-disciplinary team (Matsea et al., 2018). Matsea et al. (2018) further indicated that PHC facilities frequently refer patients to a second or tertiary level facility in order to access the full complementary mental health service. It is crucial that community mental health services should be flexible enough to accommodate MHCUs varying needs (Yotsidi & Kounenou, 2018). At the time of the research, none of the participants were known clients at the occupational therapy department at the Prof ZK Matthews Hospital. This was a factor that acted as a driver for this current study–the lack of access to occupational therapy services for mental health clients when there was proven evidence of the beneficial contribution of occupational therapy towards mental health and community re-integration.

Many researchers identify the importance of the occupational therapy profession as part of the mental healthcare service package (Miles & Morley, 2013 & Rouse & Hitch, 2014 & Kamat & Vajaratkar, 2020). According to a position statement by the World Federation of Occupational Therapist 2019, occupational therapy allows people (including MHCU) to be productive through skills training, group work, community participation, and inclusion, while enabling life participation which influences wellbeing and quality of life (Kamat & Vajaratkar, 2020). Occupational therapy groups in combination with routine follow up clinic appointments would enable MHCUs to derive positive benefits and contribute to the successful community re-integration for participants in the Dikgatlong sub-district.

Clearly established from the findings are the need for occupational therapy practice to be cognisant of the occupational needs relevant to participants. Therapy can include, but not limited to, vocational training, employment skills development, social skills development, psycho education and recreational activities. The practice can also include psycho-education for families and create interdepartmental collaborations which would impact on the community re-integration of MHCUs in the Dikgatlong sub-district. Occupational therapy can also play a role in advocating for meaningful and purposeful occupational opportunities and thereby limiting the occupational injustices experienced by the participants. Since no occupational therapist is employed at the PHC level in the Dikgatlong sub-district, the Department of Health should revisit the role of current occupational therapists and implement stringent targets to address the occupational needs of the MHCUs. Referral policies should be analysed to determine how best to link MHCUs to available occupational therapy services prior to their discharge.

Kramer-Olen (2014) convincingly stresses the importance of interdepartmental collaboration which results in optimal rehabilitation outcomes and sustainability. Interdepartmental collaborations which includes, but are not restricted to, supported employment, educational and skills training facilities and vocational placements (Kramers-Olen, 2014) should be explored when developing psychosocial rehabilitation and occupational therapy services.

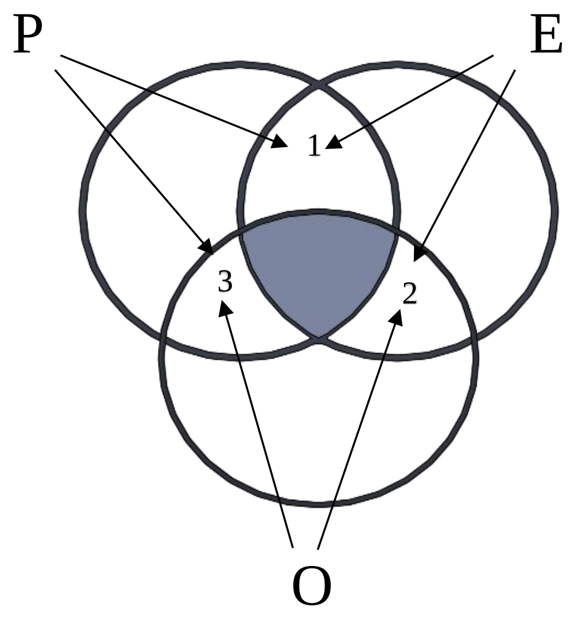
Dikgatlong sub-district would be able to improve the mental health status of the community if such community-based rehabilitation and interdepartmental collaboration are operational.

5.5 COMMUNITY RE-INTEGRATION OF MHCUs IN THE DIKGATLONG SUB-DISTRICT: PERSON-ENVIRONMENT-OCCUPATION INTERACTION

The practical implementation of the theoretical frameworks i.e. the PEO model and psychosocial rehabilitation framework offers a more holistic and comprehensive understanding of how the participants' experience community re-integration. The main focus of the study was to determine how participants perceived and experienced community re-integration in the Dikgatlong sub-district. The eight study participants transitioned through community re-integration and the findings reported on the identified challenges and facilitating factors which impacted on their community re-integration.

Figure 4 presents an illustration of the PEO model which will be discussed below.

Figure 4: The PEO Model



1- Person – environment interaction

2- Environment – occupation interaction

3- Person – occupation interaction

Adapted from Strong et al. (1999)

5.5.1 PERSON-ENVIRONMENT INTERACTION

The occupational injustices which affect the participants should be identified in order that specific practices can be introduced to address these injustices. The factors which impacted on the person-environment interaction were stigma, lack of available health services, financial stressors and the lack of social interaction. The concept of occupational alienation can be used to conceptualise these factors. Occupational alienation is used to label and represent barriers which are external to a person's strength, thus these are factors outside the control of the participant (Krupa et al., 2009). Wilcock and Hocking (2015) suggest that occupational alienation is related to “deep feelings of incompatibility with the occupations associated with a place, situation or others” (in George & Stanley, 2018, p.10). Additionally, occupational alienation is closely connected to powerlessness as often seen in the social exclusion experienced by MHCUs (George & Stanley, 2018). Stigma and financial strain were identified as the main factors which contributed towards the occupational alienation experienced by all the study's participants. It is vital that shortcomings associated with these factors are addressed by mental health practitioners. Attending to these factors would create better occupational opportunities for MHCUs in the Dikgatlong sub-district and thus facilitate their community re-integration. Furthermore, it was noted that some participants experienced factors which were enablers into their community re-integration, such as being welcomed by family and friends on their return home from hospital, having faith-based leaders to pray for them in their need and being surrounded by supporting family members. These factors should also be taken into consideration when considering interventions to community re-integration.

5.5.2 ENVIRONMENT-OCCUPATION INTERACTION

The environment-occupation interaction relates to the limited occupational opportunities available to participants. There were no community-based groups to provide skills training and also no supported employment opportunities which resulted in constrained occupational engagement. The undesirable environment-occupation interaction aligns with occupational deprivation. Occupational deprivation describes circumstances where people are unable to do what is necessary and meaningful since external restrictions prevent such action (George & Stanley, 2018). The environment-occupation interaction and occupational deprivation are significant considerations for advocacy towards ensuring that necessary and meaningful occupations are equally available, accessible and beneficial for the MHCUs in the Dikgatlong sub-district. It creates a purpose for interdepartmental collaborations and possible policy changes for the benefit of participants.

5.5.3 PERSON-OCCUPATION INTERACTION

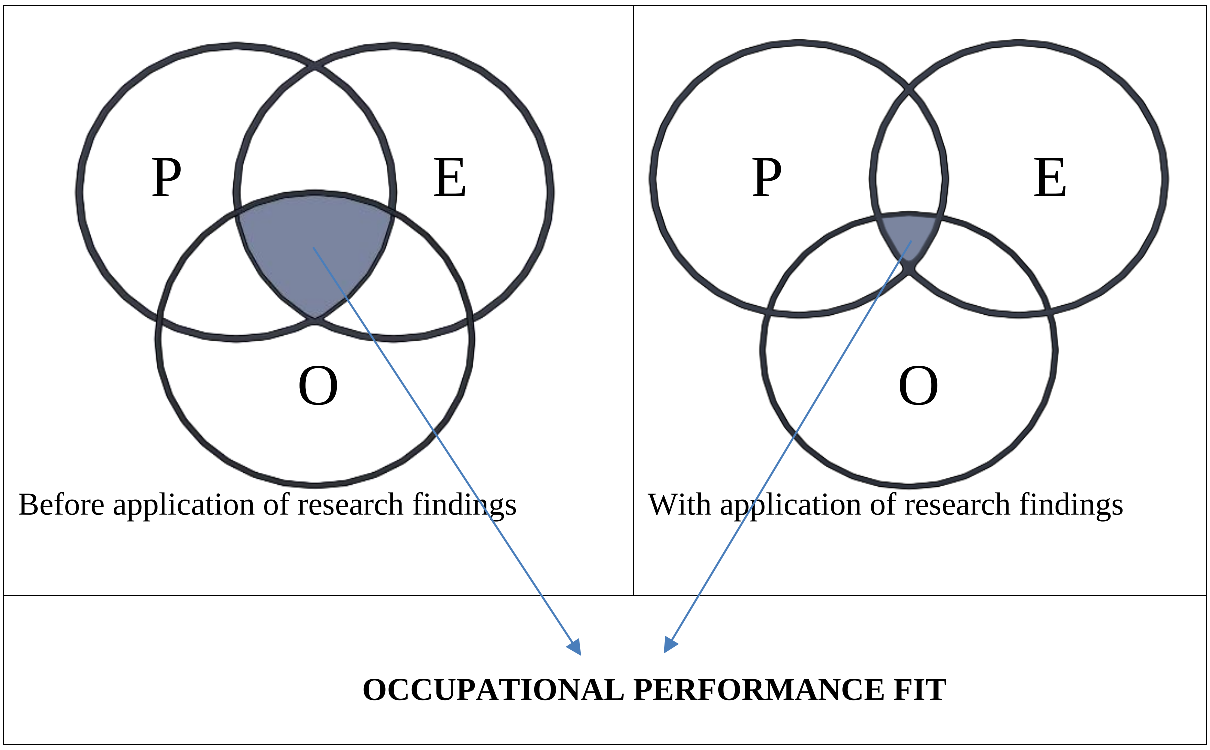
In the person-occupation interaction the applicable factors are the participants' limited vocational training skills which increases the difficulty they experience in finding employment. Additionally the negative side effects of medication impacts on ADLs engagement and decreases social engagement. While participants expressed a desire to work, it was often extremely difficult for them to secure and maintain employment. The occupational injustices relevant here are occupational imbalance and occupational marginalization. Occupational imbalance occurs when a person is over, under, or un-occupied in their engagement in a range of occupations (George & Stanley, 2018). As a result of the multiple side effects participants experienced, they were unable to engage in all ADLs. Occupational marginalisation occurs when people are discriminated against or are prevented from engaging in occupations. Participants recounted that workplaces would not employ them due to their mental illness. These occupational injustices emphasize the importance of mental health awareness and disability advocacy campaigns in communities and workplaces. Mental health awareness cannot be avoided. Policy makers and health awareness campaigns should target all citizens in urban and rural areas.

5.5.4 THE COMMUNITY RE-INTEGRATION

The ability of participants to successfully re-integrate into the community created an incongruent occupational performance fit as depicted in figure 5.

Figure 5 below illustrates the comparison between occupational fit and the constrained incongruences experienced due to the occupational injustices experienced.

Figure 5: Comparison of Occupational Fit



Strong et al. (1999)

As clearly depicted (by the occupational performance fit – in Figure 5) the occupational performance fit is decreased on the right-hand figure after the application of the research findings. It is commonly agreed that community re-integration moves individuals out of patient roles and health centres into typical adult roles in community settings (Tirupati et al., 2021). The transition from adolescent to adulthood is linked to the attainment of income, education, work experience, and independence from parents or caregivers (Lui et al., 2014). Hence, if community re-integration of MHCUs are only assessed against their ability to meet adulthood roles in the definition by Lui et al. (21014), then the participants' experiences will be unsuccessful due to their inability to attain these. Although participants moved from a hospital setting to a community setting they did not attain adult roles once back in their communities. While some participants expressed their desire to obtain an education, none were studying. Most participants were unemployed and all participants received disability grants. Although participants showed varying degrees of independence, most were still dependent on their caregivers for some form of care.

5.6 SUMMARY

In this discussion chapter the objectives of the study were integrated with the main findings of the study and evaluated against the findings of other relevant research. The main sections in this chapter discussed the numerous challenges participants' experiences, alongside their perceived needs and the factors which were seen as facilitating their re-integration into the community. Also discussed in this chapter were the application of the theoretical frameworks. In Chapter 6 the recommendations and limitations of the study will be presented.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

In this chapter, a conclusion of the study is given by presenting a summary of the main research findings. The recommendations and limitations to the study are also discussed in this chapter.

6.2 CONCLUSION

The participants in the study described the numerous challenges experienced when re-integrating into their communities. The main challenges encountered were; financial stressors, limited access to employment opportunities, decreased occupational engagement and stigma. Although all the participants received a disability grant, this allowance frequently did not cover all their basic needs. Unemployment represented a significant concern as their mental illness often precluded their ability to work. However, the high unemployment rate and thus scarcity of employment opportunities, especially in the Dikgatlong sub-district, compounded the ability of participants to secure and maintain meaningful work opportunities. The crucial role played by work to improve mental health was consistently emphasized, alongside the positive contribution it can make to the successful re-integration of MHCUs into the community. The significant and supporting role of psychosocial rehabilitation and community-based occupational therapy in developing vocational skills and diminishing the burden of financial strain was confirmed by the literature.

Despite these reported challenges, participants displayed a broadly, positive outlook on life and were able to describe several factors that positively impacted on their re-integration into their communities. These included; their ability to engage in occupations and the personal strength they derived from their spiritual beliefs and faith. All participants identified as Christian, and their faith and deep reliance on their spirituality and belief in God was identified as fundamental factors that enabled them to navigate daily routines and instilled a general feeling of wellbeing. Despite not always knowing who to turn to during moments of despondency, participants could rely on and entrust God. The influencing role of spirituality and faith and feelings of hope were identified as significant and ways in which to incorporate this into community-based rehabilitation programs should be strongly considered.

Family support and health services were identified as crucial components that enable a successful and burden-free community re-integration process for participants. The significance of family support structures reported in the findings suggests that healthcare providers should consider the availability and consistency of family support when assessing and treating MHCUs. Furthermore, the positive contributing influence of including community-based occupational therapy and community-based psychosocial rehabilitation services as part of mental health service delivery was emphasized.

6.3 RECOMMENDATIONS

The findings of the study affirm the benefit of mental health service development and the role that occupational therapy can play in the treatment and support of MHCUs in rural areas. Particular attention should be devoted to enabling robust family support structures, strategies to decrease stigma associated with mental illness and enhancing supported employment opportunities. Consequently the following recommendations are made:

6.3.1 COMMUNITY-BASED PSYCHOSOCIAL REHABILITATION GROUPS

It is recommended that community-based groups that are available and accessible to MHCUs are implemented in the Dikgatlong sub-district. These groups should address aspects of community re-integration and coping mechanisms and include an education and skills training component as well as a focus on psychosocial rehabilitation and community based rehabilitation to improve the quality of life for MHCUs in rural areas. The groups can be facilitated by healthcare professionals with the assistance of volunteers or community-based rehabilitation workers. The appointment of occupational therapy technicians and community-based rehabilitation workers warrants consideration as they could be employed to facilitate relevant community-based groups.

6.3.2 COMMNUITY-BASED OCCUPATIONAL THERAPY SERVICES

It is recommended that the Department of Health employ additional occupational therapists at the PHC level in Dikgatlong sub-district. Community-based occupational therapy services should be implemented specifically for MHCUs in the Dikgatlong sub-district. Community-based occupational therapy services should facilitate the community re-integration of MHCUs and address the occupational needs of MHCUs already living in the community. The community-based occupational therapy service in collaboration with discharging hospitals should establish and implement a step-down programme to address aspects related to community re-integration such as; occupational engagement, social inclusion, employment, education and skills development, and strategies to combat stigma. These should be enacted through group work, community awareness campaigns and collaboration between inter-departmental stakeholders. For MHCUs already living in communities, further investigations on how to improve the occupational injustices experienced through community-based occupational therapy services should be undertaken. Attention should be placed on the enhancement of pre-vocational skills, the re-establishment of social connections and the promotion of recreational activities. A final recommendation is for occupational therapist working for the Department of Health to become included in mental health service delivery planning and implementation, at all levels of service delivery. Occupational therapists should form part of community-based mental health forums and thus highlight the importance of community-based occupational therapy services.

6.3.3 FAMILY SUPPORT STRUCTURE

It is recommended that the mandatory management of all MHCUs should include a component addressing family support structures and the education to families regarding mental health. Family support structures should be an integral component in the assessment and treatment of all MHCUs. On initial discharge from hospital the healthcare practitioners of that hospital should assess if MHCUs have appropriate and quality family support structures prior to community re-integration as well as the level of insight family has on diagnosis and management of MHCU. As part of routine monthly visits to PHC facilities, healthcare providers should continuously reassess the family support structures to prevent burden of care and to ensure MHCUs receive continuous and necessary support. To accommodate for MHCUs with limited or inadequate family support structures, the services of social workers should be available to assist with the re-establishment of these support structures. Family support groups should be considered to inform and train family members on how to manage and cope with their loved one in order to provide adequate support.

6.3.4 COMBATING STIGMA

Strategies to combat stigma associated with mental illnesses should be implemented. It is recommended that service providers throughout the mental healthcare system, addressing all levels of care, should conduct educational and advocacy programmes aimed at the general public, prospective employers, caregivers and mental healthcare workers. Mental health awareness campaigns should target all citizens and consideration should be given to integrate topics related to de-stigmatization of mental illness into the existing formal educational system. Strategies should include inter-departmental stakeholders to collaborate and create a manner in which public campaigns can create awareness regarding mental health and to aim at de-stigmatization.

6.3.5 EMPOWERMENT FOR SUPPORTED EMPLOYMENT

It is recommended that stakeholders including healthcare workers, policy makers, civil society and social development practitioners advocate for supported employment opportunities for MHCUs, especially in rural areas. NGO’s should be supported to create opportunities for MHCUs that can enable their skills development and increase their social functioning and the ultimate contribution they can make to society. This is regarded as a key mechanism to address occupational deprivation experienced due to the lack of available supported employment opportunities for MHCUs in the Dikgatlong sub-district.

6.3.6 FUTURE RESEARCH

Future research should focus on investigating the experiences of caregivers, families, healthcare practitioners of MHCUs as well as stakeholders such as faith-based leaders and community members as potential target populations. This would contribute towards the development of a more holistic and comprehensive understanding of the many factors that contribute towards the successful community re-integration of MHCUs. Research should also be conducted in other, similar rural contexts, with existing occupational therapy community-based groups to determine their impact on community re-integration.

6.4 LIMITATIONS OF THE STUDY

This study was limited to participants from the Dikgatlong sub-district and the inclusion of participants representative from residential areas within the sub-district. The vulnerability of the study group required the adoption of a cautionary stance and the strict adherence to social distancing and other COVID-19 protocols. Due to the Covid-19 pandemic which limited the gathering of groups, the use of focus groups was precluded as a data collection strategy. COVID-19 further impacted on the number of key informants and thus primary caregivers, who could be interviewed. An exploration of MCHUs community re-integration from the perspectives of caregivers is regarded as a noteworthy and important avenue for any future research, as reflected in the recommendations of the study. Notwithstanding these factors, the study generated a rich and in-depth analysis of MHCUs perceptions and experiences of community integration in the Dikgatlong sub-district.

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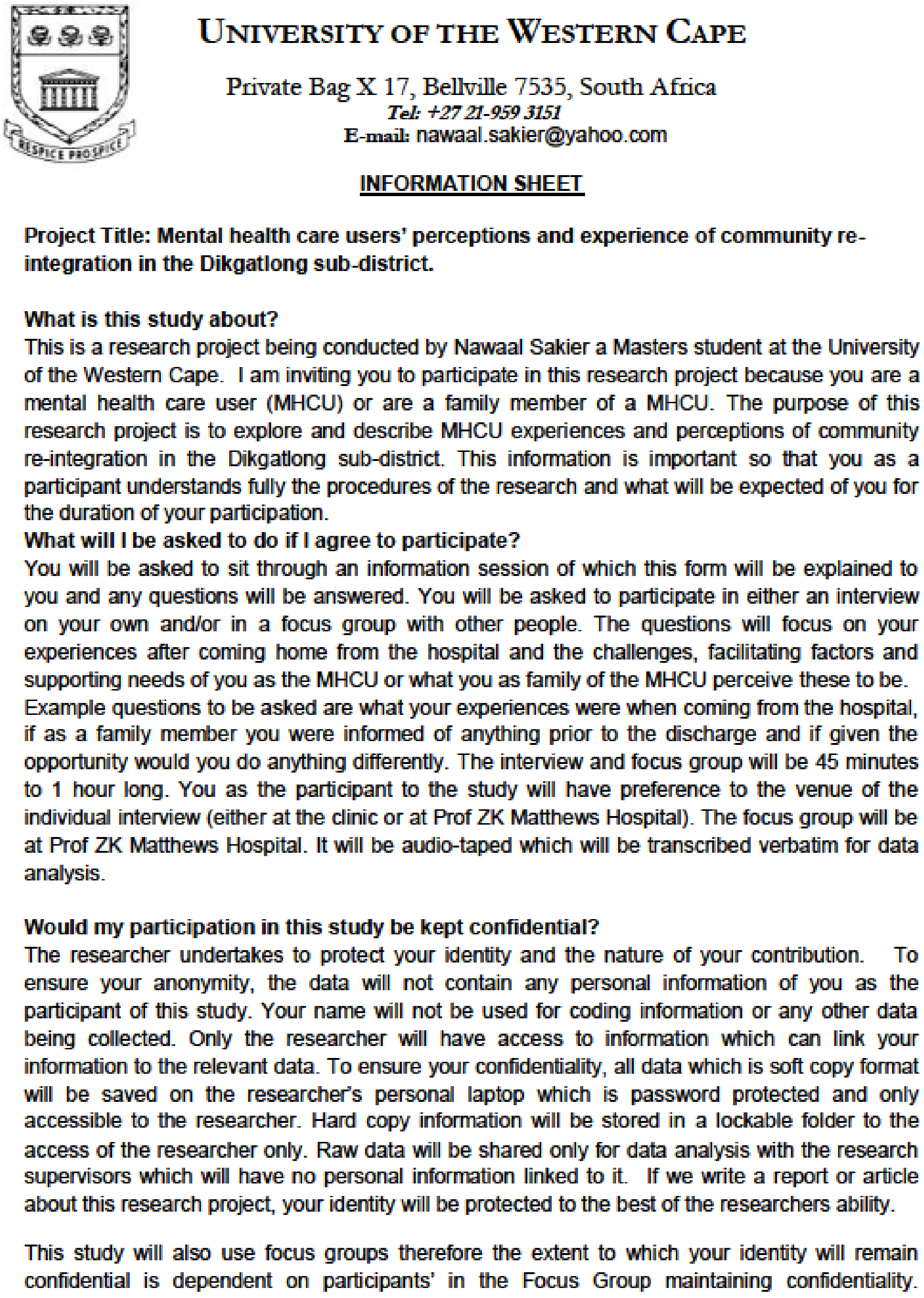
APPENDICES

Appendix 1: Information Sheet - English



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INFORMATION SHEET

Project Title: Mental health care users' perceptions and experience of community re-integration in the Dikgatlong sub-district.

What is this study about?
This is a research project being conducted by Nawaal Sakier a Masters student at the University of the Western Cape. I am inviting you to participate in this research project because you are a mental health care user (MHCU) or are a family member of a MHCU. The purpose of this research project is to explore and describe MHCU experiences and perceptions of community re-integration in the Dikgatlong sub-district. This information is important so that you as a participant understands fully the procedures of the research and what will be expected of you for the duration of your participation.

What will I be asked to do if I agree to participate?
You will be asked to sit through an information session of which this form will be explained to you and any questions will be answered. You will be asked to participate in either an interview on your own and/or in a focus group with other people. The questions will focus on your experiences after coming home from the hospital and the challenges, facilitating factors and supporting needs of you as the MHCU or what you as family of the MHCU perceive these to be. Example questions to be asked are what your experiences were when coming from the hospital, if as a family member you were informed of anything prior to the discharge and if given the opportunity would you do anything differently. The interview and focus group will be 45 minutes to 1 hour long. You as the participant to the study will have preference to the venue of the individual interview (either at the clinic or at Prof ZK Matthews Hospital). The focus group will be at Prof ZK Matthews Hospital. It will be audio-taped which will be transcribed verbatim for data analysis.

Would my participation in this study be kept confidential?
The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, the data will not contain any personal information of you as the participant of this study. Your name will not be used for coding information or any other data being collected. Only the researcher will have access to information which can link your information to the relevant data. To ensure your confidentiality, all data which is soft copy format will be saved on the researcher's personal laptop which is password protected and only accessible to the researcher. Hard copy information will be stored in a lockable folder to the access of the researcher only. Raw data will be shared only for data analysis with the research supervisors which will have no personal information linked to it. If we write a report or article about this research project, your identity will be protected to the best of the researchers ability.

This study will also use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

Therefore due to this jeopardy of your confidentiality all members in the focus group will be asked to sign a focus group confidentiality form.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. The interview conversation involves participants to reflect back on a time period which could or could not have been hurtful to the participant. The researcher will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

As a MHCU who is re-integrated in the community you may not personally benefit from it. Furthermore the results will help the researcher to learn more about community re-integration from the MHCU perspective. I hope that, in the future, other people might benefit from this study through improved understanding of MHCU perceptions and experiences of community re-integration in a rural setting. The benefits include the recommendations to the development of community-based occupation therapy services within the Dikgatlong area.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. You will neither be forced to return to participating in the study at any time while the study is still occurring.

What if I have questions?

This research is being conducted by Nawaal Sakier a Masters student at the occupational therapy department at the University of the Western Cape. If you have any questions about the research study itself, please contact Nawaal Sakier at: Prof ZK Matthews Hospital OT department, 053 531 9424 or nawaal.sakier@yahoo.com .

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: BM/17/1/20)

Appendix 2: Information Sheets – Afrikaans and Setswana

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INFORMASIE BLADSY

Titel van Navorsings Projek: ***Geestestoestand gesondheidssorg gebruikers se persepsie en ervaring van gemeenskapsintegrasie in die Dikgatlong sub-distrik.***

Waaroor gaan die studie?

Hierdie is ‘n navorsings studie wat deur Nawaal Sakier ‘n Meesters student aan die Universiteit van die Wes Kaap voltooi word. Ek nooi u uit om aan die studie deel te neem omdat u ‘n Geestestoestand Gesondheidssorg Gebruiker (GGG) of ‘n familie lid van een is. Die doel van die studie is om te ondersoek en verduidelik wat GGG ondervind en die persepsie van die gemeenskap is tydens her-integrasie in die Dikgatlong sub-distrik. Hierdie informasie blad is belangrik sodat jy as deelnemer al die prosedures van die studie volledig verstaan en presies weet wat van jou verwag word tydens die deelname aan hierdie studie.

Wat gaan van my gevra word sou ek deelneem?

Daar sal van jou verwag word om ‘n informasie sessie by te woon waar hierdie bladsy verduidelik sal word en enige vrae beantwoord sal word. Daar sal van jou verwag word om deel te neem aan ‘n onderhoud op u eie of in ‘n fokusgroep met ander deelnemers. Die vrae sal fokus op jou ervaring nadat jy van uit die hospitaal ontslaan is, uitdagings, fasiliterende faktore en ondersteunings behoeftes van jou as ‘n GGG, of wat die familie van ‘n GGG begryp dit sal wees. Voorbeeld vrae sal wees wat jou ervaring was toe jy uit die hospitaal ontslaan is, of jy as familie lid vooraf van enige iets in kennis gestel was en as die geleentheid gegee word sou jy enige iets anders gedoen het. Die onderhoud en fokusgroep sal ongeveer 45 minute tot 1 uur duur. Jy as deelnemer van die studie sal die voorkeur van vergaderplek van die individuele onderhoud he (plaaslike kliniek of Prof ZK Matthews Hospitaal). Die fokusgroep sal by Prof ZK Matthews Hospitaal wees. Dit sal op band opgeneem word wat dan oorskrywe sal word vir data annalise.

Sal my deelname aan die studie anoniem gehou word?

Die navorser onderneem om u identiteit en bydrae tot die studie anoniem te hou. Die data sal geen persoonlike informasie van u as deelnemer beskik nie. U naam sal nie gebruik word om data te ontleed nie. Slegs die navorser sal toegang tot persoonlike informasie he wat jou tot relevante informasie kan koppel nie. Fisiese afdrukke sal in ‘n toesluit binder gestoor word waartoe net die navorser toegang het. Rou data sal slegs vir data analisie gebruik word met die navorsings fasiliteerders waaraan geen persoonlike informasie gekoppel is nie. Indien daar ‘n verslag of artikel van die studie geskryf word sal jou identiteit anoniem gehou word tot die beste van die navorsers se bekwaamheid.

Die studie maak gebruik van fokusgroepe so die mate waarvan identiteit anoniem gehou word is afhanklike van die konfidensialiteit wat die deelnemers van die fokusgroep. Dit is dus vir daardie rede dat elke deelnemer van die fokusgroep gevra sal word om ‘n vertroulikheids form te teken om annonimiteit te verseker.

Wat is die risikos van die studie?

Alle interaksie met mense en gespreke oor jouself dra 'n risiko. Die onderhouds gesprek verwag van die deelnemer om terug te dink na 'n tydperk wat dalk skadelik was vir die deelnemer. Die navorser sal teen al tye in so 'n geval dadelik optree om die situasie te vergemaklik en enige ongerief tydens die studie te vermy. Wanneer 'n situasie opduik sal die navorser 'n verwysing aan die gepaste gesondheidsorg werker verwys vir intervensie sou dit nodig wees.

Wat is die voordele van die studie?

As 'n GGG wat geher-integreer is in die gemeenskap kan jy dalk nie persoonlik voordeel trek nie. Die studie sal wel die navorser hulp om meer van die her-integrasie van 'n GGG se persoonlike perspektief te leer. Ek hoop dat in die toekoms ander mense voordeel vanaf die studie kan trek deur 'n beter interpretasie van 'n GGG se perspektief en ondervinding van herintegrasie in 'n plattelandse gemeenskap. Die voordele sluit in voorstelle vir die ontwikkeling van gemeenskaps baseerde beroeps terapie dienste in die Dikgatlong sub-distrik.

Moet ek deel wees van die studie en kan ek ten enige tyd onttrek?

Jou deelname aan die studie is heeltemal vrywillig. Jy mag ten enige tyd besluit om van die studie te onttrek. Sou jy besluit om aan die studie deel te neem kan jy enige tyd onttrek. Sou jy op enige stadium besluit om te onttrek en nie meer aan die studie deel te neem nie sal jy nie gepenaliseer word of enige voordele verloor waaroor jy reeds beskik nie. Jy sal ook nie forseer word om weer aan die studie deel te neem terwyl die studie voortgaan nie.

Wat as ek vrae het?

Hierdie navorsings studie word deur Nawaal Sakier 'n meesters student van die Arbeidsterapie Departement aan die Universiteit van die Wes Kaap voltooi. As jy enige vrae oor die studie het kontak asseblief vir Nawaal Sakier by: Prof ZK Matthews Hospitaal Arbeidsterapie departement, 053 531 9424 of epos by nawaal.sakier@yahoo.com.

Sou jy enige vrae hê aangaande die studie en jou regte as 'n deelhebber of jy voel dat jy enige probleme wat jy tydens die studie ervaar het wil raporteer kontak asseblief:

Prof L Wegner
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
lwegner@uwc.ac.za

Prof José Frantz
Dekaan van die Fakulteit Gemeenskaps Gesondheids Wetenskape
Universiteit van die Wes Kaap
Privaat Sak X17
Bellville 7535
chs-deansoffice@uwc.ac.za

Die navorsing studie is goed gekeur deur die Universiteit van die Wes Kaap se Navorsings Etiese komittee. (verwysings nommer: sal deur die onvanger daarvan ingesit word)

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Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 3151
E-mail: nawaal.sakier@yahoo.com

LEKWALO LA TSHEDIMOSETSO

Setlhogo sa patlisiso: ***Maikutlo, megopolo le maitemogelo a badirisi ba ditirelo tsa bophelo tlhokomelo tsa balwetsi jwa tlhaloganyo, mo go busediweng le go amogelwa gape mo motseng wa Dikgatlong.***

Thuto e ke ka go eng?

Se ke patlisiso e e dirwang ke Nawaal Sakier moithuti ko Universete ya Kapa Bokone ke go laletsa go tsaya karola mo patlisisang e gonne o na le bothata tlhaloganyo, kgotsa o le leloko la losika lwa botlhoko jwa tlhaloganyo jaaka mo tsaya karola mo go ithuteng ga me. Maitlhomo magolo mo matlisisang e ke go tlhaloganya kitso le maitlhomo a MHCU go anamisa kitso mo motsing wa Dikgatlong.

Ke eng se ke tla kopiwang go se dira fa ke dumalana go tsaya karolo?

O tla kopiwa go dula go newa kitso e mo papetlaneng e tla beng o e tlhalosetswa le dipotso di tla arabiwa. O tla newa tetla yo go saena pampiri ya tetlelelo kgotsa ya sephiri, go tla tswa gore ke puisana ya mofuta ofeng e o tla nna metsotso e 45 go fitlhela go ura e le nngwe boleele. Fa o memelwa kopano e nngwe gape e tla nna setlhopha sa batsaya karolo. Nako e tletseng e o tla mo gereng wena o tla nna teng mo puisanon. Kopakopano ya dipotso tse di tla bodiwang di tla akaretsa dikgwetlho, dithutho, gammogo le kemanokeng e o e tlhokang jaaka MHCU kgotsa wena jaaka leloka la MHCU go amogela tse ka teng.

A tsenelelo ya ka mo thutong e, e tla nna sephiri?

Mobatlisisi o tshwanetse go sireletsa seemo se gago le maema a go tsenelela ga gago mo patlisisang e, go direla go sa itsegeng gag ago. Kgobokanya ya kitso e ka se nne le sepe sag ago jaaka mo tsaya karolo mo thutong e. Leina la gago le ka se tlhagelele go naya tshedimosetso e e tla kgobokanwang. Mobalitsisi ke ena fela yo o tla nna le tshedimosetso e e siameng. Go dira bonnete gore sephiri sa gago ga se itsiwe. Go ithuta gag ago go tla dira gore go tsaya tsia ga gagogo tswelele mo eleng gore seemo sag ago se tla sireletsega. Setlhopha sa batho ba tla kopiwago saena lokwalo lwa go tshwara sephiri.

Ke dikotsi dife tse di mo patlisisong e?

Batho botlhe ba ba tsayang karolo ba bua ka bona kgotsa ka ba bongwe ba rwele morwalo wa dikotsi. Mo puisanong e go akareditswe ba tsaya karolo go nagana ka tse difetileng jaaka tsa go utlwisa kgotsa tsa go se utlwise botlhokogo ba tsaya karolo. Mobatlisisi o tla fokotsa dikotsi tseo, le go go thusa fa o le mo maemong a a sa itumediseng. Fa go tlhokega mo batlisisi o tla go romela kwa go ba bagolo go thusa mo go tlhokegang

Moshola wa patlisiso e ke ofeng?
Dipatlisiso di tlile go tswela baagi ba Dikgatlong mosola. Jaaka molwetsi wa tlhaloganyo ga nkita o ungwelwa sepe mo dipatlisisong, mme e tla thusa mo batlisisi go ithuta go kopantsha molwetsi le baagi. Ke tsepa gore mo tsamaong ya nako batho ba tla ungwelwa go ithuta go tlhaloganya molwetse wa botlhoko jwa tlhaloganyo.

A ke tshwanetse go nna mo dipatlisisong kgotsa go tlogela nako le nngwe?
Go tsaya karolo ke go ithaopa, o ka tsaya karola mme fa o batla go ikgogela morago o na le tetla ya go ka dira jalo. Ga nkitla o bonwa molato ope, ebile o ka se latlhegelwe ke sepe mo maemong a gago. Go nkita o patelediwa go tsaya karolo fa dithuto di tsweletse.

Jaanong fa ke na le dipotso?
Fa o nale dipotlisiso o ka ikopanya le Nawaal Sakier kwa bookeng jwa Prof ZK Matthews mo diphaphosing tsa OT, 053 531 9424 or nawaal.sakier@yahoo.com .
Jaaka motsaya karolo wa patlisiso a nale dipotso ka patlisiso le ditshwanelo tsa gagwe kgotsa a batla go tlhagisa mathata le maitemogelo a sa itumediseng; ikopantshe le:

Prof L Wegner
Head of Department
University of the Western Cape
Private Bag X17
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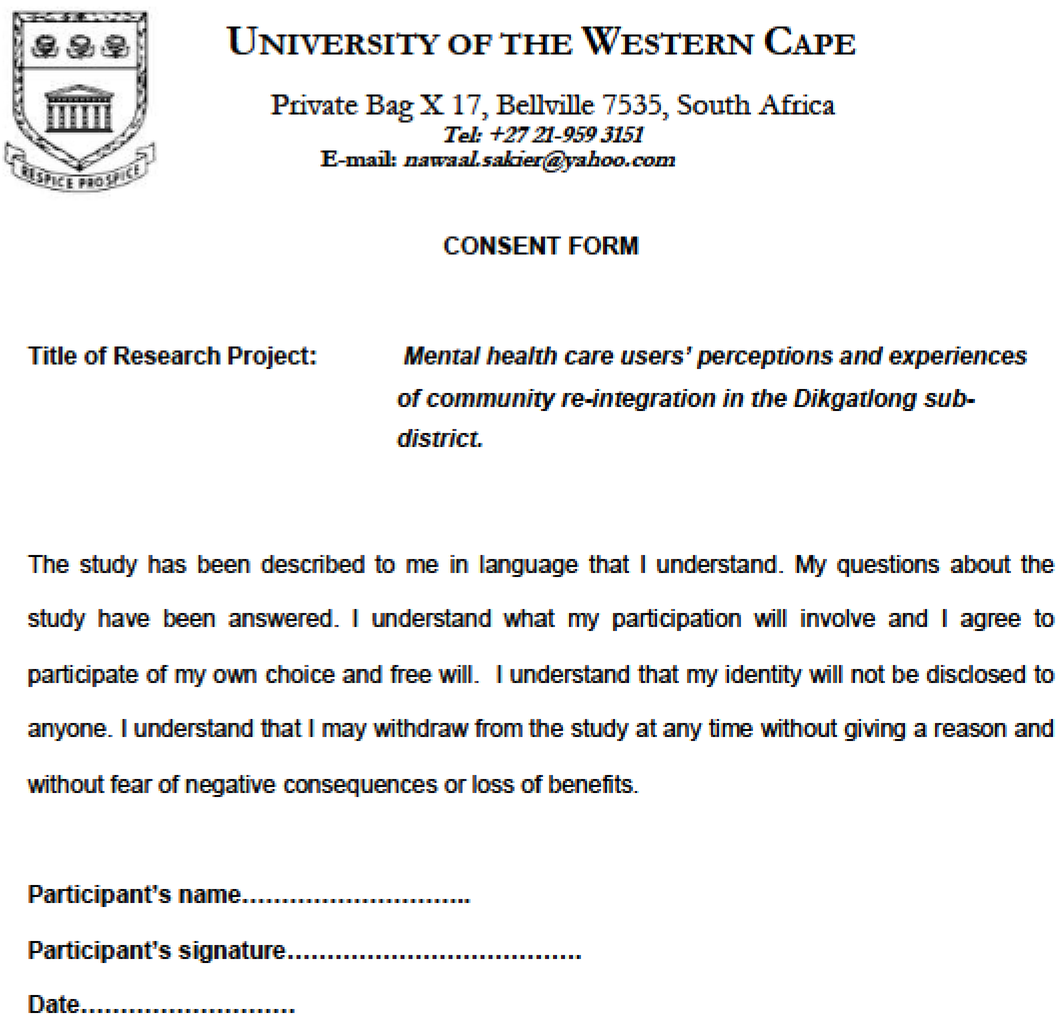
lwegner@uwc.ac.za

Prof José Frantz
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

Appendix 3: Consent Form - English



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E-mail: *nawaal.sakier@yahoo.com*

CONSENT FORM

Title of Research Project: ***Mental health care users' perceptions and experiences of community re-integration in the Dikgatlong sub-district.***

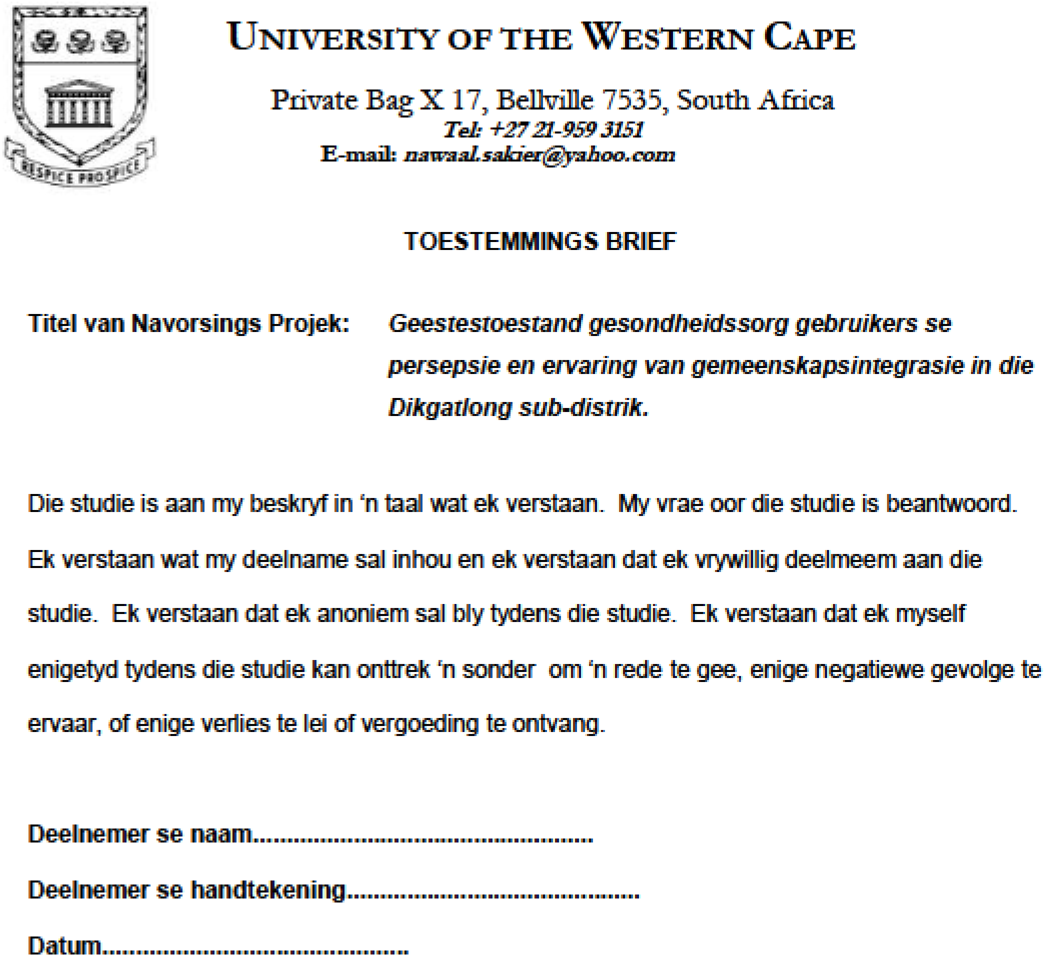
The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name..............................

Participant's signature.....................................

Date...........................

Appendix 4: Consent Forms – Afrikaans and Setswana



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TOESTEMMINGS BRIEF

Titel van Navorsings Projek: ***Geestestoestand gesondheidssorg gebruikers se persepsie en ervaring van gemeenskapsintegrasie in die Dikgatlong sub-distrik.***

Die studie is aan my beskryf in ‘n taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verstaan wat my deelname sal inhou en ek verstaan dat ek vrywillig deelmeem aan die studie. Ek verstaan dat ek anoniem sal bly tydens die studie. Ek verstaan dat ek myself enigetyd tydens die studie kan onttrek ‘n sonder om ‘n rede te gee, enige negatiewe gevolge te ervaar, of enige verlies te lei of vergoeding te ontvang.

Deelnemer se naam..

Deelnemer se handtekening..

Datum...

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Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 3151
E-mail: *nawaal.sakier@yahoo.com*

LEKWALO LA GO ITLAMA KA SEPHIRI LE GO TSHEPANA MO KEPANANG TSA PATLISISA

Setlhogo sa patlisiso: ***Maikutlo, megopolo le maitemogelo a badirisi ba ditirelo tsa bophelo tlhokomelo tsa balwetsi jwa tlhaloganyo, mo go busediweng le go amogelwa gape mo motseng wa Dikgatlong.***

Patlisiso e tlhalositswe ka puo eke e tlhaloganyang. Dipotso tsotlhe tseo ke diboditseng di arabilwe. Ke a tlhaloganya gore go tsaya karolo game go akaretsa eng, ebile ke dumelana go tsaya korolo ka gorata game kesa patelediwa ke ope. Ke tlhaloganya gore leina le boshupo jwame gankitla bo tlhagiswa go ope ke babatlisisi. Ke a tlhaloganya gore ke a kgona go ikgogela morago ka nako engwe le engwe, kwa ntle ga lebaka, mme kese letlhegelwe ke meputso efe kapa go tshosediwa. Ke a tlhaloganya gore go tshepana ka kitso ya kopano ya patlisiso go ikegile mo magetleng a batsakarolo ba patliso kapano.

Ka moo ke dumelana go somarela kitso e tswang mo kopano patlisisong le gose tlhagisi maina le boshupo jwa batsakarolo kapa se o ba se tlisang mo kapanong tsa patlisiso kwa ntle kgotsa go batho ba eseng maloko a patlisiso e.

Lena…………………………..

Sign…………………………………

Le tlha………………………

Appendix 5: Interview Guide - Key Informants

Key Informant Interview Guide

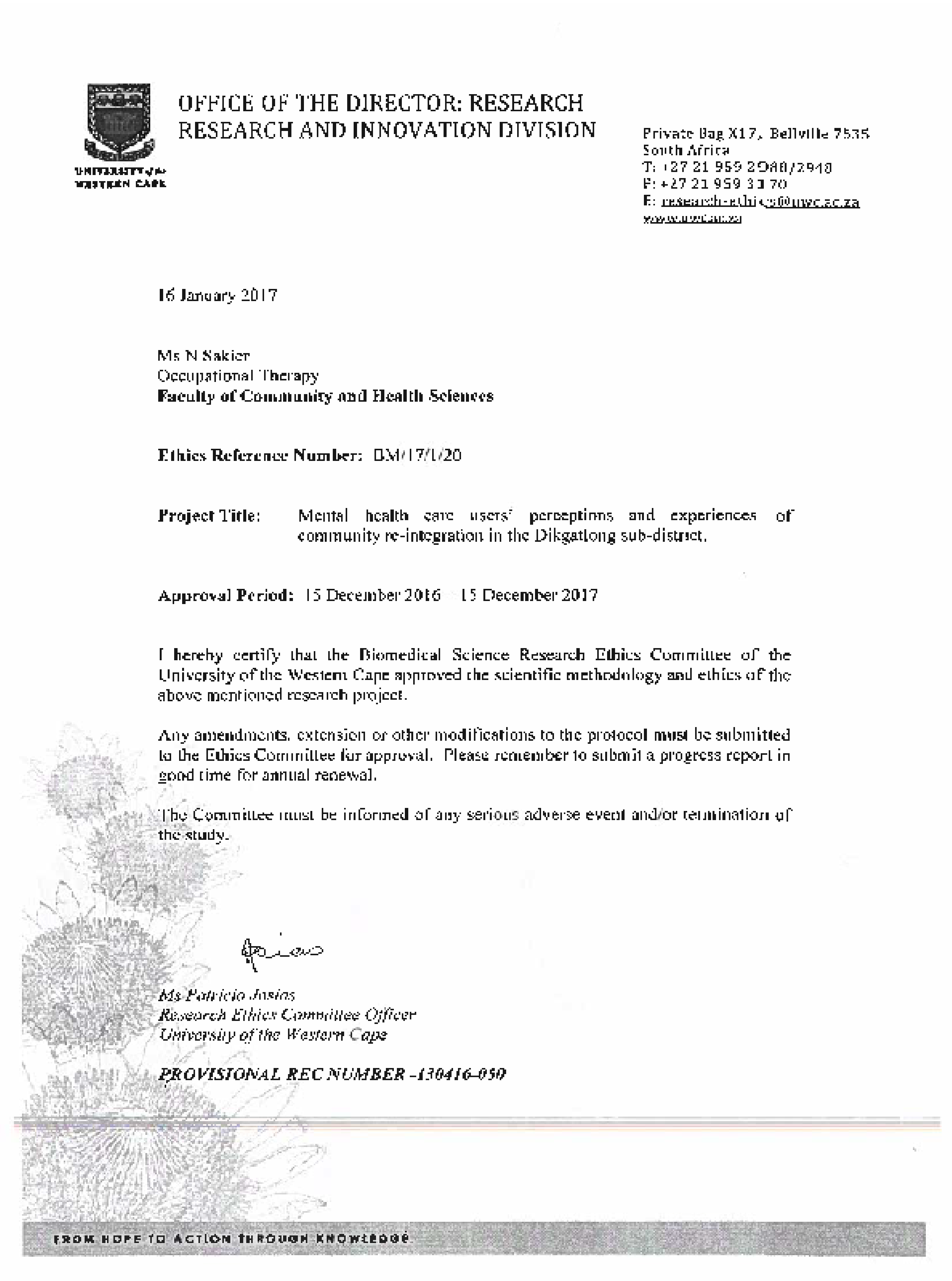
1. How do you feel (emotion) about your family member returning home?
2. How did you plan the arrival of your family member (MHCU) that was coming home from hospital?
3. What information did you receive from the hospital before your family member came home?
4. What do you think helps MHCU reintegrate at home and in the community? Please explain.
5. What support do you think need to be provided for MHCU after their discharge form hospital? Please explain.

Appendix 6: Interview Guide – MHCU participants

Participant individual interview guide

1. How did you experience leaving hospital?
2. What were your expectations on what would happen after you left the hospital before being discharged?
3. What were some of the challenges you faced after you were discharged from the hospital? Explain.
4. What were some of the things that helped you to reintegrate into the community again?
5. Are there any follow-ups which occurred (home visits, follow up appointments, etc) to better assist your re-integration into the community? Please explain.
6. Now that you have been through the experience of being discharged from hospital, what do you think you needed at that time or what do you think could have helped you in that time after leaving the hospital?
7. What would you have liked to be done differently?

Appendix 7: Ethics Approval – UWC



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www.uwc.ac.za

16 January 2017

Ms N Sakier
Occupational Therapy
Faculty of Community and Health Sciences

Ethics Reference Number: BM/17/1/20

Project Title: Mental health care users' perceptions and experiences of community re-integration in the Dikgatlong sub-district.

Approval Period: 15 December 2016 – 15 December 2017

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

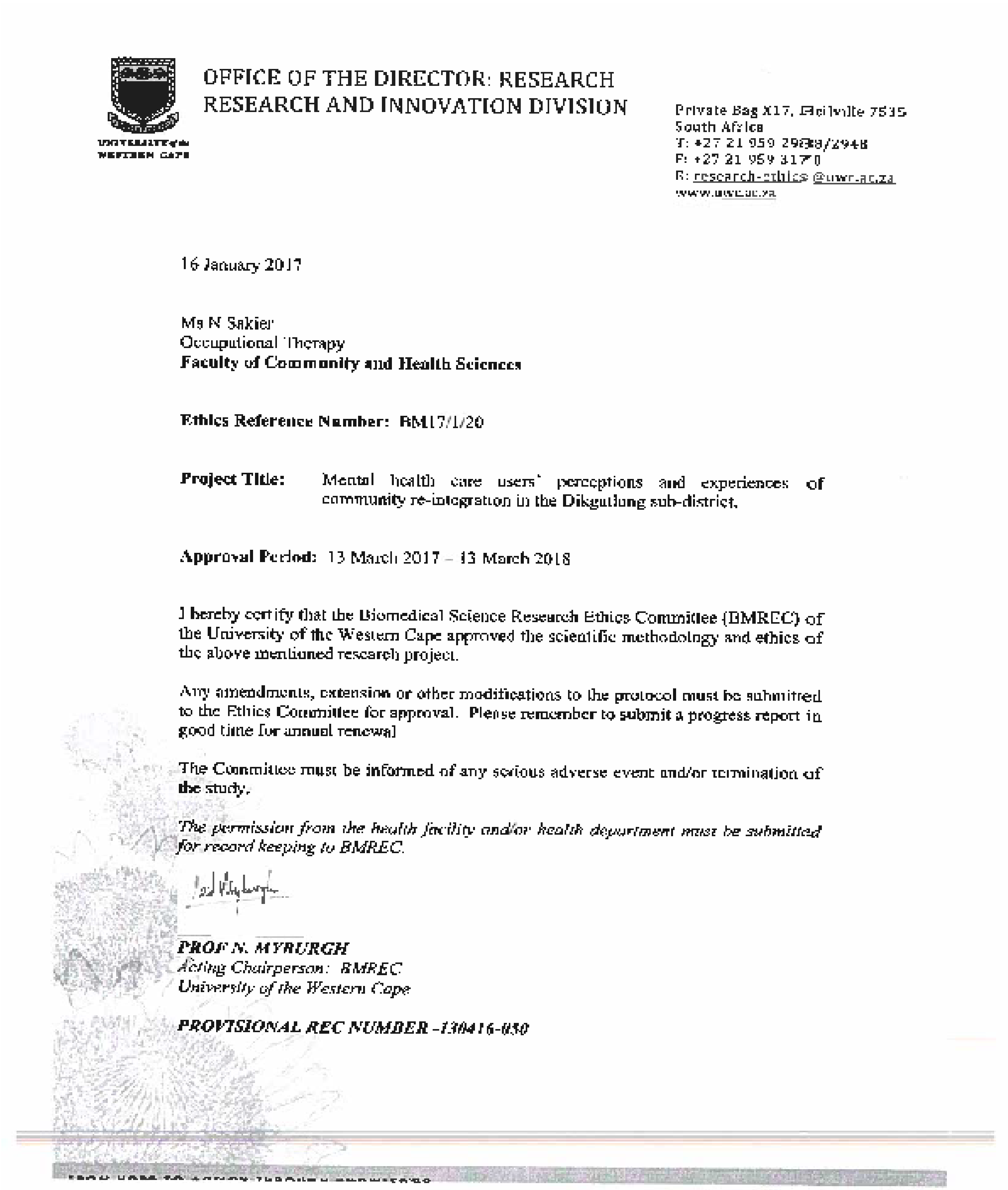
Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE



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16 January 2017

Ms N Sakier
Occupational Therapy
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/1/20

Project Title: Mental health care users' perceptions and experiences of community re-integration in the Dikgatlong sub-district.

Approval Period: 13 March 2017 – 13 March 2018

I hereby certify that the Biomedical Science Research Ethics Committee (BMREC) of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

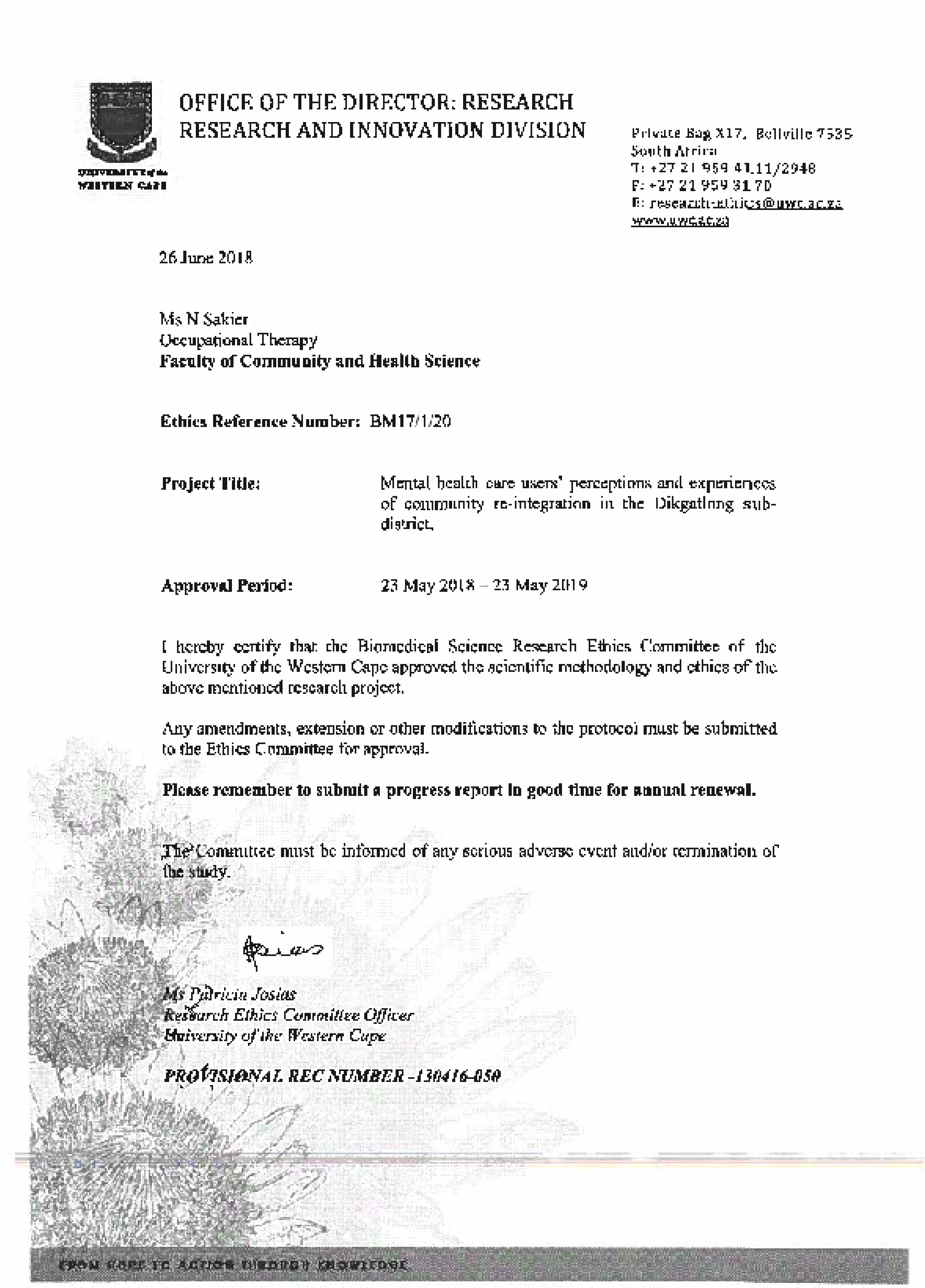
Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

The permission from the health facility and/or health department must be submitted for record keeping to BMREC.

PROF N. MYBURGH
Acting Chairperson: BMREC
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050



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26 June 2018

Ms N Sakier
Occupational Therapy
Faculty of Community and Health Science

Ethics Reference Number: BM17/1/20

Project Title:	Mental health care users' perceptions and experiences of community re-integration in the Dikgatlong sub-district.
Approval Period:	23 May 2018 – 23 May 2019

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

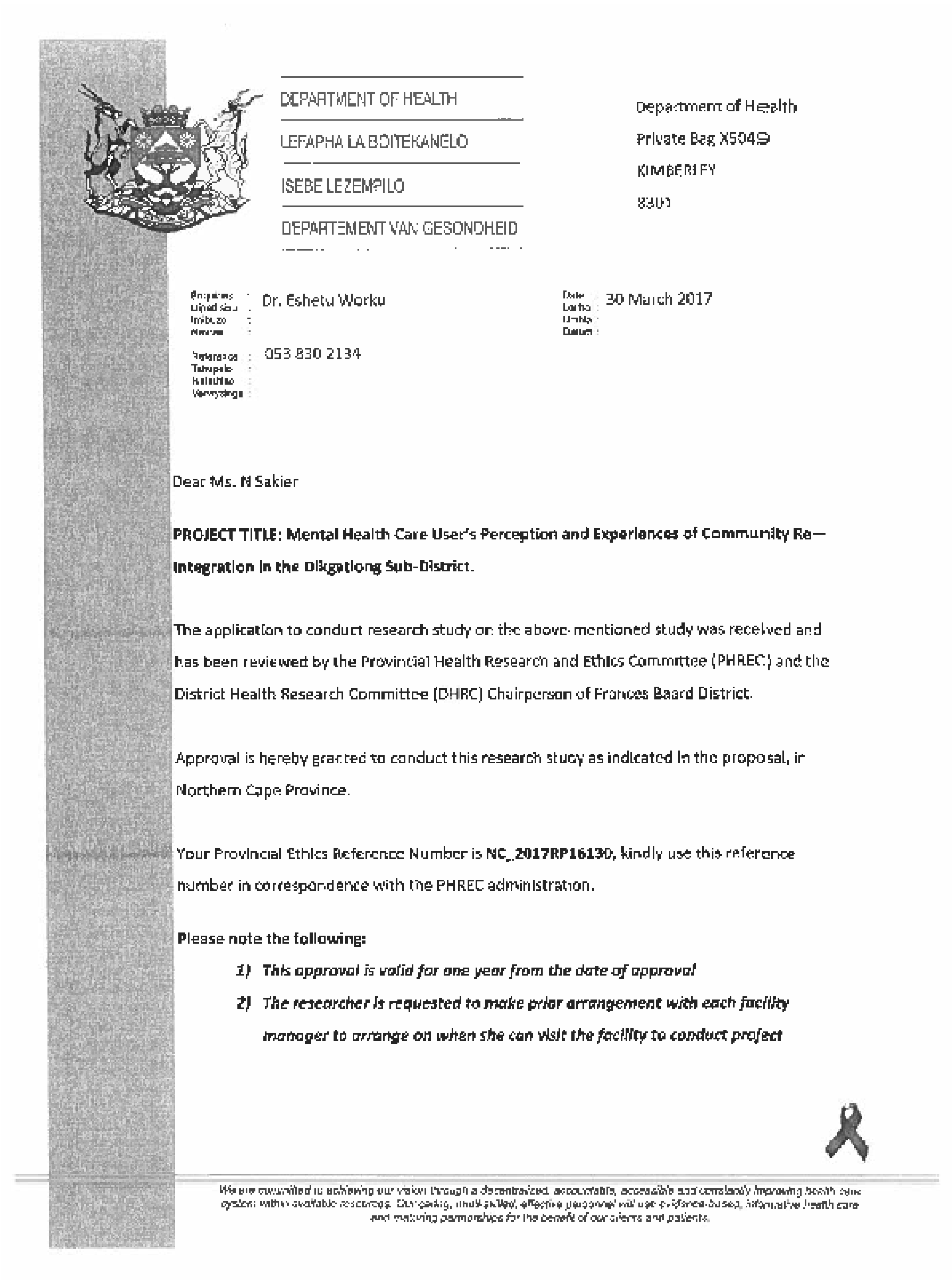
The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

Appendix 8: Ethical Approval – Northern Cape



DEPARTMENT OF HEALTH
LEFAPHA LA BOITEKANELO
ISEBE LEZEMPILO
DEPARTEMENT VAN GESONDHEID

Department of Health
Private Bag X5049
KIMBERLEY
8300

Enquiries / Lipatlisiso / Imibuzo / Navrae : Dr. Eshetu Worku

Date / Letlha / Umhla / Datum : 30 March 2017

Reference / Tshupelo / Isalathiso / Verwysings : 053 830 2134

Dear Ms. N Sakier

PROJECT TITLE: Mental Health Care User's Perception and Experiences of Community Re–Integration in the Dikgatlong Sub-District.

The application to conduct research study on the above-mentioned study was received and has been reviewed by the Provincial Health Research and Ethics Committee (PHREC) and the District Health Research Committee (DHRC) Chairperson of Frances Baard District.

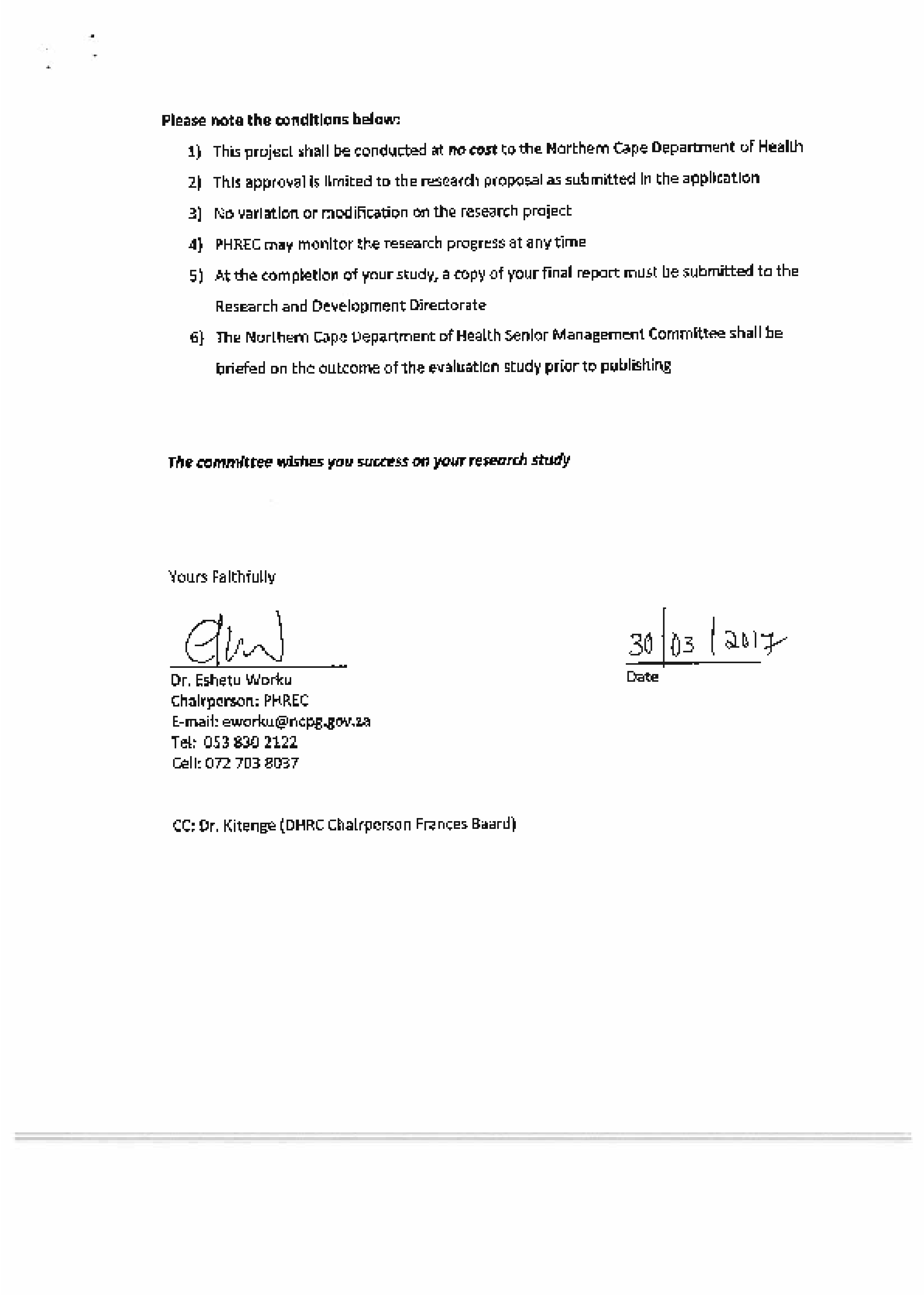
Approval is hereby granted to conduct this research study as indicated in the proposal, in Northern Cape Province.

Your Provincial Ethics Reference Number is **NC_2017RP16130,** kindly use this reference number in correspondence with the PHREC administration.

Please note the following:

1) ***This approval is valid for one year from the date of approval***
2) ***The researcher is requested to make prior arrangement with each facility manager to arrange on when she can visit the facility to conduct project***

We are committed to achieving our vision through a decentralized, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence-based, informative health care and mobilising partnerships for the benefit of our clients and patients.



Please note the conditions below:

1) This project shall be conducted at ***no cost*** to the Northern Cape Department of Health
2) This approval is limited to the research proposal as submitted in the application
3) No variation or modification on the research project
4) PHREC may monitor the research progress at any time
5) At the completion of your study, a copy of your final report must be submitted to the Research and Development Directorate
6) The Northern Cape Department of Health Senior Management Committee shall be briefed on the outcome of the evaluation study prior to publishing

The committee wishes you success on your research study

Yours Faithfully

30/03/2017

Date

Dr. Eshetu Worku
Chairperson: PHREC
E-mail: eworku@ncpg.gov.za
Tel: 053 830 2122
Cell: 072 703 8037

CC: Dr. Kitenge (DHRC Chairperson Frances Baard)