

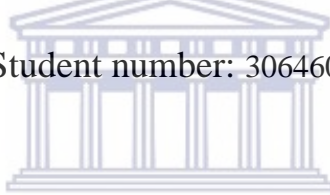


UNIVERSITY *of the*
WESTERN CAPE

**MENTAL HEALTH CARE USERS' PERCEPTIONS AND
EXPERIENCES OF A HOSPITAL-BASED VOCATIONAL
REHABILITATION PROGRAMME IN A RURAL SETTING.**

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A thesis submitted in fulfilment of the requirements for the degree of Masters Science in the
Occupational Therapy, Department of Occupational Therapy, Faculty of Community and
Health Sciences, University of the Western Cape

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November 2018

ABSTRACT

Return to work is a recognised goal of rehabilitation by the occupational therapy discipline that is addressed through vocational rehabilitation as a key feature of work practice. Programmes that fall under the umbrella of vocational rehabilitation include work preparation and training, work hardening and supported employment. In the case of mental health care users (MHCU), meaningful employment contributes to their sense of identity and the prevention of relapse. Vocational rehabilitation is thus important in preparing MHCU for self-employment or employment in the community after they are discharged from the hospital. There is however a dearth of literature pertaining to how vocational rehabilitation programmes particularly in a rural setting, is experienced by MHCU in South Africa. Therefore, the aim of this study was to explore the experiences and perceptions of MHCU regarding the usefulness of the vocational rehabilitation programme at a rural hospital in enhancing their worker roles. A qualitative research approach and exploratory descriptive research design was utilised. Purposive sampling was used to select participants for the study. Semi-structured interviews were conducted with ten MHCU participants as well as two focus groups. Semi-structured interviews were furthermore conducted with two key informants. All interviews and the focus group discussion were audio-recorded, transcribed verbatim and analysed through thematic data analysis. Strategies implemented to ensure trustworthiness included member checking and peer review. Ethics clearance was obtained from the UWC Research Committee and permission to conduct the study at the hospital was requested from the Mpumalanga Provincial Health Ethics Committee and hospital management. Three themes originated from the findings of this study. Theme one describes the barriers experienced by people with mental illness while returning to work. Theme two describes the programme factors that influence return to work in respect of work habits, work skills, and community re-integration.

Theme three captures the value of participating in the work programme as experienced by the participants. The findings of the study is related to the Model of The Ecology of Human Performance (EHP) to show how the vocational rehabilitation programme effected the MHCU's return to work. The findings show that the context as well as the person's skills and abilities are very important factors in reintegrating the user back to work. The study illuminated recommendations for the further development of the vocational rehabilitation programme.

Keywords

Mental illness, mental health care users, work, occupational therapy, vocational rehabilitation, work preparation, work training, return to work, qualitative research.



DECLARATION

I, HENRY MSIMANGO, declare that this thesis: *Mental health care users' perceptions and experiences of a hospital-based vocational rehabilitation programme in a rural setting*, is my own original work (except where indicated otherwise), and that it has not previously or in its entirety or in part been submitted for a degree at this or any other university.

I give permission to the University of the Western Cape, to reproduce either in full or any portion of this thesis for the purpose of future research.

FULL NAME: Henry Msimango



A handwritten signature in blue ink, appearing to be "H. Msimango".

SIGNATURE:

DATE: November 2018

ACKNOWLEDGEMENTS

All praise to the Almighty God for granting me the opportunity to complete this research study. I am grateful to Him for granting me strength and a healthy mind to present these findings and experiences of the study participants.

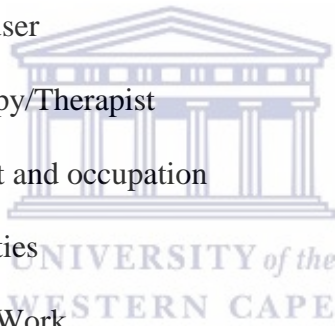
I would also like to acknowledge the people who have guided me through the completion of this thesis. Most credit to my supervisors, Dr Lucia April-Hess and Prof S Soeker, from the University of the Western Cape, for their patience, encouragement and invaluable guidance and constructive criticism during the writing up stages.

To the participants of this study, I am grateful for their willingness to participate and for sharing their stories. I am humbled by their courage and dedication to life after being affected by mental illness. A big thank you to the Tintswalo Hospital Occupational Therapy department and the hospital at large for their dedication to MHCU.

I would like to express a warm thank you to my family who supported me throughout the study and thank you also to my colleagues for their support.

ABBREVIATIONS AND ACCRONYMNS

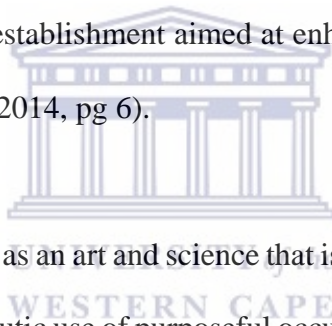
ADL	Activities of daily living)
EHP	Ecology of human performance
FET	Further education and training
HR	Human resources
ICF	International Classification of Function, Disability and Health
ILO	International Labour Organisation
I/V	Interview
MHCU	Mental health care user
OT	Occupational Therapy/Therapist
PEO	Person, environment and occupation
PWDs	People with disabilities
RTW	Return/returning to Work
SASH	South African Stress and Health
SE	Supported Employment
VR	Vocational Rehabilitation
WHO	World Health Organisation
UWC	University of the Western Cape



LIST OF DEFINITIONS

Mental illness: refers to a wide range of mental health disorders that affect the way a person thinks and behave. Mental illness is also described as any clinically significant behavioural or psychological syndrome characterised by the presence of distressing symptoms or significant impairment of functioning (WHO, 2003).

Mental health care user: The term mental health care user (MHCU) is defined in the Mental Health Care Act no. 17 of 2002 as “a person receiving care, treatment and rehabilitation services or using health service at a health establishment aimed at enhancing the mental health status of a user” (Parliament of South Africa, 2014, pg 6).



Occupational Therapy: is defined as an art and science that is aimed at improving the functioning of an individual through the therapeutic use of purposeful occupational activities (Schwartz, 2003).

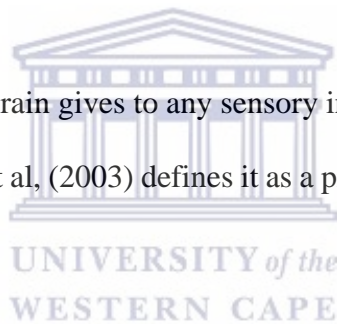
Vocational rehabilitation: is a set of services offered to people with mental or physical disabilities. These services are designed to enable the person to attain skills, resources, attitudes, and expectations needed in returning to work. It is an intervention strategy that aims to enable people with disabilities, including MHCU to return to or obtain work (Johansson and Bernsprang, 2001).

Barriers: the term refers to the factors that prevent participation in the return to work process. The World Health Organisation defines these as “factors in a person’s environment that, through their

absence or presence, limit functioning and create disability.” (W.H.O, 2001:192). This may include and be not limited to physical environment that is inaccessible, lack of relevant social support, and negative attitudes of people towards disability (stigma).

Facilitators: refers to factors that are seen as contributing factors towards the return to work process of a person. Facilitators can prevent disability or impairment from becoming a restriction in participation (W.H.O, 2001:192) and may include and not be limited to the physical environment that is accessible, the availability of relevant assistive devices, and positive attitudes of people towards disability or towards the person.

Perception: the meaning that the brain gives to any sensory input and it could also mean how the brain interpret the input, Crepeau et al, (2003) defines it as a process that involves recognising and interpreting sensory information.



Experience: It is when there is participation in an activity over a period of time (Crepeau et al, 2003). It can also mean the process of learning about something and or acquiring a skill through doing an activity (Hornby & Ruse, 1988).

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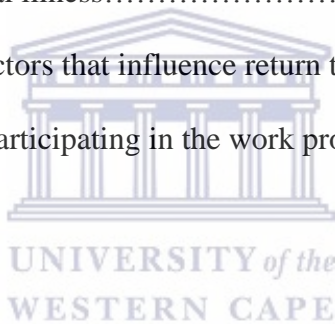


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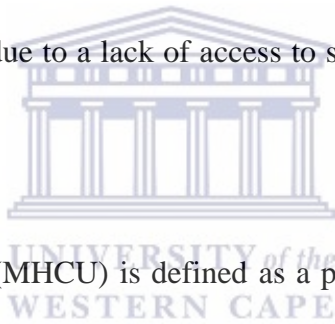
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CHAPTER 1

INTRODUCTION

1.1 Background to the study

The focus of this study was the perceptions and experiences of mental health care users (MHCU) regarding their participation in a hospital-based vocational rehabilitation programme in a rural practice setting in Mpumalanga, South Africa. The research setting for the study was the Tintswalo hospital in the rural district of Accornhoek, Mpumalanga. Rurality in South Africa is often associated with poverty where occupational injustice have its greatest impact and people with disabilities remain disadvantaged due to a lack of access to services, education and employment (Sherry, 2015).



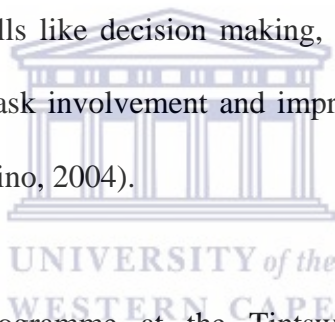
The term mental health care user (MHCU) is defined as a person receiving care, treatment and rehabilitation services or using health services aimed at enhancing his or her mental health status (Department of Health, 2013). This includes state patients and mentally ill offenders and, where the person concerned is below the age of 18 years or is incapable of taking decisions, a family caregiver or person authorised to act on that person's behalf (Department of Health, 2013). Mental illness is described as any clinically significant behavioral or psychological syndrome that is characterised by the presence of distressing symptoms or significant impairment of functioning (Brissos, Molodynski, Videira & Figueira, 2012). Mental illness can be related to impairment of cognitive, emotional, or social abilities that may require intervention due to the impairment causing disruptions in a person's behaviour, emotions, or thoughts that may last for weeks, months or years (World Health Organisation [WHO], 2002).

From a very early age, people often dream about where they will work and what kind of work they will do to earn a living. Then, as they get older, they start pursuing these dreams through education and training. However, this is not always true for people with mental illness who have to struggle to reach their life goals (Jackson, 2014). Most MHCU describe feelings of rejection and failure due to them being marginalised by society including their home environments; and the feeling of rejection is often exacerbated when they are unemployed (Macias, Rodican, Hargreaves, Jones, & Barreira, 2006).

According to Ross (2007) the terms work and employment are used interchangeably and can be described in different ways according to different categories. Paid work or employment refers to workers receiving a reward, usually financial, for work delivered and holds the highest status in society as most people want employment that can pay them well. Unpaid employment plays an important supporting function towards maintaining society despite the worker not receiving payment. It may take place at home as in performing household tasks and care giving, or outside the home as in the case of volunteering (Killackey, 2008).

Occupational therapists have a particular understanding of the relationship between an individual's medical condition, functional abilities, psychosocial status and work demands (Oka, Otsuka, Yokoyama, Mintz & Hoshino, 2004). Return to work is a recognised goal of work practice within the occupational therapy discipline and vocational rehabilitation as part of occupational therapy practice plays an important role in mental health rehabilitation (Davis & Rinaldi, 2004). For MHCU, participation in work fosters the development of a reliable worker identity, a sense of

belonging and a sense of being able to make a real contribution in the workplace (Van Niekerk, 2008). Programmes that fall under the umbrella of vocational rehabilitation include work preparation and training, work hardening and supported employment (Van Niekerk, 2008). The main intervention programmes offered to MHCU by occupational therapists in the public health system in South Africa however involves work preparation and training, with work hardening and supported employment mainly being offered in private practice. The overall goals of vocational rehabilitation include sustained participation in work related activities and reduced supervision required for work participation (Oka, Otsuka, Yokoyama, Mintz & Hoshino, 2004). More specific goals include improvement in work habits like social interaction with staff and other clients, improvement in specific work skills like decision making, problem solving and attentiveness; improved comprehension during task involvement and improved quality of performance (Oka, Otsuka, Yokoyama, Mintz & Hoshino, 2004).



The vocational rehabilitation programme at the Tintswalo psychiatric hospital in rural Mpumalanga was implemented to address the work preparation and training needs of MHCU who undergo long-term hospitalization. The overall purpose of the programme is to prepare them for self-employment or employment in the community after they are discharged from the hospital. The main goal of the programme is to promote the highest level of well-being and vocational functioning. The programme is therefore geared towards work preparation and training that involves re-training the vocational skills of MHCU particularly in the domains of work habits and work skills. The programme developed from one that initially only focused on simple craft activities to one that currently includes woodworking, shoe repair, gardening, a carwash and a tuck-shop. MHCU are allocated and placed in different work activities according to interests and

abilities. They are able to generate an income through their participation in the different activities thereby addressing their self-esteem and motivation to seek employment post discharge. Accordingly, life-skills training sessions, where skills such as job seeking skills, social skills and financial management skills are addressed, also forms part of the work preparation programme.

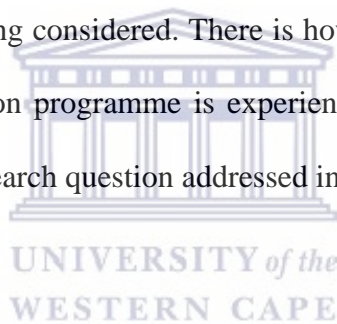
1.2 Problem statement

Relapse is defined as aggravation of psychopathology symptoms that often leads to the rehospitalisation of MCHU after hospital discharge (Schennach et. al., 2012). While the reasons for the relapse of MCHU are complex, MCHU who do not participate in any type of work or community programme tend to relapse faster than MCHU who return to work (Launer, 1997). Relapse could be due to a lack of employment and MCHU being idle upon discharge brought on by them being stigmatized, excluded and isolated in the community (Mkhize and Kometsi, 2008). Substance abuse is one of the major contributing factors to relapse, but it could also be caused by boredom and a lack of routine in daily life (Mkhize and Kometsi, 2008). Stressful life events has been highlighted as a risk factor in the prevalence of relapse of MCHU as opposed to employment which has been highlighted as a protective factor against relapse (Sariah, Outwater & Malima, 2014). Supporting MCHU to find and maintain employment through appropriate work rehabilitation programmes thus contribute to the prevention of relapse.

MCHU at Tintswalo hospital often complain that they do not have opportunities for any meaningful occupational engagement after their discharge from the hospital. They encounter finding or maintaining work as challenging and while they might be interested and willing to work, they are generally not accommodated in the workplace due to their mental illness. Thus, some

MHCU experience feelings of powerlessness and frustration when they are not able to work and support their families financially. This cause stress which could be a contributing factor to the high relapse rate amongst MHCU at Tintswalo hospital.

In rural provinces such as Mpumalanga there are however limited work related services for MHCU (Mkhize and Kometsi, 2008). Accordingly, there is a need for the development of work rehabilitation programmes for MHCU in rural areas in order to ensure the provision of relevant intervention and support for MCHU in this practice area. This is also the case at Tintswalo hospital where expanding the hospital's vocational rehabilitation programme into the community as a means of support to MHCU is being considered. There is however a lack of evidence pertaining to how the vocational rehabilitation programme is experienced by the MHCU involved in the programme. This informed the research question addressed in this study.



1.3. Research question

The research question addressed in this study was: What are the experiences and perceptions of MHCU regarding the usefulness of the Tintswalo vocational rehabilitation programme in enhancing their worker roles?

1.4 Aim & objectives

1.4.1 Aim

The aim of the study was to explore the experiences and perceptions of MHCU regarding the usefulness of the Tintswalo hospital vocational rehabilitation programme in enhancing their worker roles.

1.4.2 Objectives

The objectives were to explore and describe MHCU perceptions and experiences:

- i. Of the work preparation activities,
- ii. Of the work training activities,
- iii. Of the life-skills sessions, and
- iv. About re-integrating to their worker role after participating in the vocational rehabilitation programme.



1.5 Study purpose and significance

The purpose of this study was to explore and describe the perceptions and experiences of MHCU regarding the work rehabilitation programme offered at the Tintswalo hospital in rural Mpumalanga in order to generate an understanding of the perceived value of the programme in enhancing the worker role from their perspective. The significance of the study lies in the generation of knowledge that is valuable to furthering the development of the Tintswalo hospital's vocational rehabilitation programme as well as informing current work practice to be relevant to the needs of MHCU in rural settings and facilitate their return to work.

1.6 Outline of thesis

The thesis comprises the following chapters:

Chapter 1 provides the background, problem statement, research question and aims and objectives of the study. This is followed by a brief overview of the study significance and methodology utilised.

Chapter 2 presents the literature review pertaining to the study's conceptual and theoretical framework.

Chapter 3 describes the study's methodology. It outlines the research design, research setting, sampling, and data collection methods.

Chapter 4 reports on the findings of the study. It commences with a description of the participants of the study.

Chapter 5 presents a discussion of the findings. During this chapter the research aim and objectives are discussed in relation to relevant literature.

Chapter 6: offers the main conclusion derived from the study, lists the limitations of the study and offers recommendations as informed by the key findings.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This Chapter aims to highlight literature that contextualises mental illness in South Africa and addresses the effects of mental illness on occupational performance in particular work. Literature pertaining to how occupational injustice affects MHCU with regards to employment or return to work is discussed. Literature related to community re-integration in the context of mental illness is also explored. Lastly, a synthesis of the theoretical framework that underpins this study namely the Ecology of Human Performance model, is presented.

2.2 The Prevalence of mental illness in South Africa

Mental illness is described as a clinically noteworthy behavioural or psychological condition characterised by the presence of disturbing symptoms or significant impairment of functioning (WHO, 2003). The effect of the mental illness varies from person to person. Mental illness will generally cause disturbances to a person's behaviour, emotions, or thoughts that may last for weeks, month or years. Globally, one in four families has at least one member with a mental illness and in the majority of cases family members are act as primary caregivers of MHCU (WHO, 2003). Mental illness is the third most prevalent condition that contributes to the burden of disease in South Africa, and approximately 1 in 6 South Africans are likely to experience a common mental disorder including depression, anxiety or substance use disorder in their lifetime (Lund, Peterson & Bhana, 2012).

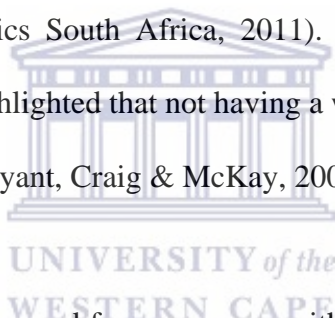
The most recent and most reliable statistics regarding the prevalence of mental disorders in South Africa was captured in the South African Stress and Health (SASH) Survey (Herman et.al, 2011). Survey data from a nationally representative sample of 4 351 adults were collected from 2003 to 2004. Of the total number of participants 42.7% had mild mental illnesses, 26.2 % serious mental illness and 31.1% moderate mental illness. The prevalence of chronic mental disorder was 30.3%, while 11.2% of participants had two or more chronic mental disorders and 3.5% had three or more chronic mental disorders. It was furthermore reported that the MHCU geographical location was 28% rural, 35% peri-urban and 37% urban. With the decentralization of funds resources for mental health care units do not always reach the users or the people that it is intended for and there are generally fewer mental health care services available in rural areas compared to urban areas (WHO, 2003).



2.3 Work as a meaningful occupation

One of the fundamental beliefs of the occupational therapy profession is that humans are occupational beings whose occupational identity develops through their engagement in occupations in the areas of activities of daily living, work and leisure (Barret & Kielhofner, 1998). Work is not only a source of income but functions as a critically important component of everyday life, and helps to develop self-esteem and to enable individuals to be integrated into being members in society (Rebeiro & Allen, 1998, Killackey, 2008), while satisfaction with employment status was related to health among individuals with schizophrenia (Eklund, Hansson and Bejerholm, 2001). Work is regarded as an important resource for providing sustenance and a positive sense of self-worth and identity (Gard & Sandberg, 1998, Van Niekerk, 2008).

The majority of people living with mental illness express the desire to work (Bond et al., 2007) or to be involved in meaningful tasks. Thus, work is important to MHCU because most individuals has obtaining and maintaining their worker role as a personal goal and thus work is regarded as an important outcome of successful rehabilitation (Holzberg, 2001). Engelbrecht and Lorenzo (2010) conducted a study in South Africa to explore people with disabilities' (PWDs) experiences of working in the in the open labour market. The findings of their study showed that being able to generate an income resulted in PWDs experiencing a sense of independence and satisfaction as they were able to maintain their livelihoods. In contrast, PWDs who are not able to obtain open labour market employment feel that their sense of independence in maintaining their livelihoods is seriously compromised (Statistics South Africa, 2011). Likewise, a study conducted with MHCU in the United Kingdom highlighted that not having a worker role was regarded as a major hindrance in the lives of PWDs (Bryant, Craig & McKay, 2005).

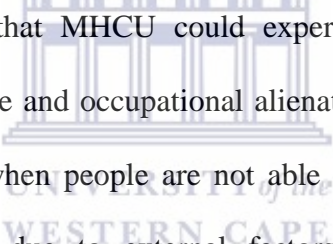


According to Ross (2007) there is a need for any person with a disability to have an occupation, regardless of their disability (Ross, 2007). Few hospital programmes in South Africa however offer work preparation training or supportive employment programmes for MHCU (Van Niekerk, 2008). This is despite the fact that enabling people to engage in meaningful occupations such as work, facilitates the development of their occupational identities (Meriano & Latella, 2008).

2.4 Occupational injustice and work

There are many challenges for MHCU that make securing and performing well in employment difficult (Bond et al., 2007). Occupational injustice is evident in the employment practices in of people with a disability in South Africa; almost 40% are not active in the labour market, while the

majority of those who work are employed in protective and sheltered workshops (Statistics South Africa, 2011). People with mental illness are often barred from enjoying the same opportunities to work as others, consequently their ability to develop their potential is minimised (Watson, 2004). Most MHCU describe feelings of rejection and failure due to them being marginalised by society including in their home environments; and the feeling of rejection is often exacerbated when they are unemployed (Strong, 1998; Macias, Rodican, Hargreaves, Jones, & Barreira, 2006). When people are not able to meet their needs for meaningful occupational engagement due to factors including social, environmental and political that they do not have any control over, they experience occupational injustice (Wilcock & Townsend, 2000).



Forms of occupational injustice that MHCU could experience in society are occupational deprivation, occupational imbalance and occupational alienation (Wilcock & Townsend, 2004). Occupational deprivation occurs when people are not able to meet their needs for well-being through engaging in occupation due to external factors (Whiteford, 2000) for example unemployment, poverty or social injustice (Whiteford, 2004). Occupational imbalance occurs when people are not able to experience a sense of well-being due to an imbalance experienced in occupational engagement as in the case of being under-employed or over-employed (Christiansen & Townsend, 2004). Occupational alienation occurs when people experience isolation, powerlessness or marginalisation as a result of being forced into engaging in occupations that does not satisfy their needs (Wilcock, 2006). Most MHCU in rural areas experience occupational injustices and there is generally a need for this to be addressed through relevant occupational programmes so that they are able to maintain their wellbeing (Sherry, 2015).

2.5 Mental health care users and community re-integration

According to Hassan, Visagie and Mji (2012), rehabilitation for PWDs should not only focus on bio-medical outcomes but also social outcomes such as community integration, including return to work. Community re-integration refers to the concept of helping MHCU to move out of patient roles and enabling them to be independence in a community setting (Bond et al., 2004) as it contributes to their social inclusion (Read, 2009). Community re-integration is therefore regarded as a significant indicator of the quality of life for MHCU (Stumbo et al. 2015).

Within the concept of community re-integration; community needs to be understood with reference to the physical boundaries that describe where a person resides as well as with reference to the common rituals and traditions of a group of people (Stumbo et al., 2015). The community is thus perceived to be an important part of a person's life as it is the place in which people come together. Granerud and Severinson (2006) assert the importance for community mental health practitioners to ensure that MHCU attain community re-integration and experience a sense of belonging in the community.

Perceived barriers to community re-integration as reported by MHCU include financial constraints, lack of access to employment and social supports as well as difficulties with vocational adjustment, time management, problem solving and money management (Stumbo et al., 2015). Further barriers to community re-integration that have been identified by Bond et al. (2004) as hindrances to community re-integration are stigmatising attitudes, fragmentation of services and lack of access to services. A qualitative descriptive study done in the Eastern Cape by Bokleni (2009) that aimed to explore the lived experiences of reintegration into the community of MHCU

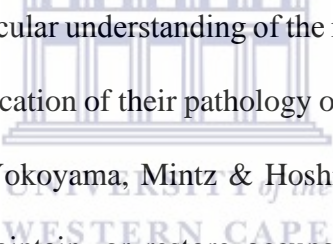
highlighted factors that assisted and hindered community re-integration. Some of the facilitating factors of community re-integration identified were encouragement from family members and community participation by attending social gatherings. The barriers which the participants expressed were non-compliance to medication, unemployment, easy access to substances, encounters of stigma and lack of housing. Therefore, Bokleni (2009) emphasise the need for inter-sectoral collaboration to increase job opportunities for MHCU and improve psychosocial rehabilitation.

2.6 Work practice in Occupational therapy

Occupational therapy enables individuals to engage in meaningful occupations such as activities of daily living, leisure and work. Work practice in occupational therapy refers to occupational therapists enabling people to return to work through work rehabilitation (Gibson & Strong, 2003). Achieving return to work entails a process that involves an assessment of the workplace and environment including specific work tasks and demands of the job. The Occupational Therapist furthermore conduct a comprehensive assessment of the person in terms of the person's ability to perform specific work tasks and engage in the work environment (Gibson & Strong, 2003).

A key role of occupational therapy is the promotion of occupational justice in the workplace and working towards having people's occupational needs and right to work, met. This role is guided by policies such as the United Nations Convention for the rights of people with disabilities (UNCRPD) that is aimed at protecting, promoting and ensuring the rights of all PWDs. This include the right to work in the open labour market (UN, 2006). Article 26 (Habilitation and Rehabilitation) of the UNCRPD offers a wide-scale, globally accepted view of rehabilitative

services as needing to have appropriate measures, including the provision of peer support, enabling persons with disabilities to attain and maintain their physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life (UN, 2006). Additionally, the Labour Relations Act No.66 of 1995 of South Africa provides imperatives for occupational therapists to advocate for the protection of workers through fair labour practices. Similarly, occupational therapists are guided by the Disability Code of Good Practice, which aims to guide employers and employees on promoting equal opportunities as required by the Employment Equity Act No. 555 of 1988 of South Africa. The act applies to all employers and workers and protects people from unfair discrimination.



Occupational therapists have a particular understanding of the relationship between an individual's bio-medical condition and the implication of their pathology on their functional abilities including on work demands (Oka, Otsuka, Yokoyama, Mintz & Hoshino, 2004). Occupational therapists thus offer services to improve, maintain, or restore occupational performance in people who experience any form of dysfunction as a result of injury, illness, delayed development, environmental barriers or a lack of access to occupations (Moyers, 2005). According to the Occupational therapy Practice Framework: Domain and Process (AOTA, 2008), occupational therapy has roles in job acquisition and job performance i.e. identifying work opportunities based on clients' skills and environmental limitations.

2.7 Vocational rehabilitation

Vocational rehabilitation is an intervention strategy that aims to enable PWDs to return to or obtain work (Johansson and Bernsprang, 2001). The main goal of vocational rehabilitation is to enable

people to achieve social and vocational functioning (Lieberman, Hilty, Drake, & Tsang, 2001). There are examples of a wide application of vocational rehabilitation in various types of employment models within developing and emerging countries namely, vocational preparation and training, transitional employment, supported employment and job coaching (Stuckley, 1997). Vocational rehabilitation intervention services in South Africa include vocational (work) preparation and training, placement and employment (Coetzee, Goliath, Van der Westhuizen & Van Niekerk, 2011; Van Biljon, Casteljen, & Du Toit, 2016).

Vocational/work preparation and training is geared towards enhancing work ability by improving the clients' formal and informal work skills, such as stress management, problem solving and work simplification (Buys, 2015). According to Buys & Van Biljon (1998) placement services involves facilitating the return to work in current or alternative work in the open labour market, or to sheltered or protected workshops while follow up should be after discharge and could involve employers, referral sources, family members and clients themselves. They assert that this is fundamental to a successful return to work outcome.

Vocational rehabilitation for MHCU has shown good outcomes related to improved functioning (Bond, 2004), while the same applies to supported employment in terms of clients obtaining employment in the open labour market as opposed to sheltered employment (Burns et al., 2007). The onset of disability generally require relearning or developing new habits (Forsyth & Keilhofner, 2006). In a qualitative study conducted on training persons with schizophrenia in problem solving, the researchers determined that only teaching social skills without also focussing on work skills training, does not necessarily enable MHCU to carry over those skills to other

domains in life, including that of work (Lieberman, Eckman, & Marder, 2001). This is an important factor to consider in facilitating MHCU return to work as training that is too generic in nature may not provide enough job-specific training that meet the needs of the client (Cheung, Tsang, and Tsui, 2006). There is however a dearth of literature that explores clients' experiences of specific vocational rehabilitation programmes.

Supported employment as part of vocational rehabilitation emerged in the 1980's with the purpose of supporting people with disability within the workplace that while they work, they must be paid as people who do not have a disability (Bond, Drake, Mueser, & Becker, 1997). Supported employment thus aim to develop new skills, increase community participation and enhance self-esteem while earning an income as a worker (Burns & Catty, 2008). Historically vocational rehabilitation was seen as an approach that first trained workers before they were placed in a work setting which is different from supported employment where clients are placed first followed by training in that setting (Waghorn, Lloyd, & Clane, 2009). Supported employment is regarded as imperative for return to work more so than vocational rehabilitation that mainly focusses on work preparation and training within simulated environments not situated within the open labour market (Van Niekerk et al., 2011). There are however very few vocational programmes in South Africa that facilitate return to work for MHCU or PWDs through the supported employment approach (Van Niekerk et al., 2011).

2.8 Theoretical framework

The Ecology of Human Performance (EHP) model is an occupational therapy practice framework that was developed by occupational therapists at the University of Kansas in response to a

perceived lack of consideration for the complexities of context in occupational therapy theory (Dunn, Brown & McGuigan, 1994). The model recognises the relationship between context and the person. Theoretically the framework combines ecological principles, occupational therapy principles and social science theories (Dunn, McClain, Brown and Youngstrom, 2003). The person is understood as a unique being whose behaviours are controlled by their context with the focus of the model being the relationship between the person and the environment and how this relationship influences human performance (Dunn et al, 2003).

The main assumption of the EHP Model is that that occupational performance can only be understood within context or the environment where the client lives. The person uses the environment where they live as prompts for tasks that they need to perform using the skills and abilities that they have. Thus, if occupational therapists evaluate or assess the person's performance without full consideration of his or her context the occupational therapist will risk making inappropriate intervention choices.

Dunn et al (1994) outline five strategies for addressing a person's occupational needs: 1) *Establish/Restore* addresses a person's ability to perform in context. In vocational rehabilitation this strategy addresses the needs of the MHCU by improving their work abilities and skills in their current (hospital) context. 2) *Alter* is a strategy that involves alteration of the context so that it supports performance. For example, in vocational rehabilitation this strategy may address the lessening of distractions that may impact performance. 3) *Adapt* addresses contextual (environmental) features and task demands to support and enable performance. This means that the therapist and the person acknowledge the person's abilities, skills, needs and natural features of the current context, then select the best possible match to enable optimal performance. MHCU

with poor memory for example could be educated to use compensatory techniques e.g. writing cues on what they need to do everywhere in the workplace. 4) *Prevent* addresses aspects of the person, task or context that could lead to maladaptive performance or a problem in the future. Thus, this strategy is about the therapist recognising the problem and finding solutions before it re-occur in future again. For example, MHCU with predictable social problems are assisted in life- and social skills groups as part of a work preparation programme that are run prior to them joining the work training programme. 5) *Create* involves the enhancement of overall functional performance where disability will not inhibit the performance in future. Thus, this strategy is about MHCU developing skills so that they will be able to find and maintain employment in the community or engage in self-employment post discharge from the vocational rehabilitation programme.



2.9 Summary

The review also identified that while the prevalence of mental illness is high in South Africa, there are few mental health care services available in rural areas. Work has been described as being central to human existence as a means of preserving self-identity. The review further identified how occupational injustice and barriers may hinder community integration. Literature reviewed suggests that people with mental illness may be successful at returning to work when they have participated in a vocational rehabilitation programme. The literature also described the occupational therapist's role in vocational rehabilitation and work practice. In conclusion the EHP framework, outlining five strategies for addressing a person's needs in context, was discussed.

CHAPTER 3

METHODOLOGY

3.1 Introduction

In this chapter the research methodology utilised in this study is discussed including the research setting, approach, design, sampling and recruitment of participants, as well as data collection and analysis. Lastly the measures implemented to ensure the trustworthiness and ethical standard of the study is presented.

3.2 Research setting and description of the programme

The study was conducted at the Tintswalo hospital in the Mpumalanga Province. The hospital is located in the Accornhoek district which falls under the Bushbuckridge municipality. The district is home for about 35000 people who are mainly of the black African ethnic group (Statistics South Africa, 2011). There is a poor infrastructure with the roads, the hospital and other public areas being in poor physical condition. The majority of people work at shops, nearby farms while some travel outside the township the city of Nelspruit. The district is however characterized by a high level of unemployment, with most people engaging in informal small businesses and bartering to maintain their livelihoods. The residents are able to access banks, grocery shops, clothing shops, take-away franchises, etc. at the local shopping complex. The township has one public hospital (Tintswalo Hospital), a Police Station, Enhlazeni FET college, a local municipality office, and a small traffic police department.

The study took place in the mental health care unit of the hospital which is a 100 bed unit of which 30 beds are reserved for long term patients. The long term patients at the hospital include forensic patients that are normally admitted for more than a year. The mental health unit team comprises of a part time doctor, psychiatrist, nurse and occupational therapist that discuss and decide which patients could benefit from the work rehabilitation program. The vocational rehabilitation programme at the Tintswalo psychiatric hospital in rural Mpumalanga was implemented to address the work preparation and training needs of MHCU who undergo long-term hospitalization. The main goal of the programme is to promote the highest level of well-being and vocational functioning. The programme is therefore geared towards work preparation and training that involves re-training of the vocational skills of MHCU, particularly in the domains of work habits and work skills. The overall purpose of the programme is to prepare them for self-employment or employment in the community after they are discharged from the hospital. The occupational therapist is responsible for the programme in which both in- and outpatients participate. The programme runs daily from 08h00 until 16h00 under the supervision of the occupational therapist. The nurses and two occupational therapy assistants observe and supervise some of the projects in the absence of an occupational therapist.

The work training programme developed from one that initially only focused on simple craft activities to one that currently includes woodworking, shoe repair, gardening, a carwash and a tuck-shop. MHCU are assessed and placed in different work training activities according to their interests and abilities. They are able to generate an income through their participation in the different activities thereby addressing their self-esteem and motivation to seek employment post discharge. Accordingly, life-skills training sessions where skills such as job seeking skills, problem

solving skills, goal planning and financial management skills are addressed, also forms part of the overall work preparation programme. The life skills programme also encompasses social skills groups that are presented to the users at the hospital to assist them with coping skills when they return to work or to the community. During the programme at Tintswalo users are given communication cards to guide appropriate responses in specific situations. The communication cards assist the users to communicate better as cues to control anger or aggressive behaviour. The social skills training groups also assist the clients with anger management, to communicate effectively and to enable them to work as a team. As part of the programme clients attend the insight group, which assist to prevent relapse and which are continued after they are discharged from the programme.

3.3 Research approach



The study was positioned in the interpretivist paradigm and it utilised a qualitative research approach. Interpretive researchers believe that reality is socially constructed and informed by subjective experiences (Creswell, 2003). Qualitative research involves developing an in-depth understanding of these subjective experiences and perspectives of research participants. Qualitative research enables the researcher to develop such a level of detail about a research participant that he or she is highly involved in the actual experiences of the participants (Creswell, 2003). In the current study, a qualitative approach enabled the researcher to explore the MHCU experiences and perceptions of the work rehabilitation programme and its usefulness in assisting them to return to work after participating in it. These subjective realities of the participants played an important role in developing an in-depth understanding of the usefulness of the Tintswalo work

programme in developing the worker role and facilitating return to work from the participants' point of view.

3.4 Research Design

An exploratory-descriptive research design was utilised. Exploratory research aim is to seek new insight and to ask questions that brings phenomena into new light (Hair, Babin, Money & Samouel 2003). Babbie (2007) recommends exploratory design as a strategy which leads to new insights into any topic and this current study pursued new insight on the work programme. This approach allowed for the exploration of the participants personal perspectives and the descriptions that characterise their experiences on the research issues of enquiry without manipulation (Denzin, 2005).



Descriptive research is intended to provide a snapshot of a situation as it naturally occurs and may be used to make judgements about, or develop current practice (Sandelowski, 2000). The purpose of a qualitative descriptive design is to explore a rich description of an experience (Neergaard, Olesen & Andersen, 2009) for example the participants' experience of participating in the work rehabilitation programme at the hospital, as was the case in this study. Using the descriptive design ensured that the knowledge generated reflect a description in a similar language to that of the participants', thereby allowing that the truthfulness of data could be maintained (Neergaard, Olesen & Andersen, 2009).

3.5 Sampling and participant recruitment

Purposive sampling, which is a subjective selection of participants according to the study to be undertaken (Cormack, 2000) was utilised to select participants for the study. Babbie and Mouton (2006, p. 87) define purposive sampling as a type of sampling in which, “particular settings, persons, or events are deliberately selected for the important information they can provide”. The research question guides the researcher about what knowledge needs to be generated and the researcher select a sample accordingly ie. people who will be able to provide the information as guided by their experience (Babbie & Mouton, 2006). For this reason, the selection of the participants in this study was guided by the research question and study aim and objectives. Cormack (2000) suggests that qualitative researchers select a sample by following inclusion and exclusion criteria as required by the in-depth nature of the study. In view of this, participants were selected according to the following criteria:

Inclusion criteria:

Participants who were male and female who were in-patients and out-patients at the hospital

Participants who participated in the work programme for at least 6 months

Participants who were discharged from the programme and were employed.

Exclusion criteria:

Participants who were younger than 18 years

Participants who were experiencing psychosis

In-patients who met the criteria and who were participating in the programme were selected from the hospital register of in-patients, while out-patients who were participating in the programme and who met the criteria were selected from the hospital register of outpatients. Ten participants

were all invited to attend an information session where the study was introduced to them and an invitation for them to participate in the study were extended. Those who were employed and met the criteria, were selected from the occupational therapy follow-up register and were contacted telephonically and the researcher had all the information explained to them and then invited to participate in the study. A total of 10 patients that met the criteria were selected as participants in the study. In addition, three key informants were selected to participate in the study (see par 3.6.2).

3.6 Data collection methods

Semi-structured interviews with MHCU's, key informant interviews with the professionals at the mental health unit and focus groups with the MHCU's were utilised as data collection methods in this study.



3.6.1 Semi structured interviews

Semi-structured interviews are useful data collection tools to in-depth knowledge from individuals regarding their views, feelings, perceptions and/or experiences about research issues (Creswell, 2003). Semi-structured interviews can be organised around a number of pre-determined questions that can be prepared ahead of time (Polit & Beck, 2008), but allows for flexibility as deemed necessary by the progression of the interview (Creek & Lougher, 2006). For this reason, an interview-guide (see Appendix 1) was utilised in a flexible manner. The interview guide assisted in prompting and bringing back the participants to the topic discussed and still kept the interview open for discussion.

Semi-structured interviews were conducted with ten participants (five in-patients and five out-patients) and they all participated as planned. One interview was conducted with each individual participant. The purpose of the interviews were to explore how the participants perceived and experienced the work preparation and training aspects of the programme and continued until data saturation occurred which was after all ten interviews. The main topics that were discussed in the interviews were how the mental illness affected the participants and how they felt about participating in the work rehabilitation programme. The interviews were conducted in the occupational therapy department in a place with minimum distractions and lasted for about 45 minutes to an hour. The interviews were audio-taped and transcribed verbatim with permission from the participants to make sure there was an accurate account of the interview for analytic purposes.



3.6.2 Key informant interviews

Key informant interviews are tools that help a researcher to develop an in-depth understanding and knowledge of qualitative issues and allow for suggestions and/or recommendations to be obtained from interviewees (Sitko, 2013). The purpose of key informant interviews is to collect information from people who have first-hand information about a community or programme (Fink, 2003). Thus, key informant interviews involve getting information from individuals who are likely able to provide the needed information related to a particular subject (Krefting, 1991). Two professionals were selected to participate in the key informant interviews 1) a professional nurse who has been in the unit for more than 20 years and worked as an outpatient co-ordinator in the unit, and 2) an occupational therapy assistant who worked at the hospital since 2012 and was there at the initiation of the programme. The key informant interviews focussed on their perceptions of

the extent to which the programme facilitated return to work. An interview guide (see Appendix 2) was used in a flexible manner. The interviews were conducted in the occupational therapy department in a place with minimum distractions and lasted for about 45 minutes to an hour. The interviews were audio-taped and transcribed verbatim with permission from the participants to make sure there was an accurate account of the interview for analytic purposes.

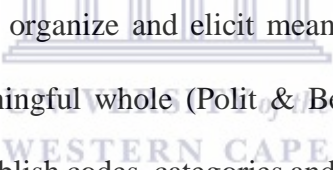
3.6.3 Focus groups

According to Wilkinson (2004) a focus group is a way of collecting qualitative data that utilises the group process and the engagement of a small number of people in a joint discussion on a particular topic. This was indeed the case in this study as participants appeared to be more expressive in the focus group as the ideas shared by their peers triggered more of their own thoughts to be shared. The advantage of focus groups is thus that the interaction and group dynamics can be utilised to generate knowledge about shared and individual experiences (Wilkinson, 2004). Accordingly, focus groups are a useful data collection tool for programme development research where the researcher aims to improve services like in this study. It was envisaged that the perceptions and experiences of the participants could inform the further development of the programme.

Two focus groups (one focus group with the five participants who were inpatients and one focus group with the five participants who were outpatients) was conducted after completion of the interviews and initial analysis of the transcripts. The purpose of the focus group was to conduct a deeper exploration of broad themes that emerged from the semi-structured interviews such as programme factors that influence return to work and the skills that participants improved. Informed

by the initial analysis of the interviews, an interview guide was compiled for the focus groups (see Appendix 3). Additional questions were added as determined during the focus groups. The focus group was facilitated in the form of an activity group. The participants were requested to first make a drawing to represent their perceptions and/or experiences of the programme on paper and then to share the drawing with the group. The participants all seemed to enjoy the activity as they were very engaged with their individual drawings that mainly showed the work they were doing at the hospital. The drawings were useful in facilitating the discussion and sharing in the group. The focus groups lasted for 45min to an hour and were audio-taped and transcribed verbatim with permission from the participants for analytic purposes.

3.6 Data Analysis



The purpose of data analysis is to organize and elicit meaning from research data, while also structuring the data into one meaningful whole (Polit & Beck 2008). In this study, inductive analysis was initially utilised to establish codes, categories and themes from the raw data. This was later followed by a deductive form of analysis as the themes were linked to the study objectives in interpreting the findings. Data analysis, organization, and interpretation, was conducted as informed by Tesch's (1992) five-step method of thematic analysis:

- 1) Get a sense of the whole: the researcher listened and re-listened to the audio-tapes, read and re-read through the transcriptions carefully and made notes about his ideas that was formed as he was reading.
- 2) Pick one transcript and go through it: the researcher spend time reading one transcript at a time and performed line by line coding to note the underlying.

3) Clustering of similar topics: the researcher made a list of all the codes and grouped together similar topics to form categories.

4) Relook at the data: The researcher took the list and went back to the data, abbreviated the topics as codes and wrote the codes next to the appropriate segments of the texts. The researcher also tried preliminary organising to see whether new categories and codes emerged.

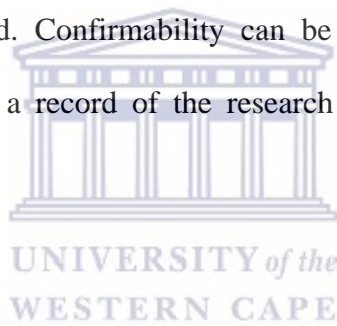
5) Reduction of categories: the researcher reduced the total list of categories by grouping together topics that relate to each other and linking categories to show their interrelationships in forming themes.

In this study, the semi-structured interviews were initially analysed following steps 1 to 4. Subsequent to the identification of emerging themes, a focus group guide was compiled to explore these topics in the focus groups. Thereafter, data from the focus groups were analysed following steps 1 to 4 as guided by Tesch. Finally, step 5 was implemented to reduce the total list of categories across all data sets by grouping together topics that relate to each other to form themes and to link categories to show their interrelationships.

3.7. Trustworthiness

The researcher ensured trustworthiness by using the measures as suggested by Lincoln and Guba (1985) and strategies as suggested by Krefting (1991). Credibility refers to the truth value in the study (Lincoln & Guba, 1985) and was ensured through member checking, reflexivity and peer debriefing. Member checking is a technique that consists of verifying the truthfulness of the data collected with the participants (Krefting, 1991). A group meeting was conducted with all the participants where the research findings was presented to them and discussed to check the accuracy

of the data collected. Reflexivity refers to the assessment of the influence of the researchers own background, perceptions, and interests on the qualitative research process (Krefting, 1991). Reflexivity was utilised by using a reflexive journal. Peer debriefing furthermore occurred with the research supervisors (Krefting, 1991). Transferability refers to the degree in which the study applies to other contexts and if the study could be generalized to other participants (Lincoln &Guba, 1985). This was ensured through a detailed description of the research process, methods and context (Krefting, 1991). Dependability is criterion that refers to the extent to which the research findings would be consistent if the study was to be repeated with the same subjects or in similar research settings (Lincoln &Guba, 1985). To ensure dependability, the same methods used to ensure credibility were utilised. Confirmability can be ensured through an inquiry audit (Krefting, 1991). For this reason a record of the research process and trail of data analysis throughout this study were kept.



3.8 Ethics statement

Ethics clearance was obtained from the UWC Research Committee (see Appendix 4) as well as the Mpumalanga Provincial Health Ethics Committee (see Appendix 5). The purpose of the research was thoroughly explained to the participants in English and Tsonga and they were provided with an information sheet (Appendix 6). Participants were given the information sheet before they participated in the study, the researcher explained every step of the study. Formal written consent (Appendix 7) was obtained from the participants. All information and forms were provided in English and/or Tsonga. Autonomy was ensured by assuring that all participation was voluntary and if participants chose to withdraw from the study they were not penalised in any way. The confidentiality of the participants was maintained by ensuring that all data gathered, including

audiotapes and transcripts were secured in a pass-word protected electronic folder and in a locked cabinet. This will be done for a period of two years following the study after which it will be destroyed. Anonymity was maintained by ensuring that any reports produced do not contain any information that might identify the participants nor will any future publications. Care was taken to minimise risks that may have occurred through human interaction and where necessary, participants were referred to the team psychiatrist as they experienced discomfort in that some participants expressed feelings of sadness at sharing some of their personal experiences.



CHAPTER 4

FINDINGS

4.1 Introduction

In this chapter the findings of the study are presented in the form of the themes and categories that emerged from the analysis of the data. Firstly a description of the participants in the study is provided followed by a report on the themes and categories as outlined in Table 2.

4.2 Description of participants

Participant 1 (P1): FI was a 30 year old single African male with a grade 12 level of education. He resided in a village about 45 km from the hospital with his parents and siblings. He started working at a steel company after matric because he could not go to the university and ended being mentally ill after taking substances at work in 2011, he was then diagnosed with a substance induced disorder (with episodes of depression). He had been in and out of hospital since then, and had been in the programme for 3 months while hospitalised at the time of the study.

Participant 2 (P2): MG was a 29 year old African male with a grade 12 level of education. He enrolled for the N4 and N5 with the district FET College and during his studies he developed psychiatric problems and was later diagnosed with bipolar mood disorder. He was admitted to the hospital where he participated in the woodwork work training programme. He was later discharged from the hospital after 3 months. He resides about 20km from the hospital. He returned to his job where he could not cope and decided to start his own project at home, doing tuck-shop, shoe repair and a carwash service. He had been participating in the programme as an outpatient for the past year.

Participant 3 (P3): DT was a 42 years old African male who was a forensic patient and had been hospitalised for a period of 2 years and was diagnosed with depression in his early 20s. He participated in the tuck-shop work training programme for 2 months in preparation for his discharge. At the time of the study he was living at home and actively engaged in seeking domestic work as a form of employment.

Participant 4 (P4): TB was 29 year old single woman with a grade 12 level of education. She was enrolled in her first year at university when her mental illness started. She has a history of substance abuse (substance induce disorder) and was admitted as a forensic patient after she committed the murder of her grandmother. She had been in hospital for a year and participates in the vocational programme where she works as an admin clerk and manages the tuck-shop at the hospital.

Participant 5 (P5): DE was a 42 year old African man who worked as an administrative clerk for a social grants company. He has a grade 12 level of education and HR management certificate. He was admitted as a forensic patient after violent outbursts and smashing property at work. He did not have a history of substance abuse. He was involved in an accident which then lead to the illness and no diagnosis yet except for depressive episodes with psychosis. He participated in the vocational programme for a period of four months where he took part in the carwash programme and assisted with serving clients at the tuck-shop. At the time of the study, he was a month post discharge, and an outpatient of the OT department.

Participant 6 (P6): SG was a 33 year old white male with a grade 9 level of education. He was admitted for 3 months with substance induce disorder as a primary diagnoses and continued to participate in the work programme as an outpatient for two weeks post discharge. Prior to the admission, he was a machine operator at Eskom and has returned to work as a general worker.

Participant 7 (P7): WD was a 39 year old African man who was a teacher before his admission to the hospital for a two year period. He was diagnosed with schizophrenia few years. Due to his delusions he was not able to return to teaching and since discharge a year ago has been running a small carwash and meat shop at his home. He attended the out-patient programme at the hospital where he was being monitored monthly for support.

Participant 8 (P8): GK was a 25 year old African male with a grade 5 level of education who was admitted to hospital a year before he joined the vocational programme. He was a domestic worker who suffered violent outbursts and was arrested. He was diagnosed with epilepsy and on medication. He participated in the work training programme for 2 months before he was discharged from the hospital. He however continues to participate in the programme as an out-patient.

Participant 9 (P9): SM was a 28 year old African male who has a grade 12 education, and was working for the local coca cola company as a general worker before his admission to the hospital who was diagnosed with substance induce psychosis. Since his discharge, he participated in the work programme for 3 months as an outpatient and was able to return to work in the same post after his discharge.

Participant 10 (P10): TT was a 32 year old female who resides close to the hospital admitted for depression. She worked at a bakery before a 3 month admission for depression during which time she participated in the work rehabilitation programme. She returned to work at the bakery post discharge but continue to participate in the programme on a two weekly basis as an out-patient.

4.3 Table 1: Themes & Categories

THEMES	CATEGORIES
Effects of mental illness	Compromised sense of well-being Poor functioning
Programme factors that influence return to work	Improvement of work habits Improvements of work skills Community re-integration
The value of participating in the work programme	Work restores a sense of self Work enhances functioning

4.4 Theme 1(Table 2): Effects of mental illness

Themes	Categories
Effects of mental illness	Compromised sense of well-being Poor functioning

Theme one captures the participant's expressions of how being diagnosed with a mental illness affected them. The theme captures psychosocial and functional disruptions caused by their mental illness before they joined the vocational rehabilitation programme and is underpinned by two categories: Low self-esteem and poor functioning.



4.4.1 Compromised sense of well-being

The treatment the participants received by other people including their families as MHCU contributed to them suffering a low self-esteem. This left them with a feeling that their sense of well-being was being compromised as well as their sense of being or sense of self. This was related to how they were treated by people in terms of negative attitudes and behaviors directed towards them. The participants expressed that families do not trust them and even when they are not ill they are left in the hospital for long periods.

sometimes my mom do not believe I am ok, I say mom I am okay and she says no... now when she brought me here I was sick but just very little, I stay in the hospital for too long because (avanilavi) they do not want me” (p 4: I/V)

They articulated that they felt that their sense of humanity was affected as they were stigmatised and prevented from participating in day to day activities like attending school, they felt mistreated by their families.

“I feel useless, I feel degraded its pressurising me, school, I was promised to be taken to school and when this illness started they just didn’t say anything about taking me to school, I am treated like I am not a person, people think I am sick and cannot hustle to be good as well, this is the bad”

(p 5: I/V)

Being stigmatised left the participants with a sense of fear and feeling disregarded by people and thus reduced their self esteem.



“It (the stigmatisation) made me to be afraid of myself and people, they are not taking me seriously” (p 6: I/V)

Stigmatisation of people with mental illness also affect their ability to work and affect their self-esteem.

“I think the stigma that people with mental illness experience affect them so that they are unable to do things for themselves, because stigma is a big issue affecting their self-esteem and actually they cannot even go back to work because everyone says this and that about them..” (K/I: 2)

The participants in the outpatient focus group expressed that even after their discharge from hospital community members as well as their family tend to isolate them causing them to have a low sense of self-esteem.

“I cannot think straight because of what people say about me, I don’t want to be around people because they can judge me of my illness and it affect me, I just worry to do things I cannot go outside because they say I am sick since I have been discharged” (p6: F/Group).

A participant elaborated on this to show that these effects furthermore lead to unbreakable habits that manifests throughout life for example in the manner that he has become socially withdrawn.

“I have low self-esteem I don’t trust myself, I don’t trust my instincts or believe in myself, because I know I am a failure...it affect me in social withdrawal, I struggle to make friends or socialise with people of my age” (p 5: I/V).

The participants further expressed that they lost hope of achieving their future goals and plans, thereby contributing to a negative sense of self. They articulated feelings of worthlessness as they felt that due to having a mental illness, they would be inadequate and never find any employment.

“When it comes to work I thought no one was ever going to hire me because of my mental illness, I was thinking that I am useless to people and I cannot do anything by myself” (p 5: I/V)

4.4.2 Poor functioning

The mental illness affected the participants 'overall functioning. In relation to being diagnosed with a mental illness, the participants expressed feelings of incompetence so that even when they wanted to do things that they liked they were unable to because of the effect that their pathology had on their functioning, thereby intensifying a low sense of self.

“I feel useless, I feel degraded its pressurising me, school, I was promised to be taken to school and when this illness started then I knew that I cannot do anything in life because I will achieve a zero, I cannot think and I look like a coward to all people even at work” (p 1: I/V)

One participant felt that the mental illness destroyed him and he did not feel that he was on par with his peers in meeting certain developmental milestones. Simultaneously, his ability to engage in social roles like forming and maintaining intimate relationships and taking care of others, were decreased.

“....It's(the mental illness) destroying me and I cannot marry a wife, I cannot do anything to enjoy life like my age mates I cannot achieve anything, imagine me taking care of a wife, when I struggle to take care of myself because of the ghost (mental illness).” (p 3: I/V).

Those participants who were employed expressed that they were unable to maintain their work activities because of a loss of concentration and other related functional challenges such as encountering difficulties focusing on one thing in particular.

“The first time when I got the illness, things started to go bad in my life, I was losing focus at work, and everything I wanted to achieve was a disturbance in my life.”(p 3: I/V).

The participants articulated a willingness to work, but that it was difficult to maintain work due to the disruption caused by the mental illness which they perceived to always taking precedence over their responsibilities and roles.

“I do work but I don’t work for a year because of the illness, when I think I have the right job, then something will happen, maybe side effects or I just get angry and stop the treatment, and balungu (white bosses) don’t want a crazy man here” (p 6: I/V).

Also, in the focus group when asked about how mental illness impacts them, the participants expressed that they could not work well because of the symptoms of mental illness. They expressed that it is difficult to function well when you are confused, depressed and anxious.

“So it (the mental illness) impacted negative in my life and I was very confused about what was going on for all that period until now I understand that I was going through depression and anxiety” (p3: F/Group).

Some participants expressed that their educational and work aspirations were not met due to a lack of focus and other problems leading them to drop out of school and feeling disappointed.

“Because (of the illness) I dropped out of matric because I started smoking and not listening in class. I was always outside.” (p 5: I/V).

“...sometimes the ghost come and go it makes work to be difficult you see, but I talk to the OT when the ghost keep on coming back” (p 7: I/V).

4.5 Theme 2 (Table 3): Programme factors that influence return to work

THEMES	CATEGORIES
Programme factors that influence return to work	Improvement of work habits Improvements of work skills Community re-integration

This theme captures the participants’ experiences of the Tintswalo work preparation and training programme. The theme illustrates the participants’ perspectives of specific components of the programme as factors that influenced establishing their worker role. The theme is supported by three categories: improvement of work habits, improvement of work skills, and community re-integration

4.5.1 Improvement of work habits

In referring to work habits, the participants identified activities that assisted them to establish a routine and manage their time. They regarded these as factors that facilitated their ability to successfully return to work. For some participants, these acquired work habits allowed them to

manage their time well so that on return to work post discharge from hospital, they were able to practice it on a daily basis.

“I wake up on time every morning and bath, clean, umh to go work at the shop to go work at shop and give people change, it’s good that no one tells me to do it, I do it because I know I can’t be late on the job... (p 1: I/V)

One key informant also emphasised the importance of punctuality and other skills as a pre requisite for return to work in the programme.

“In the prevocational programme patients are held accountable in terms of punctuality....The programme also focus on building of work competency skills where patients are trained on ability to initiate tasks, execute them sequentially, noting errors in own work and being able to evaluate the quality of their work, you know... all of this is important in terms of incorporating the patients in to open labour market/ work” (K/I: 1)

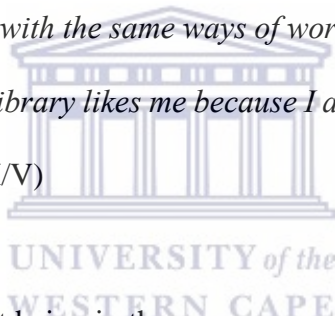
Punctuality which also appeared to be an indicator of increased motivation, was one of the acquired work habits that were highlighted by participants. The participants seemed to be motivated to stop the wrong habits since they were replaced by good vocational habits.

“The things I have been taught is not to be late at work, I even wake up on Saturdays to come to work because I know every day at 9 exactly I must work- work is good and giving me more money and a lot of things to learn to survive outside” (p 9: I/V).

“Waking up in the morning to work makes me happy ...waking up is the same everywhere you need to do it until you get used to it....you know work gives you that inside thing....You know in you that now you can do a lot more things than in the beginning, you know... I want to do a lot more at home when I get discharge” (p 1: I/V).

The participants expressed that the work habits that were instilled in them through the programme assisted them when they returned to work. They identified habits like being on time, being able to work in a team and respect for others as important facilitators of a successful return to work.

“Hey I got my job and now I work with the same ways of working that they taught me in hospital, ... my team that I work with at the library likes me because I am better than before I come early at work and I respect my boss,”(p 8: I/V)



The participants also expressed that being in the programme assisted them to be able to take care of the important work habit of personal hygiene.

“Personal hygiene you have to practice whether you like it or not because you working with people, if you urinate you sometimes don’t see a need to wash your hands because you were urinating so when you know that you are working with people think for their health. Cleaning my space I must always be clean (p 7: I/V)

Social interaction is a social- and life skill that they expressed to have improved at the completion of the work preparation programme and being able to relate better with their friends, family and everyone.

“So OT teaches me to interact with people the right way and become good in my life everywhere and also to be careful so that I can live and work well with people” (p 9: I/V).

“being friendly and having manners, being able to greet others well like your neighbours, maybe loving them a little, so that they are happy to walk with you in public I learned that in OT” (p 10: I/V).



The participants further expressed that their social interaction has improved to the extent that they are able to control arguments and interact constructively. For example when they feel that they are provoked they are now able to practice self-control due to the work programme.

“mhhhh right I can co participate to the people if now somebody can come to me and embarrass me with a bad provoke me then I can stop to argue with him because i have learned so much myself on o.t they said that” (p7:F/group).

4.5.2 Improvement of work skills

The participants highlighted specific work skills that they felt was improved through their participation in the work training programme. They considered these skills to be most useful for

them in returning to work. This means that after the completion of the programme, participants felt that they were now able to perform specific work tasks to optimal quality. They highlighted that learning and acquiring new skills was an important feature of the work skills programme that lead to an improvement in the quality of their work.

“All the jobs that I was doing with the therapist I am doing even now at work, I work and learn a job very fast and love my people and my job, nothing I do without good quality, all jobs want a good worker.” (p4: F/Group).

Entrepreneurship was one key skill that they acquired in the programme that was highlighted by the participants. For example, they expressed that they were able to implement skills related to developing and maintaining an informal small business.

“I can take this budget skill to go, eh and make my own car wash at home now, I also started my business, selling airtime, snacks... they are many I cannot explain them all” (p3: F/Group).

“The programme it helped me to know about the business all in all, let me break it down ngizothi (I will say) from stock taking, counting money, counting profit and buying stock again... all those things I have learned about it and its helping me at my work” (p 6: I/V).

The participants expressed that they were also encouraged to use their own initiative to run their own business as well as learning to do market research so that their entrepreneurial ambitions may be sustainable.

“Yes because what I do here its business I will do it outside in my own business and I will do market research on how to grow my consumer market, it will just give me ideas and if I open a fast food and then I add pop corns it’s another benefit because I think people love them” (p 5: I/V).

They valued the programme since it made them discover new skills that they didn’t know were important for future jobs they may do on returning to work post discharge form hospital.

“Every day I was made to count stock morning and late afternoon, I did not know it was so that I was going to work some job, now I can do any job I did in hospital in Therapy” (p4: F/Group).

They expressed that the work training was meaningful to them and made them to be more productive at their workplace when they returned to work. As they became more competent with their newly developed skills, they expressed a sense of satisfaction and positive outlook that appeared to motivate them to strive to better their lives overall. One participants in particular expressed that she made sure that customers are satisfied by her services and this made her feel good about her work.

“...making popcorn and the compliments I get after they eat my popcorn it encourages me in a way that they think I did something good to them or put something in them while I did nothing. I just know I must wait for the right time for them to just pop...as soon as I saw that I make people smile when they get the popcorn from my shop, then I was like yeah I can do more with my life than weed, you know...” (p 5: I/V).

A positive attitude made participants to value and enjoy work, thus making them to take responsibility for tasks given to them. They started showing more initiative and ownership of their work and its environment, being able to run their own work while also engaging in problem identification and solving.

... so I think we can open ngo 07:00 rather than ngo 09:00 because in the morning abantu baningi (there are a lot of people) so that's where you get customers but we lose customers due to our time so I can change the time slot. (p 7: I/V).

The classes I attended on Friday, I made plans for home, I will save money to start a business which had been my dream and plan for some time since I have been here. (p 8: I/V)

The participants also related how they were able to maintain a routine work life and being in control of their duties while taking responsibility at work.

“In the morning around 09:00 I take the hoover and everything that we are using and go to our working place, we start working with the people I'm working with, my job is to ensure that the things that we use are all there, we don't leave anything or nothing must get lost in the cars, and to make sure that our customers are satisfied with our work if they are not we talk to them and do it again, it's helping us to work with people and there is no other thing that to respect” (p 6: I/V).

4.5.3 Community re-integration.

When participants were asked about programme factors that influenced their return to work they also spoke about their ability to integrate as well as the challenges they encountered with re-integrating into the community. In the focus group the participants expressed a sense of ambivalence about returning to work as they feared relapsing due to a lack of a community support and being unsure about the availability of a support system at home.

“I don’t want to be discharged because they will make me drink and I will get sick again...home is a big problem, there are problems you see....problems that make you lose a lot of focus.” (p5: F/Group).



One difficulty participants encountered with regards to re-integrating into the community was that of dealing with the stigma of having a mental illness, even by their own family.

“...home is not homey anymore ...because people do not accept me as I am they do not trust me they think I am still mentally ill” (p1: F/Group)

They articulated how difficult it is to return to work or obtain employment when being stigmatised.

“...they are not taking me seriously when it comes to work I thought no one is going to hire me because of my mental illness, I couldn’t listen to people anymore thinking that I’m useless to people, it’s even very bad when family call you crazy ...who will give me a job if family say I am crazy” (p 1: I/V)

When they were discussed the challenges they face at work, participants expressed that even at work they face a problem of acceptance, whereby all mistakes done are always associated to mental illness.

“...a big problem is the pills that make you unwell but they think you come late because its mental illness that’s the problem, I know I’m sick but it’s not too bad, I must be trusted and feel welcome in my job. (p 4: I/V)

A key informant felt that it is very important for the programme to involve family members for support and successful community re-integration.

“...they need a complete routine that should remain the same every day and be monitored by family at home and I think if the patients continue getting positive feedback, then maybe some support from family that could restore the identity of that person...if they support him and he does well he will trust his work (K/I:2)

Another key informant alluded to the fact that MHCU are not well accepted in the community and also suggested that increased family support may aid community acceptance.

“we struggle getting relatives to support their people, they all do not want to accept these people in the community, ... so if the OTs can do something to involve family as well in the programme it will benefit all of us, you see, For example, selling tuck shop goods to community members or making other objects to sell” (K/I: 1)

One of the key informants did however mention that the engagement and support in work assisted some to a point where they are able to initiate small projects in the community on their own, thus aiding their community-reintegration.

“Most of the OT patients have improved and started small informal businesses there in the centres where they are placed” (K/I: 2)

4.6 Theme 3 (Table 4): The value of participating in the work programme

Themes	Categories
The value of participating in the work programme	Work restores a sense of self Work enhances functioning

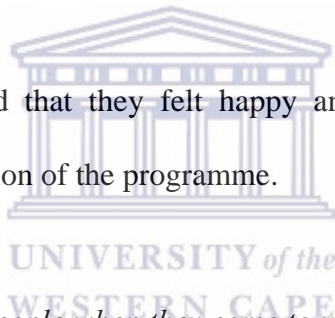
Theme three illustrates how the participants ended up valuing work as part of their daily activities during and after participating in the vocational rehabilitation programme. The theme furthermore captures the participants’ perceptions regarding its influence on return to work. The theme encompasses the following categories: Work restores a sense of self and Work enhances functioning.

4.6.1 Work restores a sense of self

The participants expressed that they felt that being able to work restored their self-esteem and enhanced their sense of self thus they were able to look to the future and set goals to better themselves.

“...work really restored me I would change what we are selling and add some other things and minus few other things, selling has now become my passion so I would change the business to be the best,” (p 8: I/V)

The participants further expressed that they felt happy and were able to start believing in themselves again after the completion of the programme.



“I feel happy...you know a lot of people when they come to wash their cars here (at the hospital) it means you know him or her when you go outside at home... they know that you are the master of the car” (p 1: I/V).

They expressed feelings of accomplishments or usefulness in their work as they felt they were acknowledged for what they achieved.

“I feel very good about the car wash and the garden and when we are done we get compliments and appreciation from the owners of the cars we washed” (p 8: I/V)

“(Like that) makunjalo and I enjoy the part that I make pop corns it’s very great they appreciate you and make compliments.” (p 5: I/V)

One of the ways participants expressed the value of participating in the work programme in relation to enhancing a sense of self was through the acknowledgement of a positive attitude towards their work. One participant felt that she was able to not just trust other people but also herself again and that allowed her to have a self-belief. They reported that this encouraged them to do more because of a renewed sense of hope.

“I had something to wake up to- no fighting others in the ward but always just being motivated and wanting to work”(p 8: I/V).



it’s helping me, yeah...swakunititibanakambe (to know myself again) because most of the time I find myself not working but being in work now it’s restoring me to how I know myself.” (p 6: I/V).

They articulated that a positive attitude helps one to cope better with any challenges they encountered. One participant expressed that work keeps him busy and take him out of substances and he is happy that he can work as well as any ‘normal’ person.

“I have learned a lot now, this carwash could take me out of dagga at home which is my plans....it keeps me busy while at work and it makes me accept myself and feel comfortable with my condition, that I can work like normal people” (p 4: I/V).

4.6.2 Work enhances functioning

When the participants were asked about how the vocational programme helps them all of them singled out the restoration of their financial status due to them being able to generate an income through work. In relation to this, they reported a major change in their livelihoods as well as that of their families.

“There is a change because I am able to do something better and take care of my family with the money that I have earned, so working is really good for me and for them” (p 6 : I/V).

“Yes it helps a lot because now when my siblings invite me I’m able to contribute R10 or R20 for them to use” (p 2: I/V).



The participants valued being able to take care of themselves and being able to provide for themselves.

“If I save that money from work hmmm I’m earning I can be able to buy myself some stuff that I need while here” (p5 F/Group)

“As it pays I won’t have to trouble my mom about my bathing things every month” (p 1: I/V).

The participants alluded to the fact that occupational engagement enables their health and well-being; work gave them strength to wake up to something every morning.

“I do have interest from the beginning I was happy because angithandi ukulala kakhulu emini, phela ngigula kakhulu mangilele (I get sick when I sleep), so when they asked ukuthi ngizovula istolo (when they said we will work at tuckshop,I don’t like sleeping a lot)” (p 6: I/V).

Participants who were admitted due to stress related illness discussed that being involved in work helped them to cope well with their depression, they explained that the more work less stress they experience which make functioning and re-integration much easier.

“I’m happy about this programme as it has given me something to do with my hands, it helps me a lot and I enjoy it... Working helps me to be active and keep my mind active” (p 2: I/V).

“I think my stress and sickness go away when I work, work even if it’s not too much pay but it makes you happy” (p 1: I/V).



The work training at Tintswalo hospital has also prepared participants to be responsible at work. They expressed that they were able to return to work and function to optimal capacity.

“I now can work again in my company like any other worker here- I think no one will tell me wake up- because my life is complete at work” (p 7: I/V).

4.7 Conclusion

This chapter described the findings of this study which reflect the perceptions and experiences that the participants had regarding participating in the work rehabilitation programme at Tintswalo which aimed to return clients to work. Theme 1 described the participants' experiences and perceptions of the effects of mental illness in their lives. Theme 2 presented the experiences and perceptions of participants regarding programme factors that influenced or facilitated the return to work process. Theme 3 described the participants' experiences and perceptions of how they value work or the vocational rehabilitation programme.



CHAPTER 5

DISCUSSION

5.1 Introduction

In this chapter a discussion of the findings of the study as it relates to its objectives i.e. perceptions and experiences of the work preparation activities, perceptions and experiences of the work training activities, perceptions and experiences of the life skills sessions, and perceptions and experiences about re-integrating to their worker role after participating in the vocational rehabilitation programme. The findings of the study will be synthesised to offer an interpretation of the usefulness of the Tintswalo vocational rehabilitation programme on return to work and developing the worker role of the participants, as guided by the Model of The Ecology of Human Performance (EHP).



5.2 The effects of mental illness

5.2.1 Compromised sense of well-being

A compromised sense of well-being that in fact encompassed a feeling of restriction in being as well as a low sense of self and self-esteem was expressed by participants that impacted on their ability to cope with their daily lives and hindered integration back to work. The findings highlighted that the participants were of the opinion that being stigmatised and being at a mental health institution degraded them. This combined with a lack of opportunities for occupational engagement affected their sense of self in a negative way. These findings concur with that of the study conducted by Karakaş, Okanl, Ylmaz (2016) that also revealed that MHCU self-esteem decreased with increasing levels of stigmatisation. Identity and self-esteem are closely related and

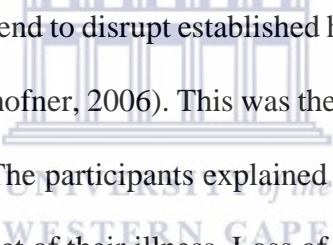
important to mental health. This point of view is reiterated by several authors who asserts that due to MHCU being marginalised the feeling of rejection is often exacerbated when they are unemployed (Strong, 1998; Macias, Rodican, Hargreaves, Jones, & Barreira, 2006) and this was certainly so for the participants of this study.

According to Maslow (1970) once individuals have satisfactorily met their need for love and belonging, they develop a sense of self-worth and pride in their work (Henwood, 2015). However, with the participant's feeling of stigmatisation or discrimination it was difficult to have a sense of wellbeing or self-esteem because they did not feel loved and a sense of belonging. Well-being is however influenced by people feeling safe, secure, and part of a group such as a community. If the needs that are at the lowest on the hierarchy are not met, it is also difficult for the person with mental illness to return to work. The important role that the Tintswalo Work Rehabilitation Programme plays in restoring the identity and self-esteem and by implication mental health of the participants, is therefore illuminated by these findings as work has been stated to be a means of self-worth and self-identity (Gard & Sandberg, 1998, Sanders & Wright, 2000, Van Niekerk, 2008).

5.2.2 Poor functioning

According to WHO (2000), the main problem for people with mental illness is decreased functioning in activities of daily living, including work. Activities of daily living (ADLs) refers to the common, everyday activities or tasks that people do to become able to cope with and respond to the demands of life (Ivarson, Carlsson & Sidenvall, 2004). Activities of daily living (ADLs) may include daily activities such as bathing, eating and dressing and other necessary activities for

basic survival. In the case of the participants, they experienced a disruption in these activities due to their mental illness. Examples of how this occurred was in their inability to maintain their personal hygiene, lacking concentration, being unable to focus on tasks at school or work; and finding it difficult to interact with others socially. This is not surprising as mental illness can affect a person's thoughts and behaviour and the ability to function within context (WHO, 2000; Corrigan and Miller, 2004). The participants' experiences of the negative effects of mental illness shows a strong similarity with that described by Corrigan and Miller (2004) in their study where the participants also experienced difficulties with social interaction and came to the realisation that tasks which they could perform before, they could no longer do due to their mental illness.



As the onset of disability or illness tend to disrupt established habits, relearning or developing new habits are required (Forsyth & Keilhofner, 2006). This was the main reason for the initiation of the Tintswalo vocational programme. The participants explained how they had difficulty performing their expected work tasks at the onset of their illness. Loss of concentration on work related tasks and school based activities were key problems experienced by the participants. This in turn negatively impacted their level of motivation in the performance area of work. Depending on the age of onset of a mental illness, an individual's working capacity may be significantly reduced or disabled (WHO, 2000). This was also the case for the participants in this study as they reported that their mental illness affected their functional and work capacity in various ways. For example, the findings highlighted that the participants experienced difficulty communicating with customers or peers during the programme and generally had difficulty coping with day to day tasks. This concurs with a study conducted by Metts (2000) where he found that people with mental illness struggle to maintain relationships and to cope at school or work.

5.2.3 Occupational injustices experienced

According to Van Niekerk (2011) work has the potential to facilitate the integration of PWDs into mainstream society but the injustice of the exclusion that they often experience can be exacerbated due to a lack of opportunities and discrimination. This is illustrated in the participants' expressions of the social exclusion they encountered when searching for work in that they were undermined due to stigmatisation and refused by potential employers. Sherry (2015) alert to the fact that most MCHU in rural areas experience occupational injustices and in relation to this highlights access to work as an occupational injustice. Some participants related how they were refused work due to their mental illness, thus they experienced occupational deprivation as they were unable to fulfil their needs due to external factors that restricted them (Whiteford, 2000). Other participants spoke of feeling isolated in hospital where they mainly slept and experienced a lack of meaning in their days, thus they experienced occupational imbalance as well as occupational alienation (Wilcock, 2006). The situation however did not change for most of the participants post discharge as they encountered stigmatisation which hindered their community re-integration and return to work.

It can thus be argued that the role of the occupational therapist in work rehabilitation should also involve addressing barriers to access to work in order to facilitate full community-reintegration and return to work for MCHU. It is a fundamental principle of the occupational therapy profession that occupational performance is a basic human right (Wilcock, 2006). This highlights the need for the Tintswalo work rehabilitation programme to be more actively engaged in the promotion of equal opportunities and the facilitation of access to work aimed at promoting and ensuring the right of MCHU to work in the open labour market (UN, 2006).

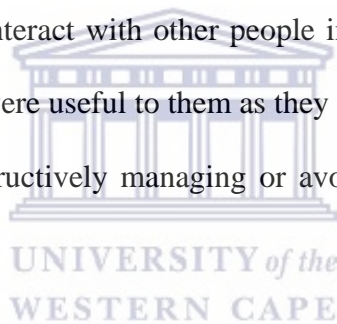
A further barrier to community re-integration that was highlighted by the findings is that of a lack of social and family support. This is substantiated in the literature as the importance of encouragement from family members, participating in the community by attending social gatherings and establishing social support networks are emphasised as important facilitators of community re-integration for MHCU (Bohleni, 2009; Stumbo et al, 2015). While one of the key informants acknowledged the need for the programme to extend its work with regards to generating increased family support the findings also highlight the need for the programme to actively engage in the facilitation of community-based support networks for clients post discharge from hospital in order to facilitate community re-integration and return to work.

5.3 The work preparation and life skills activities in the programme

With regards to the participants' perceptions and experiences of the work preparation and life skills activities in the programme, it was revealed that they generally placed a high value on these activities. The WHO (2000) states that the consequences of mental health problems in the workplace include poor time keeping and poor social interaction, while the main goal of vocational rehabilitation is to promote the highest levels of social functioning, vocational functioning and wellbeing for MHCU (Lieberman, Hilty, Drake, & Tsang, 2001). Accordingly, the work preparation programme inclusive of social- and life skills training at Tintswalo hospital appeared to be geared towards enhancing work ability by improving skills such as good work habits, social interaction, stress management and problem solving. It emerged that work habits such as punctuality, respect for others and being a team player as well as life skills such as time management; communication, conflict management and problem solving showed marked improvement after participation in the programme. In particular, habits like maintaining personal

hygiene at work and good interpersonal skills were emphasized by the participants. They developed the ability to initiate tasks and taking on responsibilities became easier for them as they started to develop a positive attitude towards work.

These findings are significant as poor vocational adjustment, time management and problem solving skills have been sighted as barriers to community re-integration in respect of returning to work for MHCU (Stumbo et al, 2015). Specifically, these skills and in particular the participants' social functioning emerged as a significant predictor of the quality of their work place performance. The participants expressed that the programme allowed them to improve their social skills because they were able to interact with other people in the programme. Consequently, in returning to work the same skills were useful to them as they were able to replace bad habits with good habits for instance by constructively managing or avoiding conflict even when they felt provoked.



5.4 The work training activities in the programme

Developing specific work skills as part of work training is an important role for the occupational therapists in vocational rehabilitation (Davis & Rinaldi, 2004). The work training that the participants were exposed to can be summarised around four skill areas: social skills when interacting with people and customers, professional behaviours in the workplace, time management and problem-solving. With regards to the participants' perceptions and experiences of the work training activities in the programme, the findings highlighted the development of entrepreneurship skills as a key feature in their return to work. This was evident when some participants started to take charge of their own small businesses, initiated changes after completing

market research and managed their own budgets. Participants who were involved in the carwash and tuck-shop programmes in particular, singled out their newly acquired entrepreneurial skills as facilitators of their successful return to work. More specific skills include improvement in specific work skills like decision making and attentiveness; improved comprehension during task involvement and improved quality of performance. This is significant as literature highlighted the development of these skills as imperatives of vocational rehabilitation (Oka, Otsuka, Yokoyama, Mintz & Hoshino, 2004; Buys, 2015; Van Biljon, Casteljen, & Du Toit, 2016).

5.5 Re-integrating into the worker role

Fulfilling one's worker role is an important way of participating in one's community and, for MHCU, returning to work is important in the recovery process. In exploring factors that cause people with disabilities to enter employment in the open labour market Engelbrecht and Lorenzo (2010) found that earning an income was at the top of the list as it provided a sense of independence, self-sufficiency and satisfaction. This concurs with the findings of this study as all the participants highlighted financial independence and being able to contribute to their own and their family's livelihood as the main contributor in restoring their sense of self upon returning to work. While most participants resorted to starting their own informal small businesses working from home, with those who returned to work in the open labour market being in the minority the restoration of their identity and functional status stood out in the findings as a key experience related to their re-integration into the worker role. This furthermore concur with the point of view of Meriano and Latella (2008) who states that enabling people to engage in occupations that are meaningful to them, such as work, facilitates the process of them redefining their occupational

identities. As discussed earlier, employment contributes to the recovery of MHCU by giving them facilitating social inclusion as they re-integrate into the worker role (Champney & Dzurec, 1992; Rebeiro & Allen, 1998; Boyce et al., 2007). This is illustrated in the findings by means of the increased motivation and commitment to meeting their work goals that was displayed by the participants therefore enabling them to engage in meaningful occupations.

Facilitators of a programme is described by WHO (2003) as factors that by their presence in an individual's environment, improve functioning and reduce disability in a person. In 2001 a qualitative study was conducted on training social problem solving among persons with schizophrenia, the researchers Liberman, Eckman, and Marder (2001) determined that just teaching social skills will not always enable mental health care users to generalize those skills to other domains in life, possibly work. This is an important factor in facilitating clients' re-integration to the worker role and return to work as training that is too generic in nature may not provide enough job-specific training, hence the skills given should be specific skills according to the goals of the client (Cheung, Tsang, and Tsui, 2006). The findings of this study show that the Tintswalo work rehabilitation programme was able to facilitate return to work through the environment it created for the participants to acquire and develop specific work habits and skills according to their specific goals.

An important finding that emerged in respect of re-integrating into the worker role is the increased level of motivation and change in attitude towards work and the future that was articulated by some of the participants. Charness and Kuhn (2007) found that worker attitude directly affects behavior and thus overall quality of work when returning to work after an injury or an illness. For example,

while non-compliance to medication due to decreased motivation and substance abuse have been identified as barriers to community re-integration (Bokleni (2009), the findings of this study highlighted that some participants, upon the restoration of their worker role, were able to turn away from drugs thereby enhancing the success of their return to work.

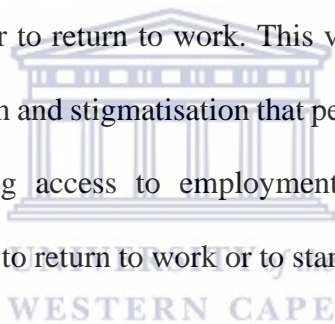
It must however be noted that it cannot be conclusively claimed that the Tintswalo work programme fully achieved community re-integration inclusive of return to work. The programme is situated in a rural area where the community still lack knowledge about mental illness and community integration is challenging because of the stigma carried by mental illness in the community. There are people in the community, including some family members, who still believe that all mental illness is due to witchcraft and is associated with evil. In the community there is also little knowledge about how mental illness can be treated, because the community still believe that it can be cured traditionally, which affects the users in that, they end up not adhering to the treatment given and delay return to work.

The role that the programme should play with regards to advocacy for the rights of MHCU to work in the open labour market was discussed earlier. An additional area for development of the programme is that of supported employment in the where most clients reside. Buys and Van Biljon (1998) assert that supported employment is fundamental to a successful return to work outcome and should involve employers, referral sources and family members as well as follow-up after discharge. There is little evidence from the findings to suggest that the programme engages with any of these practices and thus how this could be addressed by the occupational therapist warrants an exploration. It is recommended by Van Niekerk et al. (2011) that policy to guide the

implementation of supported employment in South Africa need to be developed. They further suggests that successful vocational rehabilitation and supported employment programmes are dependent on the necessary funding to support the integration of PWDs in returning to work. These are factors that need to be taken into consideration in exploring the further development of the Tintswalo programme.

5.6 The Tintswalo work programme: (in relation to the EHP Model)

The main aim of the Tintswalo work programme is to integrate MHCU (that include in-patients, voluntarily, referred patients from other hospitals and out-patient users) by preparing them and equipping them with skills in order to return to work. This vocational rehabilitation programme aims to overcome the discrimination and stigmatisation that people with mental illness experience, in order to facilitate their having access to employment. Once participants complete the programme they receive assistance to return to work or to start their own informal small business.



This EHP model expresses the importance of context and its impact on the occupational performance of the person, emphasising that in order for a person to be understood fully they must be studied in context (Dunn, McClain, Brown, & Youngstrom, 2003). Components of the model are the person, the context, tasks and performance. Persons are embedded in their contexts. Performance results when the person interacts with the context to engage in tasks. Figure 1 provides an illustration of the Tintswalo programme in assisting return to work as perceived and experienced by the participants from the perspective of the EHP model. The different strategies of the EHP are presented followed by a discussion of how this impacted the participants to improve work performance.

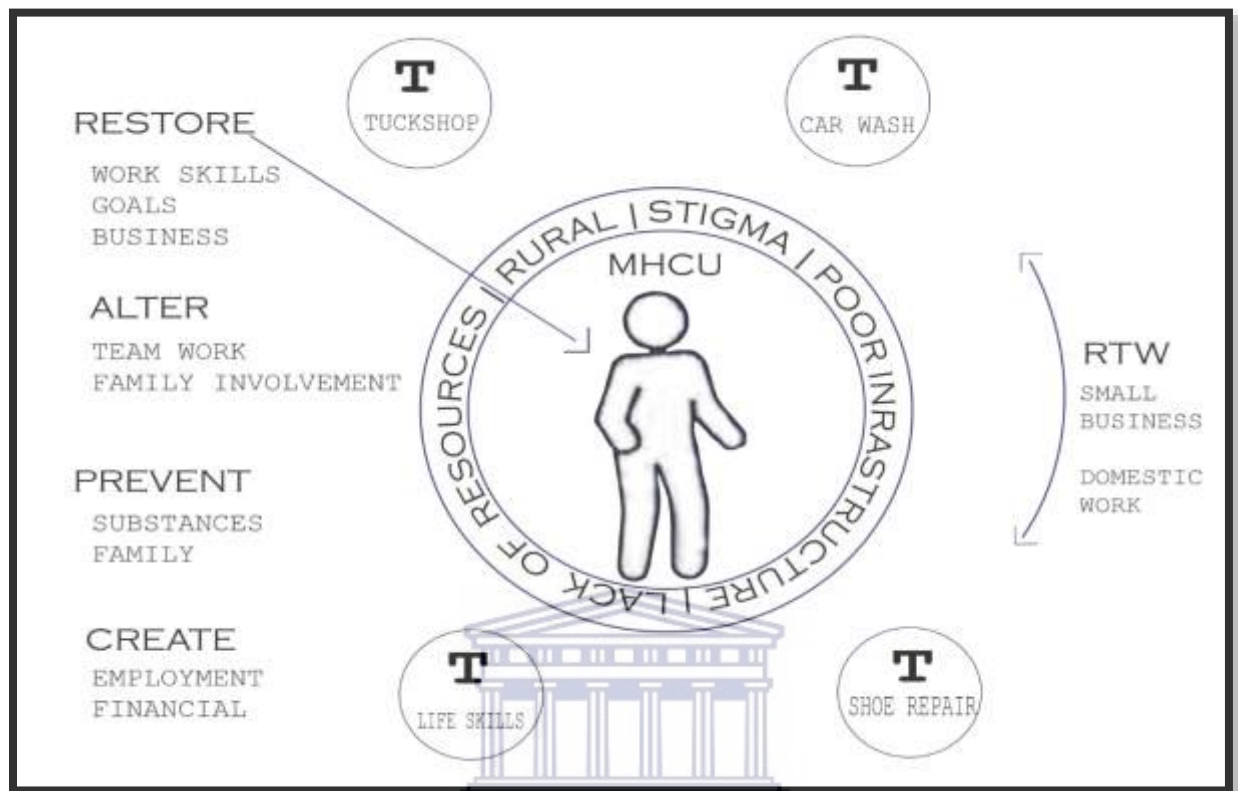


Figure 1. The Tinswalo work programme

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The person

The person refer to the MHCU or the research participant. The main focus of the EHP framework is on the interdependent nature of the relationship between the person and the context; and how this relationship impacts on occupational performance. In theme 1 the participants reported the challenges they experienced due to the poor interaction they had with the context/environment. They expressed that society rejected them resulting in low self-esteem and poor functioning. This concurs with the assumption of the model that says the relationship between the person and the environment is interdependent. The participants in this study expressed an improvement in their skills and abilities as a result of their participation in the work rehabilitation programme. This was

evident when some participants returned to work. The participants experience was that when they were able to use what they learned they were able to be motivated to continue. In the case of most participants, returning to work after a long admission could have been more challenging if they did not have life skills and work preparation and training. The vocational programme assisted the participants in acquiring alternative skills thus facilitating return to work.

Context

The Model of the Ecology of Human Performance developed by Dunn, Brown and McGuigan (1998) states that the environment (context) can support the person in their performance of tasks and that the context can offer cues for task performance and behaviour. This should be done with the assistance of the family so that there is support and sustainability of new skills developed. The participants expressed in theme 1 that even when they try to impress their relatives by showing them skills learned at the programme, they get demotivated by the stigma. There are also negative and stereotypical attitudes displayed within the community related to mental illness being seen as threatening and uncomfortable. These attitudes foster stigma and discrimination towards MHCU. The context is furthermore characterised by limited infrastructure and resources for MHCU, all contributing to them experiencing difficulty in obtaining work.

Task and occupational performance

The EHP framework enables professionals not only to consider the skills the person may be able to develop, but also the skills the person already has and ways to change tasks, methods and environments to facilitate successful performance (Dunn, Brown, McClain, & Westman, 1994). The EHP framework and vocational rehabilitation have complementary strategies and they work

similar which is the reason the concepts of EHP was of importance in this study. First, the EHP framework is a model for identifying needs and designing strategies to support an increase in functional performance in daily life inclusive of work; while vocational rehabilitation programmes share the focus of supporting people's functional abilities so that they return to work (Dunn, 1993). The focus is on the person goals, the person work together to identify strengths and barriers to returning to work and then uses the EHP strategies to address them.

The programme at Tintswalo uses similar strategies in preparing the users for a RTW. Theme 3 is a description of what the users expressed as changes in their lives after being in the programme, they expressed that the programme was useful in skills and ability development. They also expressed that the work skills created a better environment for them and improved work performance. Work has been described as beneficial in many ways for people with mental illness; apart from it providing an income, it has also been associated with personal, social and emotional development, (Jakobsen, 2004). After the participation on the programme the participants reported that they were able to set goals for their future. The work itself served as a support system for the participants, participating in the work programme or returning to work assisted them with ways to cope with the negative effects of mental illness. The strategies outlined by the EHP model was applied as follows in the programme:

1) *Establish/Restore* -The Tintswalo work programme addressed the restoration of the participants' skills. The aim of this strategy is to restore function by improving abilities and skills of the user that is dysfunctional. This strategy aims to work on the person by restoring the skills and abilities, as presented in figure 1 that whenever the skills and abilities are enhanced the person performs well within the context. After the programme some participants were able to start informal small

businesses which was meaningful to them. In the first theme participants felt that the mental illness affected them negatively and they had limited occupational performance. The participants in theme two expressed that their work skills, work habits, life skills and sense of self was improved or restored.

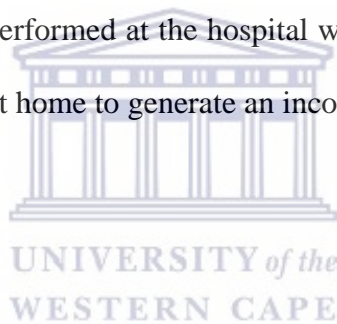
2) *Alter* is a strategy that involves alteration of the context so that it supports performance with the person's skills and abilities. In vocational rehabilitation this strategy may address the lessening of distractions that may impact performance. During the programme at Tintswalo users were given cards to respond in situations. Most users had a challenge of anger outbursts and the cue cards appeared to assist them to respond to others constructively. The social skills training groups were also groups that assisted the participants to know each other and enabled them to work as a team. The framework also emphasizes on altering the environment to support the user, the key informant expressed the need to also work with families so that the users could be best supported when they return home or to work. This is an area for development in the programme.

3) *Adapt* addresses contextual (environmental) features and task demands to support and enable performance. This means that the therapist and the person acknowledge the person's abilities, skills, needs and natural features of the current context, then select the best possible match to enable optimal performance. MHCU with poor memory for example could be educated to use compensatory techniques e.g. writing cues on what they need to do everywhere in the workplace.

4) *Prevent* addresses aspects of the person, task or context that could lead to maladaptive performance or a problem in the future. Thus, this strategy is about the therapist recognising the problem and finding solutions before it re-occur in future. At Tintswalo MHCU with predictable social problems are assisted in social skills groups that are run as work preparation prior to them joining the work training programme. Similarly, insight groups are continued with all the

participants even when they were discharged from the programme. Participants expressed that being part of the work programme assisted them not to go back to return to substance abuse, which a factor in the occurrence of relapse. The key informant in the study emphasized the issue of family support and the participants also expressed that they would be happier if their family could support them. This appears to be an area of development for the programme and this strategy would work well if not just families but also employers were fully involved in the programme.

5) *Create* is about MHCU developing skill so that they will be able to find and maintain employment in the community or engage in self-employment post discharge from the vocational rehabilitation programme. There are participants that at discharge could start informal businesses. The work training activities they performed at the hospital were acquired as new skills that they developed and were able to use it at home to generate an income for their families.



5.7 Summary

In this chapter the findings of the study as it relates to its objectives was discussed. The findings highlighted the effects of mental illness which were low self-esteem, poor functioning and the occupational injustices experienced by the users. The findings of the study were synthesized to offer an interpretation of the usefulness of the Tintswalo vocational rehabilitation programme on return to work and developing the worker role of the participants.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In this chapter, a summary of the study in reference to its objectives and main conclusion is presented. The limitations of the study are discussed and recommendations that emerged from the findings are presented.

6.2 Conclusion

MHCU at Tintswalo hospital often complained that they do not have opportunities for any meaningful occupational engagement after their discharge from the hospital. They encounter finding or maintaining work as challenging and while they might be interested and willing to work, they are generally not accommodated in the workplace due to their mental illness. The purpose of this study was to explore and describe the perceptions and experiences of MHCU of the work rehabilitation programme in order to generate an understanding of the perceived value of the programme in enhancing the worker role from their perspective. The significance of the study lies in the generation of knowledge regarding MHCU perceptions and experiences of the programme that is valuable to furthering the development of the Tintswalo hospital vocational rehabilitation programme as well as informing current work practice to be relevant to the needs of MHCU in rural settings and facilitate their return to work.

Three themes emerged from the study: Effects of mental illness, programme factors that influence return to work and the value of participating in the work programme. In theme one the participants

expressed negative effects and experiences associated with mental illness and being a MHCU when they were asked to describe themselves. The theme captured psychosocial factors i.e. low self-esteem and functional disruptions caused by their mental illness before they joined the vocational rehabilitation programme. The second theme captured the participants' experiences of the Tintswalo Work Rehabilitation Programme and their perceptions regarding its influence on return to work. In theme two participants expressed how the programme influenced or facilitated their return to work through the development of work habits and skills. Theme three illustrated how the participants ended up valuing work as part of their daily activities during and after participating in the vocational rehabilitation programme.

This study portrayed how the participants were facing barriers such as poor support systems in the home and work environment after the completion vocational rehabilitation programme. They also experienced some positive facilitators such as the enhanced their work skills, work habits and basic life skills that informed positive behavioral changes. The participants do face challenges after the completion of the programme, where communities, family and friends continue to marginalise them because they have a mental illness, while some struggle to find employment and only a few return to work.

6.3 Recommendations

The findings of this study are beneficial to the development of the Tintswalo Work Rehabilitation Programme. In relation to this, recommendations are made in respect of the following:

6.3.1 Advocacy for MHCU

There is a need for the Tintswalo Work Rehabilitation Programme to be more actively engaged in disability rights advocacy i.e. the promotion of equal opportunities and the facilitation of access to work. It is recommended that the hospital partner with disabled people's organisations, community based organisations and existing advocacy groups in the community to jointly address disability rights advocacy.



6.3.2 Family support

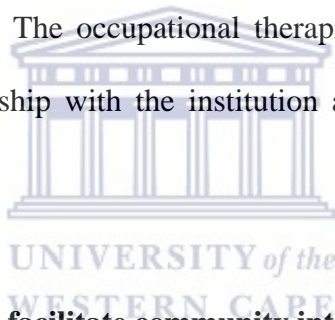
It is recommended that the Tintswalo Work Rehabilitation Programme include family support services throughout the intervention process in order to help in the creation of a strong support system for the MHCU and to address stigma in the family. Family eg caregivers could also be involved in the administration of the work training programme and the transfer of specific skills to the MHCU. They could be invited to attend the life skills sessions and also to review progress of the users.

6.3.3 Supported employment

It is recommended that the Tintswalo Work Rehabilitation Programme be developed to encompass supported employment. The occupational therapist should provide support to the MHCU when they return to work for at least 4 months and continue reinforcing the basic life skills, work habits

and basic work skills such as effective communication in the workplace, conflict management as well as addressing social factors that might impact on the workers roles. In advocating for a supported employment programme, there should be collaboration with employers, the Department of Health, the Department of Social Development and the Department of Labour. It is recommended that policy to address the creation of grants that can assist MHCU to participate in a supported employment programme be addressed.

It is also recommended that the Tintswalo Work Rehabilitation Programme could be linked with some of the available sheltered factory employment programmes to train and place the users in the Mpumalanga Bushbuckridge area. The occupational therapist and social worker should work together in establishing a relationship with the institution and other available centres so that MHCU can be accommodated.



6.3.4 Develop personal skills to facilitate community integration

It is recommended that all MHCU that participated in the programme and do not have employment post discharge be assisted to find employment or to start informal small businesses in the community. This could be done by implementing support groups and vocational projects such as the gardening, shoe repair, car wash, and crafts activities outside the hospital to assist community integration and alleviate unemployment of the MHCU and can be implemented by the community field workers.

6.3.4 Recommendations for future research

It is recommended that future research explores caregivers', employers' and families' perceptions and experiences regarding MHCU participation in the Tintswalo rehabilitation programme. This may shed some light onto how the programme can be developed to assist community integration from their perspectives.

6.4 Limitations of the study

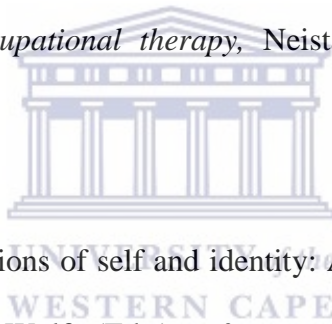
In this study, there was only one female participant. Although an effort was made to include both genders in the study, it was however not easy to obtain females who met the inclusion criteria at the time of the study. Some of the participants found difficulty expressing themselves during the interviews and focus groups, which could have been due to the side effects of their medication. It is a limitation that this study did not seek formal feedback related to MHCU participation in the work rehabilitation programme from caregivers, employers and families regarding their perspectives on the value of the programme. As recommended, this should be considered for future research.

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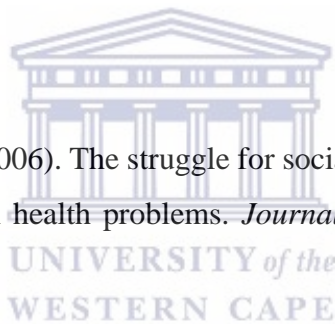
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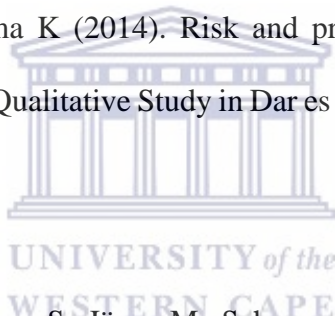
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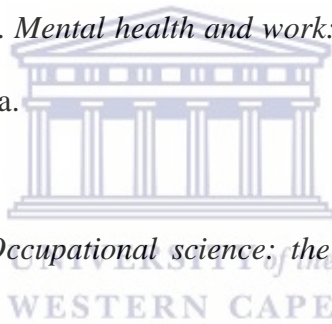
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APPENDIX 1

INTERVIEW GUIDE

- 1) Could you describe how your mental illness impacted your life, before you started the vocational rehabilitation programme?

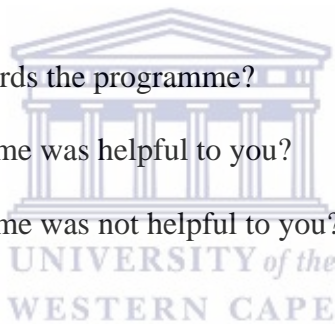
Probe: What activities did you participate in with regards to work before?

- 2) Could you describe the part of the programmes you participated in that assisted you in preparing you for work?

Probe: Describe your feelings towards the programme?

Probe: Which parts of the programme was helpful to you?

Probe: Which parts of the programme was not helpful to you?



- 3) Could you describe how the programme assisted you in terms of work training?

Probe: Would you say, you had an input in choosing which activities you could do in the programme? Please explain.

Probe: Were you able to focus on areas which you felt needed attention?

- 4) Could you describe the how the programme assisted you in terms of life skills and how you improved in this area?

- 5) What would you like to be changed in the work rehabilitation programme? Please explain.

APPENDIX 2

Key informant interview guide

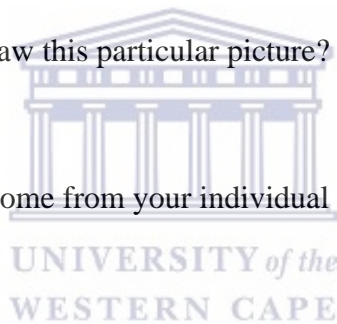
1. Please describe the vocational rehabilitation programme that is offered at Tintswalo Hospital.
2. How do you understand the rationale for the manner in which the programme is implemented?
3. What are your perceptions regarding the value of the programme for mental health care users with regards to work preparation and training?
4. How do you think the programme could be developed to meet the needs of MHCU in the community?



APPENDIX 3

Focus group interview guide

1. Please draw a drawing that how you feel about doing the work you do at Tintswalo hospital as part of the vocational rehabilitation programme. Think of ways in which the programme has assisted you with regards to work.
2. Please describe your picture that you have drawn to the group.
3. Why have you chosen to draw this particular picture?
4. The group discussion will come from your individual drawn pictures.



APPENDIX 4



OFFICE OF THE DIRECTOR: RESEARCH RESEARCH AND INNOVATION DIVISION

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16 January 2017

Mr H Msimango
Occupational Therapy
Faculty of Community and Health Sciences

Ethics Reference Number: BM/17/1/19

Project Title: Mental health care users' perceptions and experiences of a hospital-based vocational rehabilitation programme in a rural setting.

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.

A handwritten signature in black ink, appearing to read 'Josias'.

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

PROVISIONAL REC NUMBER -130416-050

APPENDIX 5



No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province
Private Bag X11285, Mbombela, 1200, Mpumalanga Province
Tel t +27 (13) 766 3429, Fax: +27 (13) 786 3458

Lilika Letempho

Departement van Gesondheid

UmNyango Wazolaphilo

Escuaries: Theoria Mulanga (013) 786 3811

15 February 2017

Mr Henry Msimango
Tintswalo Hospital Street 11 B
Acornhoek
BUSHBUGRIDGE
1320

Dear Mr Henry Msimango

APPLICATION FOR RESEARCH & ETHICS APPROVAL: MENTAL HEALTH CARE USERS' PERCEPTIONS AND EXPERIENCES OF A HOSPITAL-BASED VOCATIONAL REHABILITATION PROGRAMME IN A RURAL SETTING

The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent.

PHREC REF: MP_2017RP58_373

UNIVERSITY of the
WESTERN CAPE

Kindly ensure that the study is conducted with minimal disruption and impact on our staff, and also ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards


MS. T.Z. MADONSELA
MPUMALANGA PHRC



15/02/2017
DATE



APPENDIX 6



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 13-795 8706 Fax: 27 13-795 8200

E-mail: sthandwa.j@gmail.com



Project Title:

Mental health care users' perceptions and experiences of a hospital-based vocational rehabilitation programme in a rural setting.

What is this study about?

This is a research project being conducted by Mr. Henry Msimango who is studying for a master's degree in occupational therapy at the University of the Western Cape. The reason you are invited to participate in the study is because of the experience you have in the Tintswalo hospital work programme. The purpose of this study is to explore and describe the perceptions and experiences of people regarding the usefulness of the work rehabilitation programme.

What will I be asked to do if I agree to participate?

You will be required to participate in either a semi structured interview or a group interview. The interviews will take place in the occupational therapy office at the hospital or at a place convenient for you and will last for about 45 minutes or less. You will be asked to answer questions about the work activities and how you experienced it. You will also be asked your views regarding the usefulness of the work activities in preparing you for a real job.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. The researcher will keep your personal information confidential. To help protect your confidentiality, the information given will be kept in a pass-word protected computer folder and in a locked cabinet in the occupational therapy office where it will be accessed by the researcher. If I need to write a report or article about this research project, your name and any information by which you could be identified will not be included. This study will use focus groups therefore if you participate in the focus group the extent to which your identity will remain confidential is dependent on the participants in the Focus Group maintaining confidentiality.

What are the risks of this research?

There may be some risks from participating in this research study as all human interaction and talking about self or others carry some amount of risks. I 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. If talking about yourself and with other people make

you feel sad or uncomfortable, you will be referred to a suitable professional for assistance or treatment.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researchers to learn more about how you perceived and experienced the work programme. This may then guide the occupational therapist in the manner in which the programme could be developed. In future, other people might thus benefit from this study.

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, nothing will happen to you as you will not be penalized.

What if I have questions?

This research is being conducted by Mr. Msimango Henry, an occupational therapist and master's student at the University of the Western Cape. If you have any questions about the research study itself, please contact Mr. Msimango Henry at tel. 013 795 8706 or at sthandwa.j@gmail.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:

Prof Mogammad Shaheed Soeker

Head of Department: Occupational therapy

University of the Western Cape

Private Bag X17

Bellville 7535

msoeker@uwc.ac.za

OR



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

This research has been approved by the University of the Western Cape's Biomedical Research

Ethics Committee REFERENCE NUMBER:

APPENDIX 7



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E-mail: sthandwa.j@gmail.com

Ntiviso wa dyondzo



Vito ta dyondzo : mavonelo ni swilanguteriwa leswi vavabyi va miehleketo va nga ni wona eka phurogiramu ya vutshunguri bya le matiko- xikaya.

Xana dyondzo leyi yi vulavula hi yini?

Ndzavisiso lowu wu fambisiwa hi Nkulukumba Henry Msimango loyi a tlhuvutsaka tidyondzo ta yena ta Masters eka ntlawa lowu vuriwaka occupational therapy e Yunivhesithi ya Western Cape. Xivangelo xa ku va mi rhambiwa eka ku nghenelela ka lavinsiso lowu hi leswaku vumbhoni ni leswi mi swi voneke ni mapfunelo ya le xibendlhele xa Tintswalo. Xivangelo xa dyondzo leyi I ku lavisisa no hlamusela mavonelo, matitwelo ni ku pfuneka ka vavabyi lava va nga eka purogiramu ya vutshunguri bya xibendhlele xa Tintswalo.

Xana I yini lexi ndzi nga komberiwaka ku xi endla loko ndzo pfumela ku nghenelela eka dyondzo leyi?

U languteriwa ku va u hlamula swivutiso hi ntlawa kumbe ni vanhu van'wana. Swivutiso swi ta vutiseriwa a hofisini ya 'occupational therapy' esibendlhele kumbe e ka ndzhawu yin'wana ni yin'wana leyi u yi tsakelaka. Swivutiso swi ta teka kwalomu ka timinete ta 45 kumbe ehansi ka 45. U tava u karhi u vutisiwa hi leswi swi humelalaka mayelana ni ntirho nakambe u ta vutisiwa leswaku u titwa njhani hi swona. U ta vutisiwa hi mavonelo ya wena mayelana ni matirhelo lawa u dyondzisiweke wona ku ku lunghisela ku ya entirhweni wa ntiyiso.

Xana ku nghenelela ka mina eka dyondzo leyi swi ta sirheleliwa ke?

Valavisisi va ta sirhelela hinkwaswo leswi u swi vuleke nakambe va ta sirhelela wena. Mulavisisi u ta sirhelela mavito ni hinkwaswo leswi swi faneleke swi sirheleliwa. Ku pfuneta eka nsirhelelo, swilo hinkwaswo leswi unga ta va u swi vurile swi ta khiyeleriwa kumbe ku hlayisiwa eka khomphyutara e hofisini ya 'occupational therapy' laha swi nga ta kuma hi mulavisisi wa dyondzo leyi ntsena. Loko ndzi ta lava ku tsala mbuyelo ndzavinsiso wa mina a ndzi nge tshuki ndzi tsarile mavito kumbe swin'wana leswi nga ta ku chela ekhombyeni. Vangheneleli ya dyondzo leyi va ta hlamula hi mintlawa leswi vulaka leswaku leswi unga ta va u swi vurile swi ta va xihundla.

Xana ndzavisiso lowu wu ni makhombo yahi?

Ku ni makhombo yo tala eka ku nghenelela eka ku hlamula swivutiso swa ndzavisiso lowu. Xivangelo hi leswaku tani hi vanhu mi ta va mi karhi mi vulavula. Kambe a hi nge tshuki hi pfumelerile khombo kumbe xirhalanganyi xi nghenelela eka ndzavisiso lowu. Hi ta papalata ku khunguvanyeka ka wena loko u ri ku hlamuleni ka swivutiso. Loko ku ri hiku ku vulavula laha ku

nga ni vanhu swa ku khunguvanyisa kumbe ku a swi ku khomi kahle hi ta ku rhumela eka munhu loyi anga ta ku pfuna kumbe ku ku tshungula

Xana unga vuyeriwa hi yini eka ndzavisiso lowu?

Ndzavisiso lowu awu endleriwanga ngopfu ngopfu ku pfuna, kambe mbuyelo wa wona wu nga pfuna valavisisi vanwana eka ku ku ngetela vutivi eka leswi va swi tivaka hi phurogiramu leyi. Ndzavisiso lowu wu nga pfuna madokodela eka ku antswisa phurogiramu. E ka vumundzuku, vanhu van'wana va nga vuyeriwa eka ndzavisiso lowu.

Xana ndzi boheka ku tshama eka ndzavisiso kumbe ndzi nga huma nkarhi wun'wana ni wun'wana ke?

Ku nghenelela ka wena eka ndzavisiso lowu swi le ka wena. U nga hlawula ku ka u nga ngheneleli, loko wo hlawula ku nghenelela eka ndzavisiso lowu, u nga huma nkarhi wun'wana ni wun'wana. loko wo hlawula ku ka u nga ngheneleli kumbe u huma swa ha ri exikarhi, a wu nge endliwi nchumu.

Loko ndzi ri na swivutiso ke?

Ndzavisiso lowu wu fambisa hi Nkulukumba Msimango Henry, xichudeni xa ' occupational therapy' xa masters e Yunivhesithi ya Western Cape. Loko u ri ni swivutiso mayelana ni ndzavisiso lowu unga ha ti hlanganisa na mina eka 013 795 8706 kumbe u tsalela sthandwa.j@gmail.com

Loko u ri ni swivutiso hi nzavisiso kumbe dyondzo leyi kumbe mayelana na timfanelo ni ku lava ku sola leswi swo ka swi nga ku tsakisangiki hi mayelana ni ndzavisiso, u nga ha ti hlanganisa na:

Prof Mogammad Shaheed Soeker

Nhloko Ya Diphatimede: Occupational therapy

University of the Western Cape

Private Bag X17

Bellville 7535

msoeker@uwc.ac.za

Kumbe



Prof José Frantz

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

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chs-deansoffice@uwc.ac.za

Ndzaviso lowu wu pasisiwile ni ku kandziyisiwa hi komiti ya vulavisisi ' Biomedical ' ya Yunivhesithi Ya Western Cape. Nomboro ya ndzavisiso:



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CONSENT FORM

Mental health care users' perceptions and experiences of a hospital-based vocational rehabilitation programme in a rural setting.



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.....



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E-mail: sthandwa.j@gmail.com

Fomo ya pfumelelano

Vito ta dyondzo: Mavonelo ni swilanguteriwa leswi vavabyi va miehleketo va nga ni wona eka phurogiramu ya vutshunguri bya le matiko- xikaya.

Dyondzo leyi yi tisiwile eka mina no hlamuseriwa eka mina hi ririmi leri ndzi ri twisisaka. swivutiso swa mina eka dyondzo leyi swi hlamulekile. Ndza swi twisisa leswaku dyondzo leyi yi katsa yini naswona a ndzi bohiwi hi nchumu ku hlamula eka yona. Ndza swi twisisa leswaku vumbhoni bya mina eka dyondzo leyi byi nge tivisiwi munhu wun'wana. Ndza swi twisisa leswaku ndza pfumeleriwa ku tshika nkarhi wunwana ni wunwana ehandle ko nyika xivangelo, ehandle ka ku chava kumbe ku lahlekeriwa hi swo karhi.

Vito.....

Nsayino.....

Siku.....



UNIVERSITY *of the*
WESTERN CAPE